Care4Care
WE CARE FOR THOSE WHO CARE

D4.3. Country-based Descriptive Report of Care Workers' Well-being

Results per Country

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Partners:

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ABOUT THIS REPORT

This report accompanies the Care4Care project's main report, 'Quantitative and Qualitative Dataset'. Results per Target and Country'. Its purpose is to provide a brief country snapshot. It includes six chapters: France, Italy, Germany, Spain, Poland and Sweden (in that order). Each chapter follows the same structure as the general report. It begins with a short profile of the survey participants in the country and then summarises the levels they reported for key indicators, such as negative and positive well-being, work-related risk factors (demands) and protective factors (resources). This is followed by a concise overview of the predominant themes that emerged from focus group discussions with care workers, which highlight issues that help to interpret the survey results. Together with the main report, these country notes provide European policymakers, social partners and other stakeholders with clear, comparable insights to facilitate discussion.

How the Survey Data Was Collected

This cross-national study examined the perceptions of care workers in six European countries (Spain, France, Italy, Germany, Poland and Sweden) regarding their job-related risk factors, job-related protective factors and well-being. The project entailed two data collection components: a general cross-sectional survey and a weekly longitudinal questionnaire completed over a period of four weeks. The general survey collected data on demographics, employment conditions and perceptions of risk and protective factors over the past year. The weekly questionnaire, conducted over four consecutive weeks, assessed how job risks and protective factors influenced the well-being outcomes over time. This repeated-measures approach, often known as a diary study, sheds light on short-term variations in workers' experiences and minimises recall bias.

Recruiting Care Workers Across Europe

The target population included care workers who were currently employed in home-based or institutional settings. Participants were classified into three groups:

A. Home health aides: care workers who provide care at home, often without formal training.

B. Basic care workers: staff with short-term training working in care institutions, often occupying intermediate level occupations.

C. Professional care workers: individuals with vocational training or a healthcare degree.

Participants were recruited through associations and care institutions, as well as through snowball sampling. Incentives (€20) were offered to those who completed all the questionnaires. Participation was voluntary, and the recruitment process aimed to ensure a mix of rural and urban settings, as well as public and private providers.

From Consent to Completion: Study Steps

Data collection took place between 2024 and 2025 via the Qualtrics platform. After providing informed consent, participants completed the first three sections of the general survey during Week 1:

1. Section 1: Control variables.
2. Section 2: Risk factors (job demands) and Protective factors (job resources).
3. Section 3: Well-being outcomes (positive and negative indicators).

From Weeks 2 to 5, participants received a brief weekly questionnaire (5-10 minutes), for which they were sent reminders each weekend. In Weeks 6-7, participants were contacted to receive their incentive payment once completion was confirmed. A unique code was used to match responses over time while maintaining anonymity.

The Measures Behind the Results

Both the general and weekly surveys included validated scales that had been adapted into the required languages via translation and back-translation. The scales in the weekly version were shortened and reworded reflect weekly experiences (e.g. 'This week...'). The instruments included:

- Job demands/resources: COPSOQ-ISTAS21-III[1]; Autonomy Scale[2]; Intragroup Conflict Scale[3]; Workplace Incivility Scale[4]; Experiences of Discrimination Scale[5]; Requests to

[1] Burr, H., Berthelsen, H., Moncada, S., Nübling, M., Dupret, E., Demiral, Y., Oudyk, J., Kristensen, T. S., Llorens, C., Navarro, A., Lincke, H.-J., Bocéréan, C., Sahan, C., Smith, P., & Pohrt, A. (2019). The Third Version of the Copenhagen Psychosocial Questionnaire. *Safety and Health at Work, 10*(4), 482–503.

[2] Bakker, A. B., & Bal, P. M. (2010). Weekly work engagement and performance: A study among starting teachers. *Journal of Occupational and Organizational Psychology, 83*(1), 189–206.

[3] Jehn, K. A. (1995). Multimethod examination of the benefits and detriments of intragroup conflict. *Administrative Science Quarterly, 40*, 256-282.

[4] Cortina, L. M., Kabat-Farr, D., Leskinen, E. A., Huerta, M., & Magley, V. J. (2013). Selective incivility as modern discrimination in organizations evidence and impact. *Journal of Management, 39*, 1579 –1605.
Matthews, R. A., & Ritter, K. J. (2016). A concise, content valid, gender invariant measure of workplace incivility. *J. Occup. Health Psychol. 21*, 352–365.

[5] Williams, D. R., Yan Yu, Jackson, J. S., & Anderson, N. B. (1997). Racial Differences in Physical and Mental Health: Socio-economic Status, Stress and Discrimination. *Journal of health psychology, 2*(3), 335–351.

perform tasks beyond job duties[6].

- Support: Social Interactions at Work Scale[7] (Peeters et al., 1995).
- Well-being: Oldenburg Burnout Inventory (OLBI)[8]; Borg Rating of Perceived Exertion Scale[9]; Intention to Quit Questionnaire[10]; Work-Family Enrichment Scale[11]; COPSOQ-ISTAS21-III Work-Life Conflict Scale; and Flourishing Scale[12].

Ethical Approval and Participant Safeguards

All procedures were approved by the Ethics Committees of both the University of Seville and the Swedish Ethical Review Authority. Participants provided informed consent and confidentiality was ensured. Personal identifiers were collected separately and used solely for follow-up and payment purposes.

How the Data Was Analysed

The data were analysed using SPSS, Mplus and Jamovi. Descriptive statistics (frequencies, means and standard deviations) were reported, and inferential analyses (ANOVA, regression and repeated measures tests) were conducted at a significance level of $p < .05$. Only participants who completed the general survey in full and at least three weekly surveys were included in the longitudinal analysis. Of these, 582 participants completed the general survey, and 437 participants completed both the general survey and the weekly surveys.

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[6] Karlsson, N. D., Markkanen, P. K., Kriebel, D., Galligan, C. J., & Quinn, M. M. (2020). "That's not my job": A mixed methods study of challenging client behaviors, boundaries, and home care aide occupational safety and health. *American journal of industrial medicine, 63*(4), 368–378.

[7] Peeters, M. C. W., Buunk, B. P., & Schaufeli, W. B. (1995). Social interactions, stressful events and negative affect at work: A micro-analytic approach. *European Journal of Social Psychology, 25*(4), 391–401.

[8] Demerouti, E., Mostert, K., & Bakker, A. B. (2010). Burnout and work engagement: a thorough investigation of the independency of both constructs. *Journal of occupational health psychology, 15*(3), 209–222.

[9] Borg G. (1970). Perceived exertion as an indicator of somatic stress. *Scandinavian journal of rehabilitation medicine, 2*(2), 92–98.

[10] Price, J.L. (1997). Handbook of organizational measurement. *International Journal of Manpower, 18*(4/5/6), 305-558.

Rahnfeld, M., Wendsche, J., Ihle, A., Müller, S. R., & Kliegel, M. (2016). Uncovering the care setting-turnover intention relationship of geriatric nurses. *European journal of ageing, 13*(2), 159–169.

[11] Kacmar, K. M., Crawford, W. S., Carlson, D. S., Ferguson, M., & Whitten, D. (2014). A short and valid measure of work-family enrichment. *Journal of Occupational Health Psychology, 19*(1), 32–45.

[12] Diener, E., Wirtz, D., Tov, W., Kim-Prieto, C., Choi, D., Oishi, S., & Biswas-Diener, R. (2009). New Measures of Well-Being: Flourishing and Positive and Negative Feelings. *Social Indicators Research, 39*, 247-266.

Table 1. *General survey and weekly questionnaire response rate per country*

Country	Surveys sent	Completed GS	Completion rate GS	Completed GS+WQ	Completion rate GS+WQ
Spain	316	157	49,7%	111	35,1%
Germany	214	139	65,0%	113	52,8%
France	200	102	51,0%	73	36,5%
Italy	253	106	41,9%	73	28,9%
Poland	142	78	54,9%	67	47,2%
Total	**1125**	**582**	**51,7%**	**437**	**38,8%**

***Note*: GS - General Survey (sent in three parts), WQ - Weekly questionnaires (3 consecutive at the least). "Survey sent" indicates the number of individuals that agreed to participate and were sent the questionnaires.**

Table 2. *General survey number of observations*

Country	Target A	Target B	Target C	Total
Spain	303	105	63	471
Germany	45	114	258	417
France	186	63	57	306
Poland	42	66	126	234
Italy	72	144	102	318
Total	**648**	**492**	**606**	**1746**

***Note*: The General Survey was divided into three parts to avoid respondent fatigue. The numbers result from multiplying the total number of participants by three, which gives the total number of completed questionnaires in the General Survey dataset.**

Table 3. *Weekly questionnaire number of observations*

Country	Target A	Target B	Target C	Total
Spain	322	83	32	437
Germany	36	136	269	441
France	195	55	40	290
Poland	43	71	152	266
Italy	56	119	114	289
Total	**652**	**464**	**607**	**1723**

***Note*: Participants who completed at least three consecutive weekly questionnaires were included in the longitudinal/weekly dataset (most completed all four consecutive weeks). The table shows the number of weekly questionnaires completed by each group in each country.**

How Consistent the Measures Were

The internal consistency of the scales was assessed and found to be acceptable to good overall, with Cronbach's alpha coefficients exceeding 0.70.

How the Focus Groups Were Conducted

Reaching Participants for the Focus Groups

A similar process to the quantitative study was used to recruit participants. Participants were contacted through associations, nursing homes and other care-oriented organisations. A convenience sample was approached. Therefore, people voluntarily participate in the study.

As general guidelines, each focus group aimed to have between 7 and 10 people, with 10 participants invited in case someone was absent. Once the meeting was convened, it was held regardless of the number of participants, as the organisational circumstances of each country and organisation were different. Participants in each focus group were homogeneous, that is, they did not belong to different hierarchical levels or different positions in the group or society. At the same time, they were diverse so that they could provide us with as much information as possible on the topics to be discussed. It was ensured that the discussion groups were not biassed by any variable due to the recruitment process, i.e., that information favourable or unfavourable to any topic was not sought a priori. The meetings were organised about 7-10 days in advance and a reminder was made a couple of days before.

Data was collected through 33 focus groups from different countries: France (8), 4 groups for Target A and 4 groups for Target B and C; Germany (5), 2 groups for Target A and 3 for Target B and C; Italy (6), 2 groups for Target A and 4 for Target B and C; Poland (5), all groups belonged to Target B and C and Spain (9), 6 groups for Target A and 3 groups for Target B and C. The index below shows the sociodemographic distribution of the different discussion groups by country and target. The presentation is in accordance with the chronological order in which the interviews were conducted in each country.

From Questions to Conversation: Conducting the Groups

All focus groups followed the instructions given in the training session for conducting the meeting. A pleasant place with no distractions and interruptions was assured. Before the discussion, participants were asked to sign the informed consent and about the possibility to record the session only to transcript their interventions. Anonymity and confidentiality was explained.

Discussion Guide and Key Topics

1. Presentation of the participants.
2. Brief explanation of the work the participants do, what are the main difficulties they face in their daily work.
3. Brief explanation of how work affects their personal life, their well-being. What are the main challenges?
4. A short explanation of the personal and social protective factors available to them.
5. A general assessment of how the participants' working conditions could be improved.

After the focus group participants were asked if they would like to receive information about the project and the conclusions drawn from the data they provided.

Qualitative Analysis Approach

A thematic analysis was conducted (Braun & Clarke, 2006). The recordings were transcribed in two stages: first, via the Trint program, chosen for its data protection features; then, the transcripts were manually reviewed, and those in a language other than Spanish were translated into English using the back-translation method as outlined by Beaton et al. (2000) and Brislin (1970).

Atlas.ti version 9 was used to analyze the transcripts, generating codes deductively through the JD-R theory model (Bakker & Demerouti, 2011) and inductively through information from the discussion groups. Bingham's (2023) 5-step coding guide was applied, which controls for researcher bias in code interpretation and assignment. This is a mixed coding method, as defined by Anguera et al. (2021). Three researchers were involved in the code review, analysis, and refinement process in accordance with the aforementioned guidelines.

Interpretation of Qualitative Results in Each Country

The qualitative results are presented by the target group. Within each group, risk factors (demands) and protective factors (resources) have been identified. Three domains have been differentiated for both: job, relational (where applicable) and personal. Each domain is depicted using a Sankey diagram. This diagram illustrates the topics that were identified, as well as how many times each topic was repeated in the various discussion groups. The thickness of the line connecting a topic to the target indicates how many times the topic has been repeated in the different discussion groups. The number of repetitions is indicated inside the coloured line. It is important to note that the importance of a topic is not determined by how often it is repeated. While this information is important, each topic must also be evaluated individually.

The general report provides a detailed description of the results of all the discussion groups, categorised by target. This specific country-report shows the results for each target by country. Although Sankey diagrams and a table showing the topics identified, along with a representative quote from each country's discussion group, are provided, we recommend referring to the general report for a more detailed interpretation of the results.

PART 1. CARE WORKERS IN FRANCE

Chapter 1. Quantitative Data Set: What the Surveys Revealed About Care Work in France

1.1. Profile of the Care Workforce Sample

A total of 102 care workers from France participated in the study, 62 from Target A (in red, home health aides), 21 from Target B (in green, basic care workers) and 19 from Target C (in dark blue, professional care workers). The average age of the participants was 41.63 years and the majority were women (95.1%). Most were married (61.8%) and worked in urban areas (64.7%).

Figure 1. *Participants per target group*

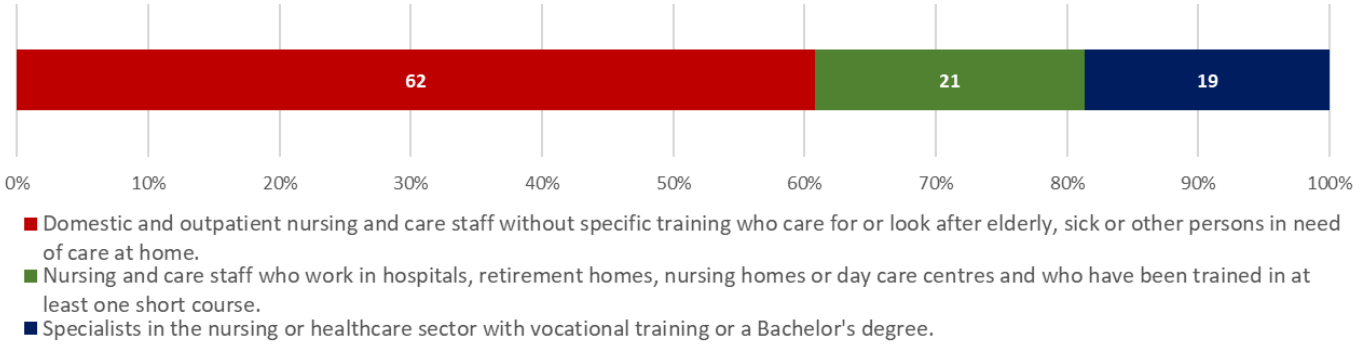


Figure 2. *Age groups*

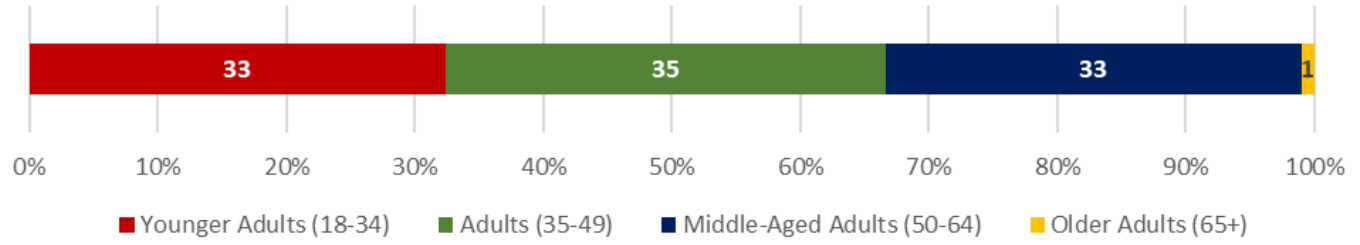


Figure 3. *Gender*

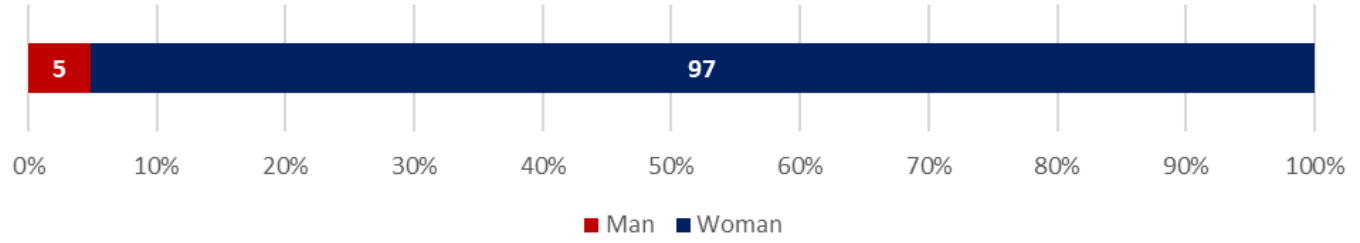


Figure 4. *Marital status*

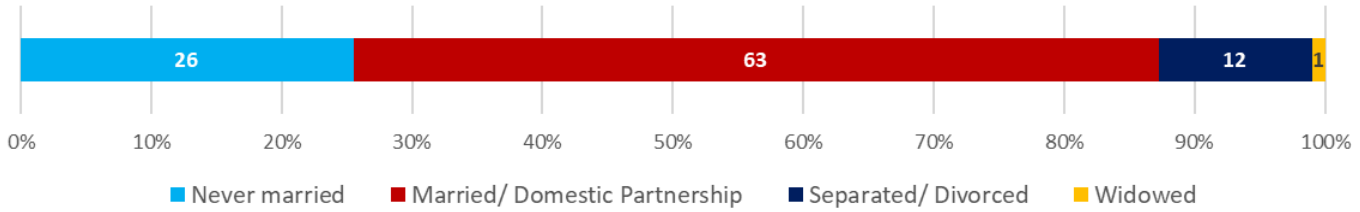
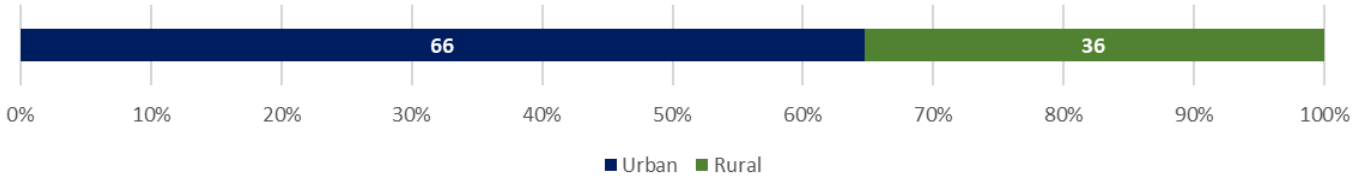


Table 4. *Descriptive statistics of the quantitative variables*

	N	Min	Max	Mean	SD
Age	102	21	66	41.63	12.07
Tenure in months	100	3	480	136.72	122.28
Monthly wages all participants	73	380	2700	1672.58	453.36
Monthly wages in Institutionalised care	29	850	2700	1914.65	440.79
Monthly wages in home based care	44	380	2500	1513.02	389.95
Hours worked in a week	97	7	157	33.17	19.56
Number of home care receivers in a week (HCWs)	66	2	210	19.80	27.77
Duration of stay (days in a week for live-in HCWs)	2	5	7	6	1.41
Months of residence (migrant workers)	8	12	636	324	249.33
Knowledge of benefits (out of 9)	102	0	9	3.38	2.55
Use of benefits (out of 9)	102	0	7	1.19	1.77

Figure 5. *Area of work*



Most participants were of French nationality (91.2%). A small number of participants reported being from other EU countries (Portugal, Belgium, Germany), African countries (Cameroon, Algeria, Benin) and Brazil. Educational levels were generally high, with 53.9% having completed post-compulsory education and 39.2% having completed secondary education. A small minority had only primary education (3.9%) or no formal education (2.9%). Most had received formal training in care services (78.4%).

Figure 6. *Nationality*

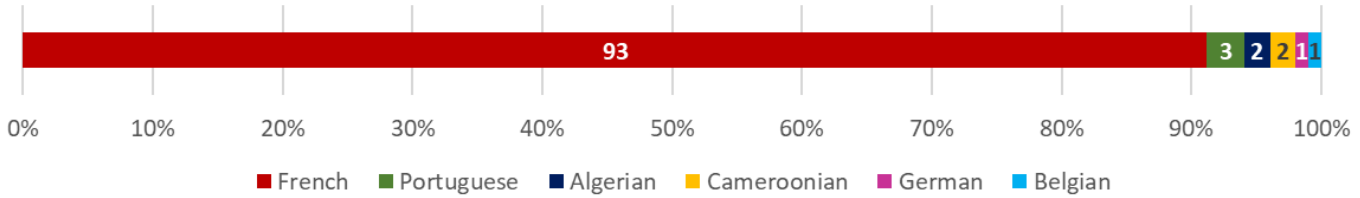


Figure 7. *Country of origin*

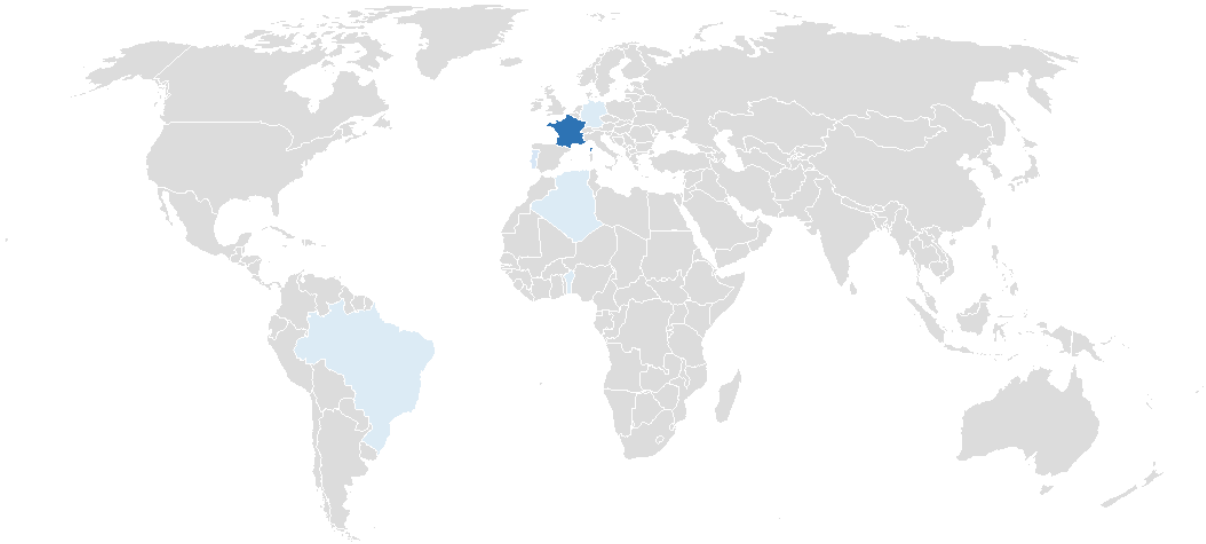


Figure 8. *Educational status*

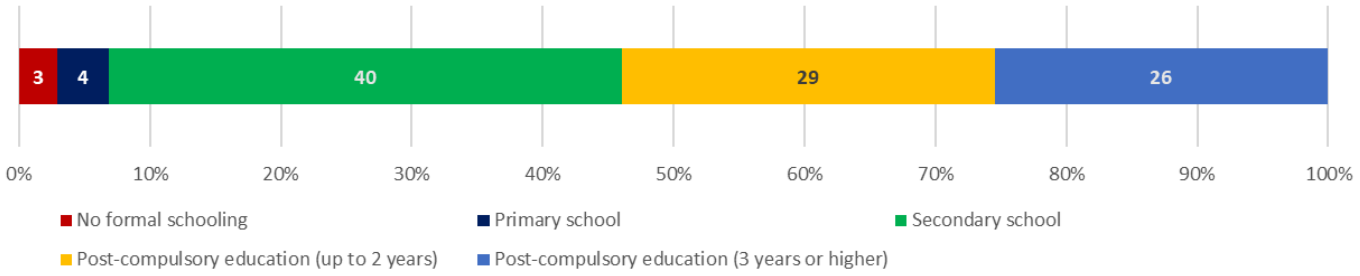
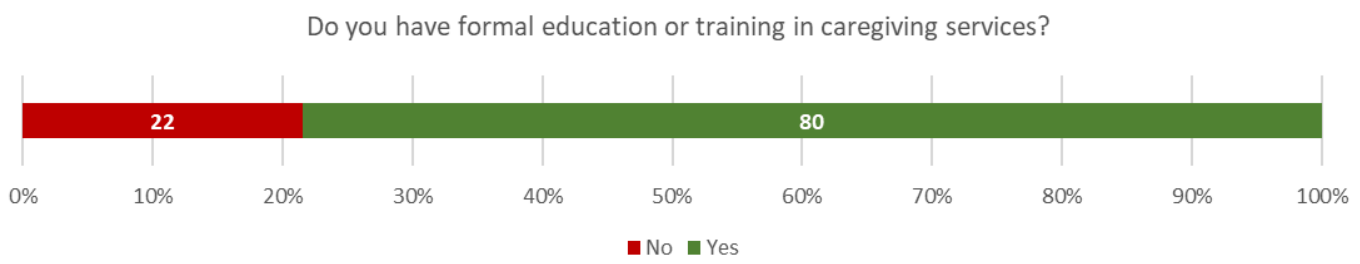
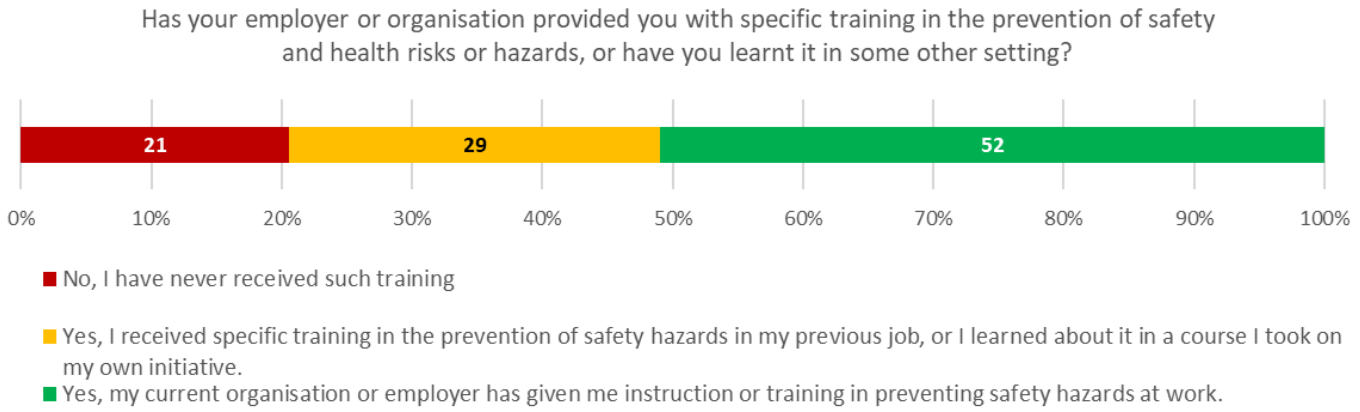


Figure 9. *Formal education in care services*



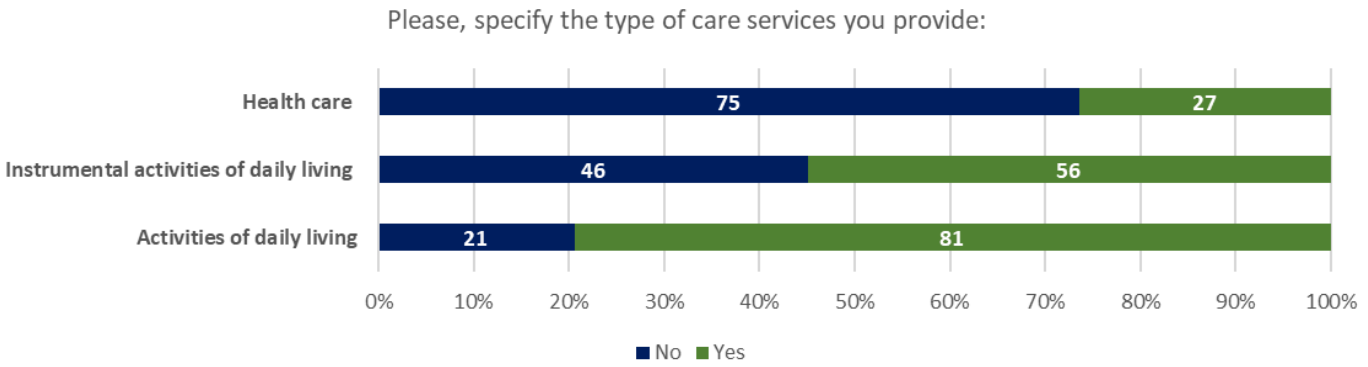
Just over half (51%) had received health and safety training from their current employer, while 28.4% had received such training in a previous job or on their own initiative. One in five workers (20.6%) had never received such training. On average, participants had over 11 years' experience in the care sector.

Figure 10. *Safety hazards training*



In terms of the types of care tasks performed, most participants reported engaging in both activities of daily living (ADLs) and instrumental activities of daily living (IADLs) more frequently than in health-related tasks. Training content appeared to be aligned with these responsibilities, as care workers were more likely to be trained in the tasks they performed regularly. However, a significant proportion (81.4%) reported a lack of training tailored to the specific diagnoses or health conditions of their care receivers. This is worrying given that 75.5% of participants reported caring for care receivers with specific health problems - most commonly mobility problems (90.2%), physical health conditions (87.3%) or behavioural and psychiatric disorders (87.3%).

Figure 11. *Type of care tasks they perform*



Note: **Activities of daily living or ADL** (dressing, toileting, mobility, bowel and bladder management, sleep time regulation, feeding, transferring from one position to another, personal hygiene, walking, caring for pets, personal care bathing, eating, toilet hygiene, grooming, ambulating, companionship and socialisation).
Instrumental activities of daily living or IADL (using the phone, shopping for groceries, managing medication, preparing meals, doing laundry, housekeeping, managing finances, assistance with using transportation).

Health services (nursing, auxiliary services, wound care, infusion therapy, physical or cognitive rehabilitation, injections, diagnostic services, prescriptions, treatment of injuries or illnesses, occupational therapy, hospice care, therapists and social workers.

Figure 12. *Type of formal education in care services*

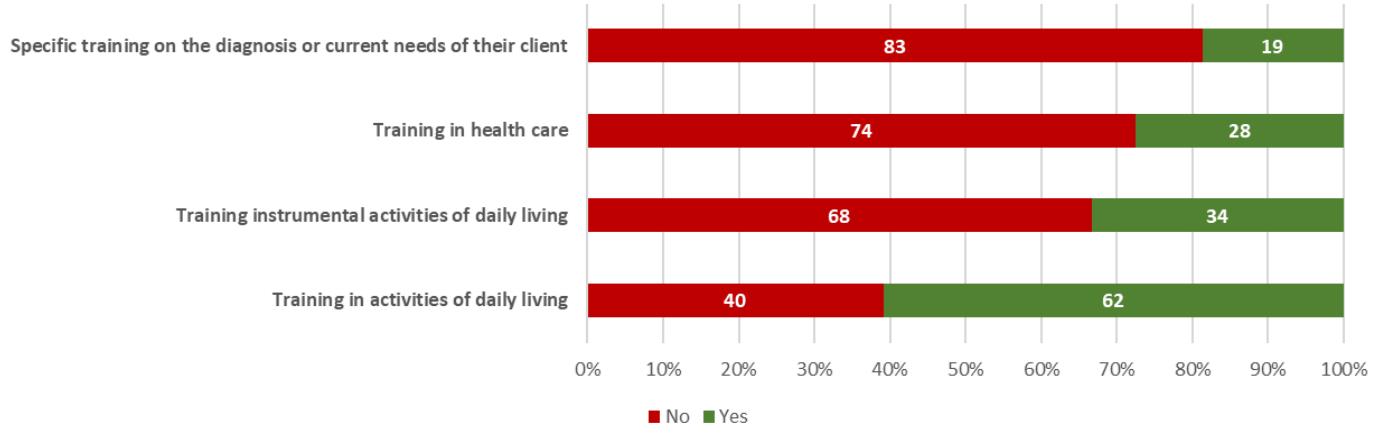
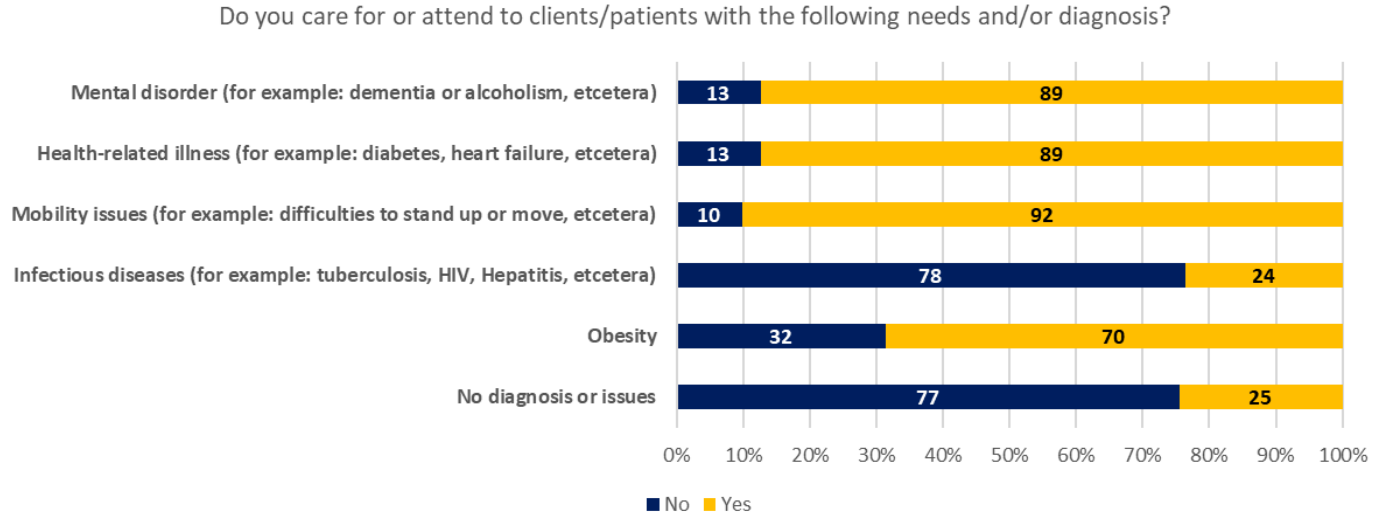


Figure 13. *Type of medical condition of the person receiving care*



Supervision was reported by 60.8% of workers. The remainder worked without direct supervision. Just over half worked in teams (52%), while the remainder worked independently with care receivers.

Figure 14. *Supervision*

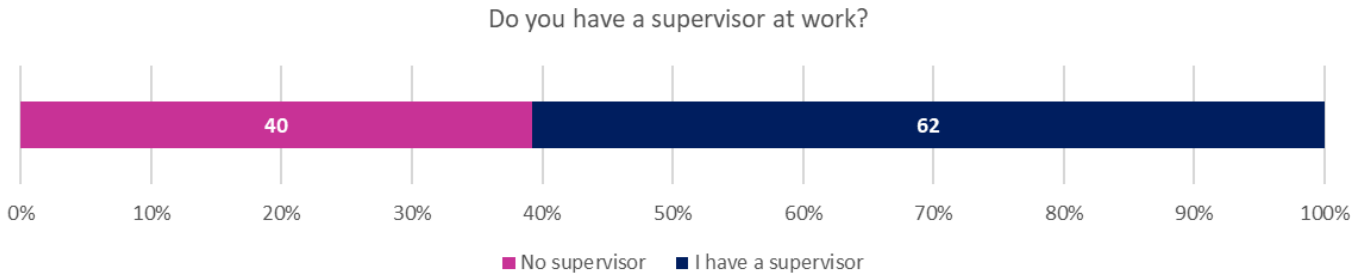
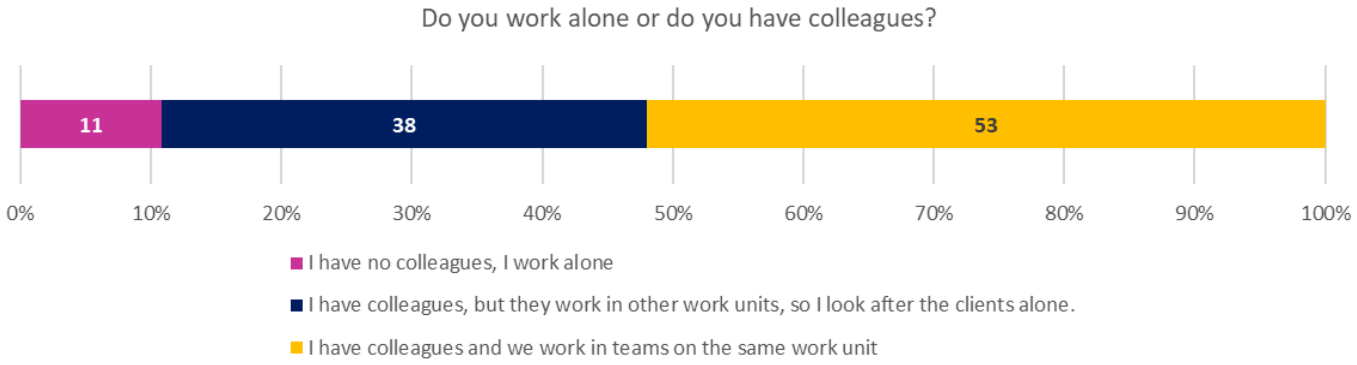


Figure 15. *Teamwork*



The majority were employed in the private or for-profit sector (57.8%), with fewer working in the public sector (24.5%) or as self-employed (23.5%). Union membership was low, with only 11.8% of participants belonging to a trade union or similar organisation. Most participants had full-time contracts (60.8%) and almost all (92.2%) had permanent jobs. Part-time contracts were reported by 39.2% and only a small number worked on temporary contracts. Almost half worked flexible hours (49%) and a similar proportion had fixed hours (47.1%). Shift work was rare (3.9%).

Figure 16. *Employment status*

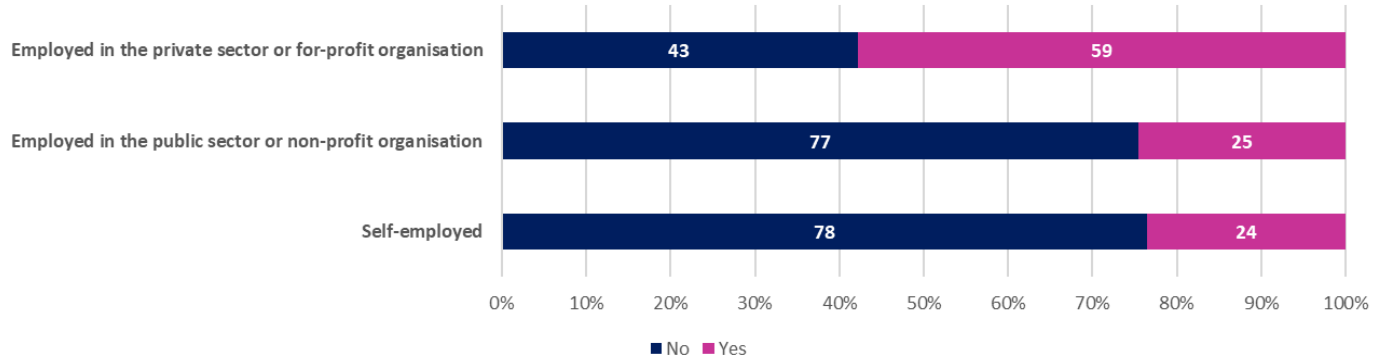


Figure 17. *Belonging to a union or association*

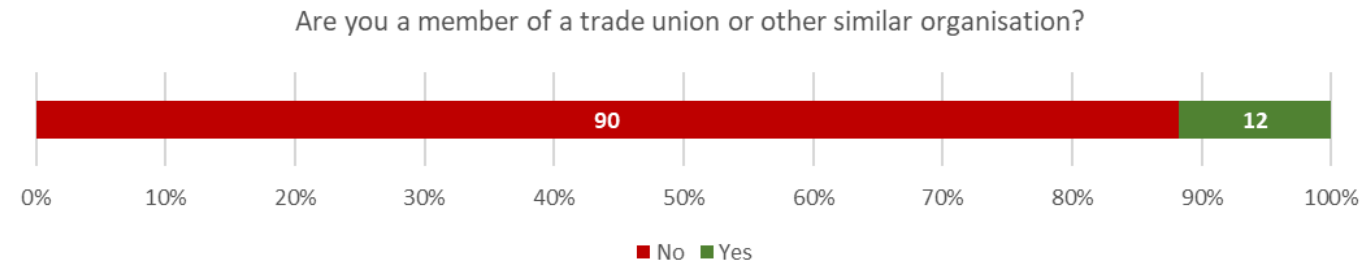


Figure 18. *Type and duration of contract*

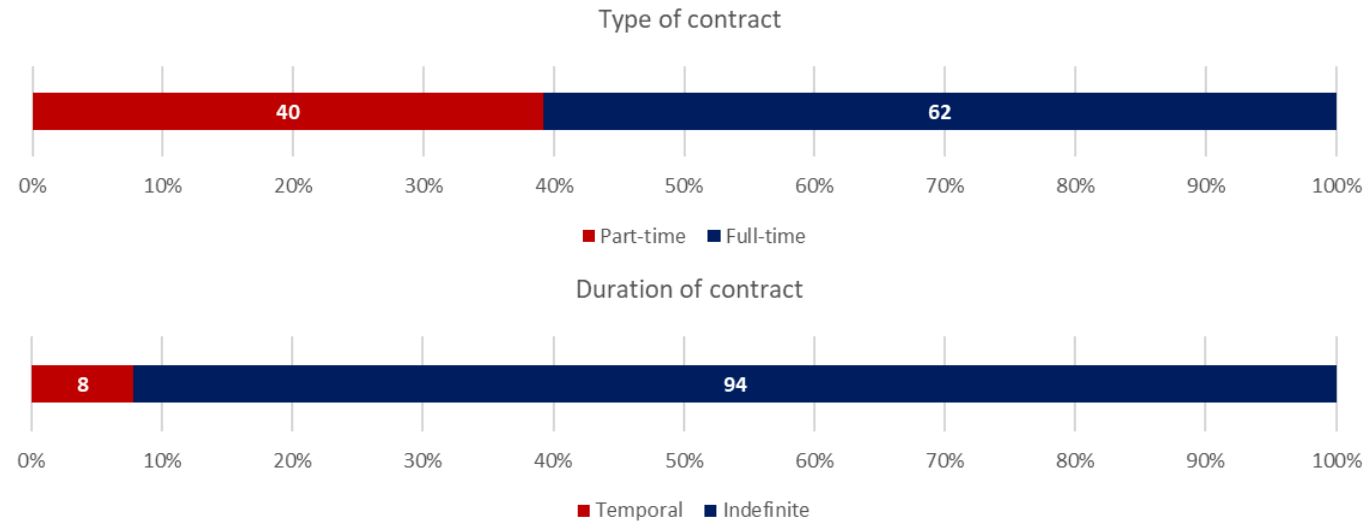
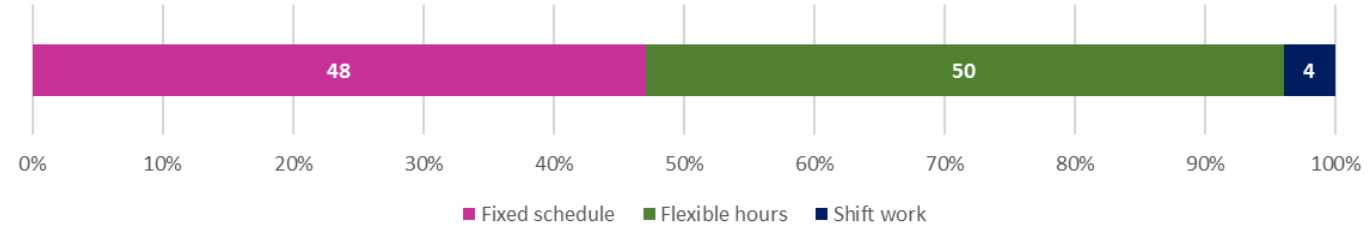


Figure 19. *Type of schedule or work shift*



Access to and use of workplace benefits and rewards was limited. On average, participants were aware of only a few of the benefits available to them, with paid vacation being the most common (74.5%). However, actual take-up or use of benefits was low across the board, including paid vacation (25.5%). Access to fuel reimbursement was limited (38.2%) and use was even lower (17.6%) - despite the fact that most care workers (88.2%) drove their own car to work. This represents a potential financial burden, particularly for home care workers who travel frequently, and may be exacerbated by the lower average wages reported by these workers compared to those in institutional care.

Most care workers from France reported having access to lifting equipment or mobility aids (89.2%), a resource that can reduce physical strain. On average, participants worked 33.2 hours per week.

Figure 20. *Knowledge and use of workplace benefits and/or rewards*

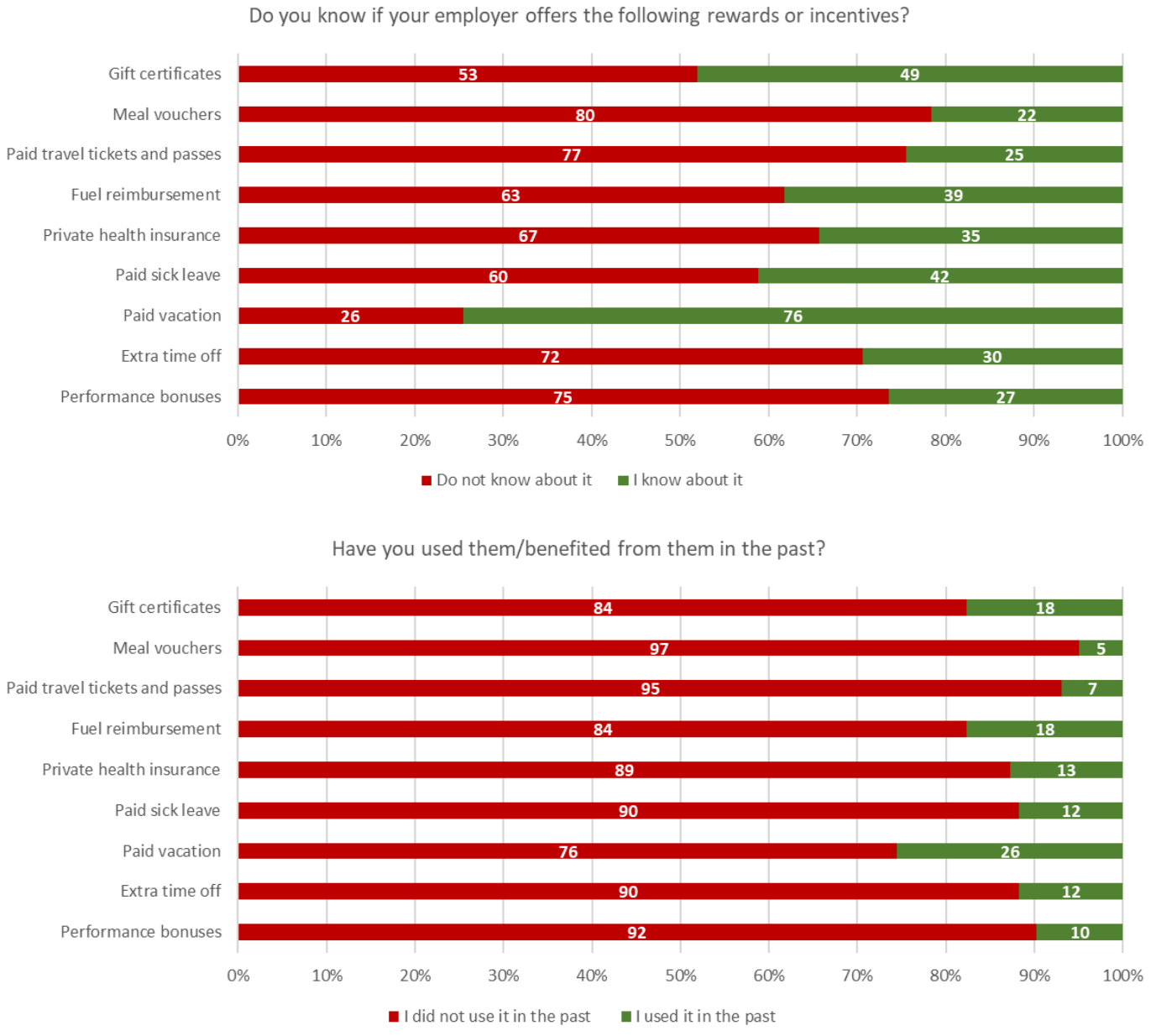


Figure 21. *Access to lifting aids or equipment*

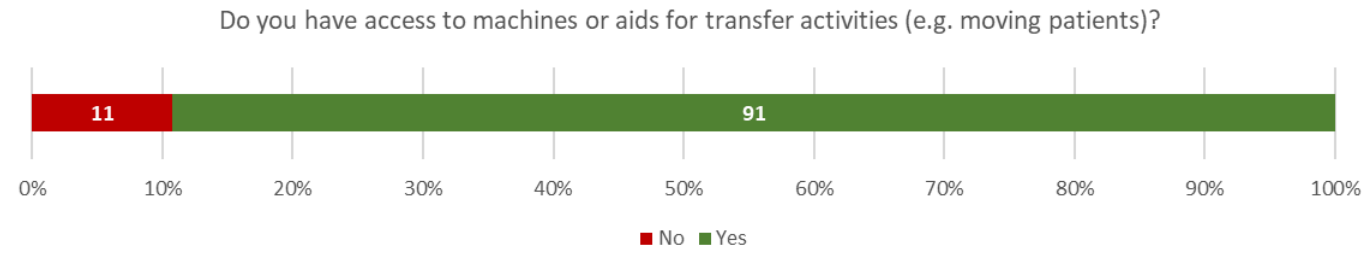
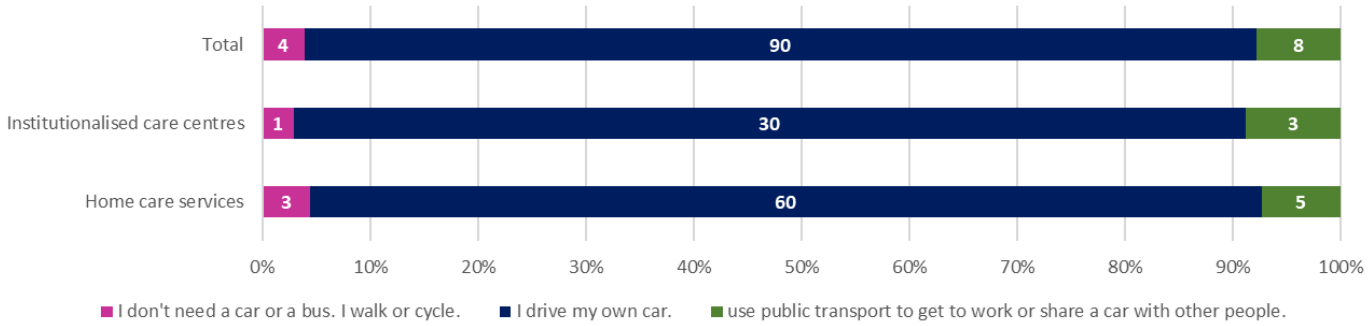


Figure 22. *Transport or commuting to work*



Two thirds of the participants were employed in home care and one third in institutional care. Two thirds of participants were employed in home care and one third in institutional settings. Among home care workers, almost all worked on a 'live-out' basis (97%), with very few employed as 'live-in' carers. Continuity of care was common: 23.9% had cared for the same care receiver for 6 to 12 months and 38.8% for more than a year. Home carers cared for an average of 20 care receivers per week, although this number varied considerably.

The sample of French participants included very few live-in carers (n = 2). In these cases, some problems with living conditions were reported, such as the lack of a private room, the lack of a personal wardrobe and exposure to extreme temperatures (especially excessive heat). Of the two live-in care workers, one stayed with his care receiver five days a week, while the other stayed full-time, seven days a week.

Figure 23. *Place of work*

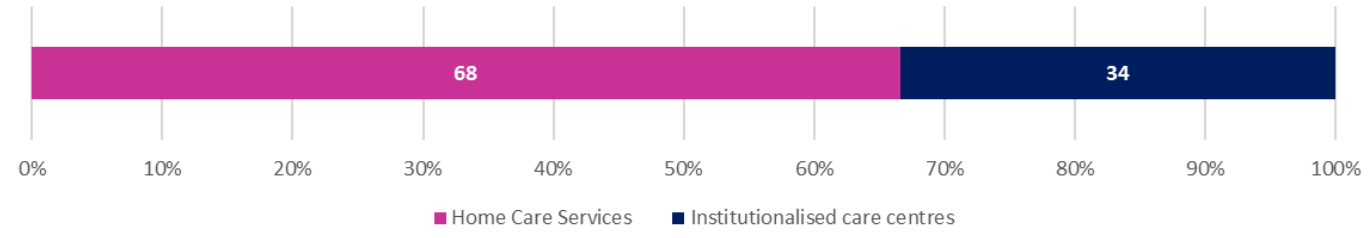


Figure 24. *Modality of home care work (HCWs)*

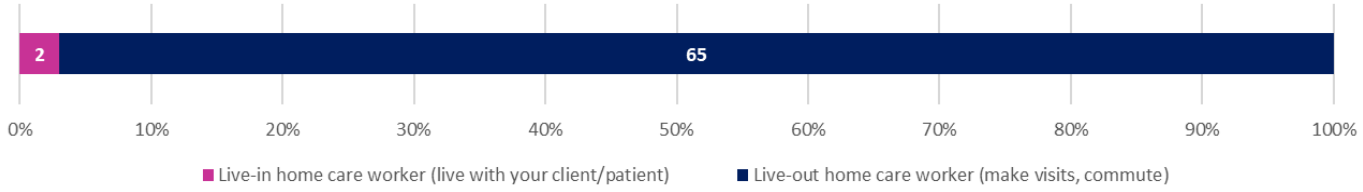


Figure 25. *Continuity of home care work (HCWs)*

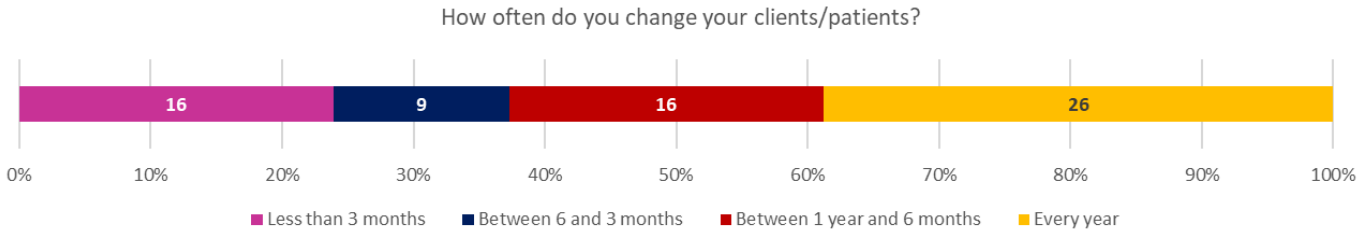
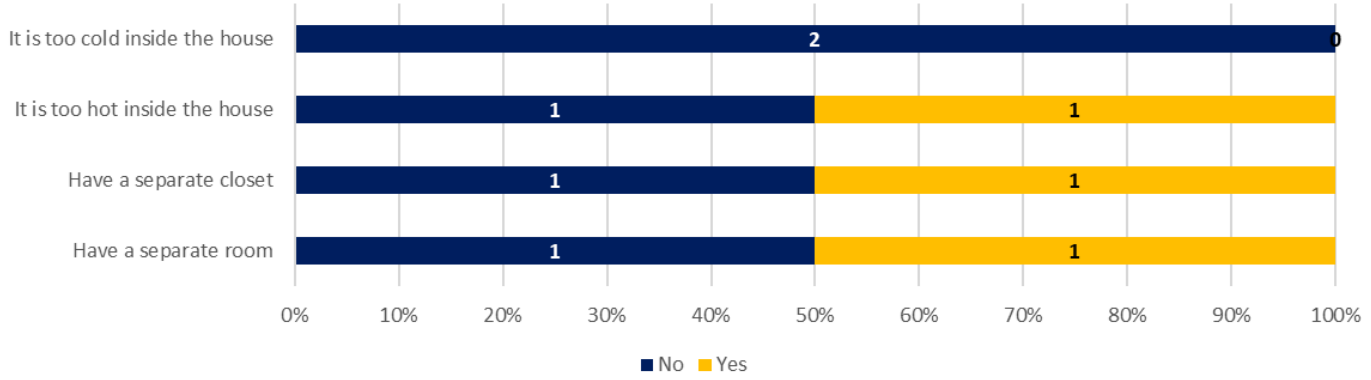


Figure 26. *Living conditions of live-in HCWs*



Only 8 participants were migrants (7.8%) and they had on average 324 months or 27 years of residence in France (SD=249.33 months). 6 of them had a permit to work within the country legally, while the other 2 did not. The majority of migrant workers had no problems with language dominance in their workplace. This was similar for all participants.

Only 8 participants (7.8%) were migrants, most of whom had lived in France for many years (average 324 months or 27 years of residence; SD=249.33 months). Six had legal work permits, and two did not. Language dominance did not appear to be a barrier in the workplace.

Figure 27. *Immigration status*

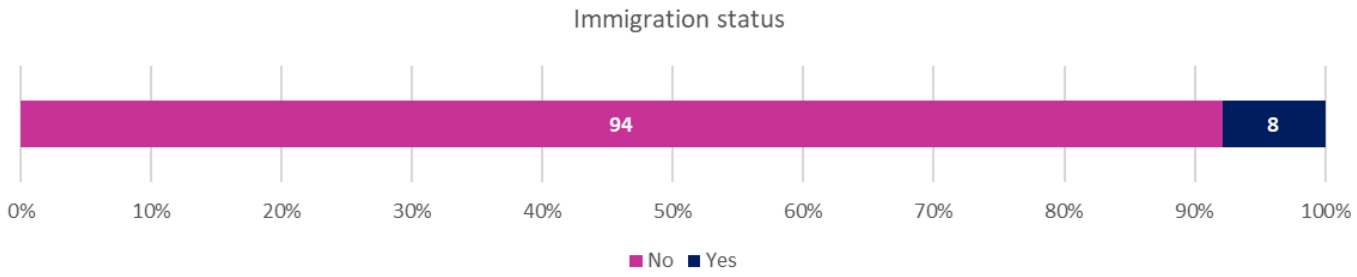


Figure 28. *Possession of work permit (migrant care workers)*

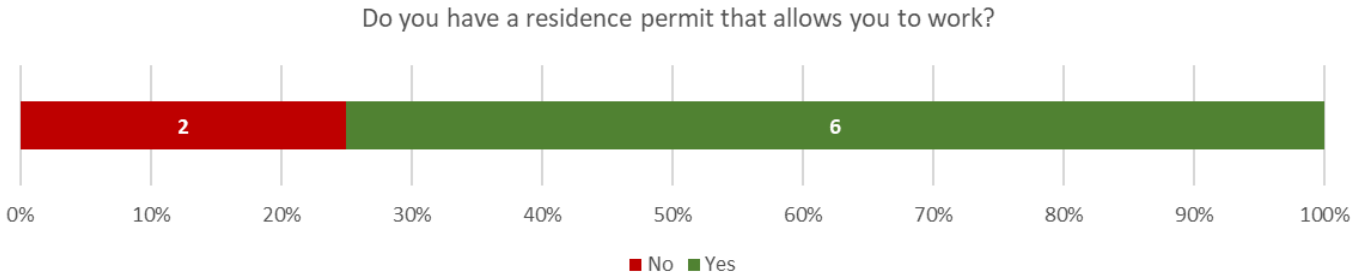
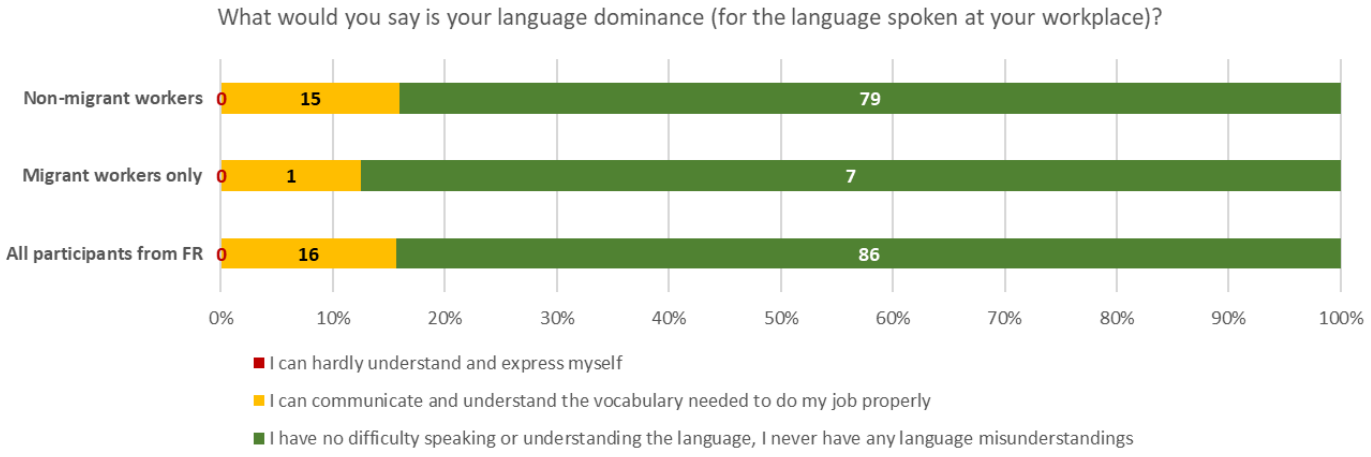


Figure 29. *Language dominance at the workplace*



1.2. Findings on prevalence: Comparing Well-Being, Risks and Protective Factors Across Targets

1.2.1. Well-Being Results

In this section, the outcomes of work are examined, considering both its positive and negative dimensions. The positive dimension is captured through indicators of psychological well-being or flourishing, while the negative dimension focuses on burnout and perceived strain. In addition, the impact of work on personal life is explored, concluding with a report on employees' expressed desire to leave their job if given the opportunity.

Table 5. *Main results of Wellbeing*

Outcomes	Target	Mean	S.D.	N
Burnout and Disengagement	Target A	2.74	0.40	62
	Target B	2.93	0.42	21
	Target C	3.04	0.39	19
	Mean	**2.83**	**0.42**	**102**
Happiness	Target A	7.47	1.38	62
	Target B	7.24	1.45	21
	Target C	7.42	1.47	19
	Mean	**7.41**	**1.40**	**102**
Perceived Exertion	Target A	5.85	2.32	62
	Target B	6.81	3.04	21
	Target C	4.95	2.66	19
	Mean	**5.88**	**2.58**	**102**
Turnover intentions	Target A	1.74	0.84	62
	Target B	2.25	1.14	21
	Target C	2.47	1.33	19
	Mean	**1.98**	**1.04**	**102**
Work-Private Life Conflict	Target A	2.41	0.87	62
	Target B	2.43	0.87	21
	Target C	2.74	0.60	19
	Mean	**2.47**	**0.83**	**102**
Work-Private Life Enrichment	Target A	3.58	0.72	62
	Target B	3.54	0.51	21
	Target C	3.29	0.76	19
	Mean	**3.52**	**0.69**	**102**
Flourishing	Target A	5.70	0.74	62
	Target B	5.60	0.94	21
	Target C	5.59	0.82	19
	Mean	**5.66**	**0.79**	**102**

Note: Target A: Home health aides; Target B: Basic care workers; Target C: Professional care workers.

Negative Indicators: Where Workers Are Struggling

Burnout Results. Burnout is a job-related syndrome that has been defined as a state of physical, emotional and mental exhaustion that results from prolonged exposure to chronic workplace stress that has not been successfully managed. This variable was assessed with the Oldenburg Burnout Inventory OLBI (Demerouti, et al. (2010). Two scales: disengagement (8 items) and psychological exhaustion (8 items). The responses ranged from 1 (strongly disagree) to 4 (strongly agree).

The average burnout score of the French care workers was 2.83 (SD = 0.42) on a scale of 1 to 4, indicating a moderately high level of burnout. This suggests that, on average, participants often felt exhausted and detached from their work. Significant differences were observed between the groups: professional care workers reported the highest levels of burnout, while home care aides reported the lowest.

Figure 30. *Cross-target burnout comparative results*

Physical Exertion Results. This construct refers to the perceived level of physical effort required from care workers during their working hours. In other words, it quantifies the degree of exertion that care workers perceive themselves to be experiencing in relation to the physical demands of their work. This variable was measured using the Borg Rating of Perceived Exertion Scale (RPE) (1970). The scale ranges from 1 (no exertion) to 11 (maximal exertion).

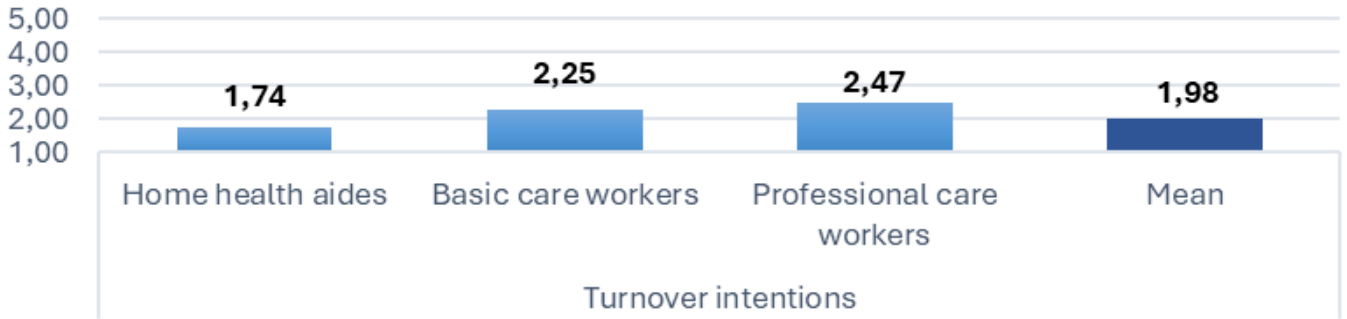
The average level of perceived physical exertion among French care workers was 5.88 (SD = 2.58) on a scale of 1 to 11, indicating a moderate perceived physical exertion associated with their work. Significant differences were found between the groups: basic care workers reported the highest levels of physical exertion, while professional care workers reported the lowest. These results suggest that perceived physical demands vary not only by care setting but also by the level of qualification of the workers.

Figure 31. *Cross-target physical exertion comparative results*

Turnover Intentions Results. This variable examined the intention or desire of care workers to leave or abandon their role within the care profession. It was measured using the Intention to Quit Questionnaire (ITQ), which was developed by Rahnfeld et al. (2016) and adapted from Price (1997). The ITQ comprises three items (example item 'despite the obligations I have made to my employer, I want to quit my job as soon as possible') that assess workers' intentions to quit their care job. Participants were asked to indicate the frequency of their intention to quit on a five-point Likert scale, with responses ranging from 1 (almost never) to 5 (almost always).

The mean score for turnover intentions among French care workers was 1.98 (SD = 1.04) on a scale of 1 to 5, indicating a generally low overall desire to leave the job. Significant differences were found between the groups: professional care workers reported the highest turnover intentions, while home health aides reported the lowest. This suggests that despite being more highly qualified and working predominantly in institutional settings, professional care workers may have greater intentions to leave their jobs than their less formally trained counterparts.

Figure 32. *Cross-target turnover comparative results*



Work-Private Life Conflict Results. This construct represents a form of inter-role conflict, characterised by a clash between the demands of one's professional role and those of their personal or familial responsibilities. The scale from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version, comprising five items (e.g., 'Do you feel that your work drains so much of your energy that it has a negative effect on your private life?'), was employed to measure the variable. The responses ranged from 1 (never) to 5 (always).

The mean score for work-life conflict among French care workers was 2.47 (SD = 0.83) on a scale of 1 to 5, indicating a moderate level of conflict between work and personal responsibilities. No significant differences were found between the groups, suggesting that work–private life conflict was experienced similarly across home health aides, basic care workers, and professional care workers.

Positive Indicators: Signs of Strength

Work-Private Life Enrichment Results. This variable pertains to a process at the work-private life intersection, in which experience or involvement in one role enhances the quality or performance in the other role. The six-item scale Work-family enrichment, as originally proposed by Carlson et al. (2006) and subsequently abbreviated by Kacmar et al. (2014), was employed to assess the variable in question. Participants were invited to indicate their level of agreement with each item on a five-point Likert scale, with responses ranging from 1 (strongly disagree) to 5 (strongly agree).

The mean score for work-life enrichment among French care workers was 3.52 (SD = 0.69) on a scale of 1 to 5, indicating that workers generally felt that their work experiences positively contributed to their personal lives and vice versa. No significant differences were found between the groups, suggesting that this positive interaction between work and personal life was similar across care settings and levels of qualification.

Happiness results. This construct was designed to assess care workers' general levels of happiness and their attitudes towards their own lives. The variable was assessed using a single item: ‘taken everything together, how happy are you with your life?’. Participants were instructed to indicate their level of satisfaction on a scale from 0 (totally unhappy) to 10 (extremely happy).

The mean happiness score for French caregivers was 7.41 (SD = 1.40) on a scale of 0 to 10, indicating a generally high level of overall happiness. No significant differences were found between the groups, suggesting that happiness was consistently high among home care aides, basic care workers, and professional care workers.

Flourishing results. The concept of flourishing can be defined as the combination of subjective and psychological well-being, in which the individual is in a positive emotional state, experiencing feelings of engagement, meaning (or purpose), having personal resources and positive interpersonal relationships. It is measured using a scale comprising eight statements (example items are 'I am optimistic about my future' and 'I lead a purposeful and meaningful life') (Diener et al., 2009), with respondents indicating their level of agreement on a scale from 1 (strongly disagree) to 7 (strongly agree).

The mean flourishing score among French care workers was 5.66 (SD = 0.79) on a scale of 1 to 7, indicating that workers generally reported high levels of overall well-being, engagement and positive functioning in their lives. No significant differences were found between the groups, suggesting that the sense of flourishing was consistent across home health aides, basic care workers and professional care workers.

1.2.2. Risk Factors among Care Workers

Drawing on the Job Demands–Resources (JD-R) theory (Bakker & Demerouti, 2011), which serves as the theoretical framework for this research, this section examines key findings related to job demands or risk factors as perceived by care workers.

Table 6. *Job, emotional and relational risk factors*

Risk factors	Target	Mean	S.D.	N
Physical Demands	Target A	4.03	1.33	62
	Target B	2.90	1.81	21
	Target C	2.79	1.32	19
	Mean	**3.57**	**1.54**	**102**
Quantitative Demands	Target A	2.40	0.72	62
	Target B	2.92	0.83	21
	Target C	317	0.60	19
	Mean	**2.65**	**0.79**	**102**
Work Pace	Target A	3.15	0.77	62
	Target B	3.60	0.99	21
	Target C	3.25	0.70	19
	Mean	**3.26**	**0.82**	**102**
Tasks Beyond Care Workers' duties	Target A	2.97	1.33	62
	Target B	2.24	1.00	21
	Target C	2.79	1.27	19
	Mean	**2.78**	**1.28**	**102**
Emotional Demands	Target A	3.10	0.81	62
	Target B	3.33	0.61	21
	Target C	3.56	0.61	19
	Mean	**3.23**	**0.75**	**102**
Demands for Hiding Emotions	Target A	4.08	0.64	62
	Target B	3.94	0.94	21
	Target C	4.01	0.56	19
	Mean	**4.04**	**0.69**	**102**
Exposure to Workplace Violence	Target A	1.95	0.78	62
	Target B	3.14	1.01	21
	Target C	2.37	0.76	19
	Mean	**2.27**	**0.95**	**102**
Exposure to Discrimination	Target A	0.24	0.76	62
	Target B	0.62	1.07	21
	Target C	0.00	0.00	19
	Mean	**0.27**	**0.79**	**102**
Intragroup Conflict	Target A	1.80	0.54	62
	Target B	2.29	0.66	21
	Target C	2.44	0.67	19
	Mean	**2.02**	**0.65**	**102**

Continuation Table 6.

Risk factors	Target	Mean	S.D.	N
Workplace Incivility	Target A	1.61	0.62	62
	Target B	1.86	0.71	21
	Target C	1.92	0.63	19
	Mean	**1.72**	**0.65**	**102**

Job-related Risk Factors

Physical Demands. This variable pertains to the frequency of physical activity that care workers are required to perform in order to fulfil the duties inherent to their role. These activities may include, but are not limited to, walking, lifting, carrying, reaching, pushing and pulling. Participants were asked to respond on a 5-point Likert scale, from 1 (never) to 5 (everyday).

The mean score for physical demands among French care workers was 3.57 (SD = 1.54) on a scale of 1 to 5, indicating that workers frequently performed physically active tasks required by their role, such as lifting, assisting with mobility or helping care receivers to move. Significant differences were found between the groups: home health aides reported higher physical demands than both basic care workers and professional care workers, who reported similar levels.

Figure 33. *Cross-target physical demands comparative results*

Quantitative Demands. Defined as the psychological demands that arise from the amount of work that must be completed within a given timeframe. These demands are typically high when the volume of work exceeds the capacity to complete it within the specified period. Four items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were employed to assess the job demand in question. An illustrative item is "Is your workload unevenly distributed so it piles up?". The respondents were asked to respond on a 5-point Likert scale, from 1 (never) to 5 (always).

The mean score for quantitative demands among French care workers was 2.65 (SD = 0.79) on a scale of 1 to 5, reflecting a moderate level of psychological demands resulting from the need to complete a high volume of work in a limited amount of time. Significant differences were found between the groups: home health aides reported lower levels of these demands than both basic care workers and professional care workers, who reported similar levels. This suggests that institutional care roles are associated with more frequent time-related workload pressures than home care.

Figure 34. *Cross-target quantitative demands comparative results*

Work Pace Demands. The term is defined as the psychological demand associated with the intensity of the work. To assess this job demand, three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were used. An illustrative item is, "Do you work at a high pace throughout the day?" Respondents were asked to indicate their level of agreement with the item on a 5-point Likert scale, from 1 (never) to 5 (always).

The mean score for work pace demands among French care workers was 3.26 (SD = 0.82) on a scale of 1 to 5, indicating a relatively high level of psychological demands related to the intensity or speed at which work must be performed. No significant differences were found between the groups, suggesting that care workers in all settings and at all levels of qualification have similar work pace expectations.

Tasks Beyond Care Workers' Duties. The variable assessed the frequency of instances over the past year in which care workers were required to perform tasks that were not included in their job description or the care receivers' care plan (question taken from Karlsson et. al. (2020) study, in which 47% of home care aides agreed or strongly agreed with the statement. In our study, the response options were adapted to be coherent with the rest of the survey. They were instructed to indicate their response on a 5-point Likert scale, ranging from 1 (never or almost never) to 5 (a lot of the time).

The mean score for exposure to requests to take on tasks outside formal care duties was 2.78 (SD = 1.28) on a scale of 1 to 5, indicating a moderate frequency of such experiences among care workers. No significant differences were found between the groups, suggesting that care workers in all settings and at all levels of qualification were similarly exposed to requests to take on tasks outside their defined roles or care plans.

Emotional Risk Factors

Emotional Demands. The construct pertains to the psychological demands that arise from the interpersonal relationships involved in the work, which require care workers to engage in emotionally charged situations. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were employed to assess the aforementioned job demand. An illustrative item is "Do you have to deal with other people's personal problems as part of your work?" The respondents were requested to respond on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The mean score for emotional demands among French care workers was 3.23 (SD = 0.75) on a scale of 1 to 5, indicating that workers often experienced emotionally challenging situations in their professional role. No significant differences were observed between the groups, suggesting that the emotional aspects of care work were experienced to a similar extent across all care settings and qualification levels.

Demands for Hiding Emotions. The variable in question alludes to the psychological demand associated with the necessity of maintaining a neutral demeanour in the face of unpredictable behaviour exhibited by care receivers, colleagues, superiors, family members, and other individuals within the professional setting. Four items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this job demand. An illustrative item is, "Are you required to be kind and open towards everyone – regardless of how they behave towards you?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The mean score for demands to hide emotions among French care workers was 4.04 (SD = 0.69) on a scale of 1 to 5, indicating that workers very often felt the need to suppress or regulate their emotional expression in professional settings. No significant differences were observed between the groups, suggesting that this demand was experienced consistently across different care settings and levels of qualification.

Relational Risk Factors

Exposure to Workplace Violence. The variable in question was designed to assess the frequency of instances in which care workers were exposed to violent behaviours or attitudes directed towards them in the workplace. Specifically, respondents were asked to respond to one question - In the last year, how often have you been exposed at work to violence from patients and/or their family members?. The respondents were required to indicate their level of agreement with the statement on a five-point Likert scale, with 1 representing "never" and 5 representing "everyday".

The average score for exposure to violence in the workplace among French care workers was 2.27 (SD = 0.95) on a scale of 1 to 5, indicating that workers occasionally encountered violent behaviour or attitudes from patients or their family members in the workplace. Significant differences were found between groups: basic care workers reported the highest levels of exposure, while home health aides and professional care workers reported statistically similar lower levels. These findings suggest that workers with intermediate qualifications, particularly those in institutional settings, may be more frequently exposed to workplace violence.

Figure 35. *Cross-target exposure to workplace violence comparative results*

Exposure to Discrimination. This variable assessed the frequency with which care workers had experienced discriminatory behaviour or attitudes that made them feel vulnerable because of their gender, ethnicity or colour in the past year. This was measured on a 4-point scale (0 - never; 1 - once; 2 - two or three times; and 3 - four or more times). The question was adapted from the Experiences of Discrimination Scale (EOD) developed by Williams et al. (1997).

Twelve out of 102 French care workers reported having experienced discrimination in their workplace over the past year. The most frequently cited reasons included weight or height, skin colour, education or income level, age, nationality, and ethnicity.

Figure 36. *Exposure to discrimination variable results*

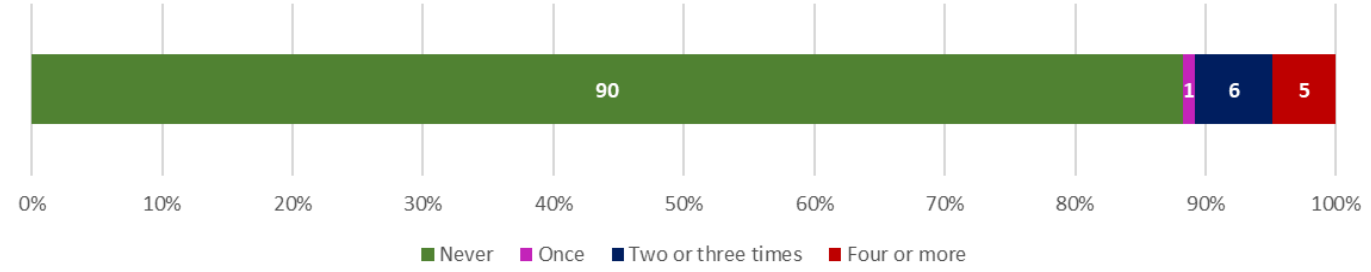
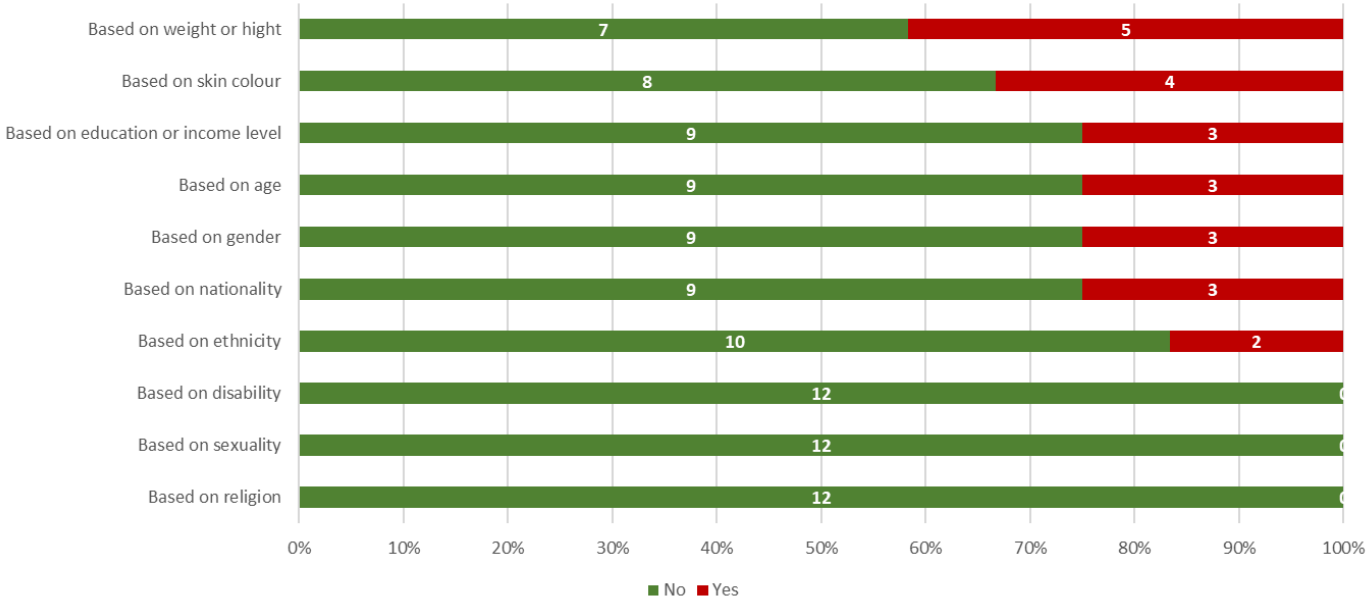


Figure 37. *Perceived motive of discrimination of those who experienced it*



The average score for exposure to discrimination was 0.27 (SD = 0.79) on a scale of 0 to 3, indicating that such incidents were relatively rare across the sample. However, there were significant differences between groups: basic care workers reported the highest frequency of discrimination, followed by home health aides, while professional care workers reported no experience of discrimination. These findings suggest that less qualified care workers - particularly those in institutional settings - may be more vulnerable to discriminatory treatment in the workplace.

Figure 38. *Cross-target exposure to discrimination comparative results*

Intragroup Conflict. The construct refers to the frequency with which carers experience conflict within a team, with the care receiver, their family members or other people at work, where members clash over work procedures or due to personality clashes. The 8-item scale was adapted from Jehn (1995). Participants were asked to respond on a 5-point Likert scale from 1 (none) to 5 (a lot).

The mean score for intragroup conflict among French care workers was 2.02 (SD = 0.65) on a scale of 1 to 5, indicating a relatively low to moderate frequency of interpersonal or procedural conflict at work. Significant differences were observed between groups: home health aides reported the lowest levels of conflict, while basic care workers and professional care workers reported statistically similar higher levels. This suggests that interpersonal conflict is more common in institutional care settings, where staff are more likely to work in teams.

Figure 39. *Cross-target intragroup conflict comparative results*

Workplace Incivility. The variable is defined as low-intensity deviant behaviour (by care receivers, family members, colleagues, etc.) with ambiguous intent to harm the target (the care worker), in violation of workplace norms of mutual respect. The 4-item scale shortened by Matthews & Ritter (2016) from Cortina et al. (2013) was used to assess this construct. An example item is "In the past year, have you been in a situation where people you interact with at work made jokes at your expense?" Participants were asked to respond on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The mean score for exposure to workplace incivility was 1.72 (SD = 0.65) on a scale of 1 to 5, indicating that care workers occasionally encountered disrespectful or inappropriate behaviour in the workplace, such as rudeness or lack of courtesy. No significant differences were found between the groups, suggesting that such low-intensity but harmful behaviours were reported at similar levels across care settings and levels of qualification.

1.2.3. Protective Factors in the Care Sector

This section focuses on the resources available to care workers to help them cope with the demands of their work. As in the previous section, both overall results and comparisons between different target groups are presented.

Table 7. *Job, emotional and relational protective factors*

Protective factors	Target	Mean	S.D.	N
Possibilities for Development	Target A	3.97	0.71	62
	Target B	4.13	0.80	21
	Target C	3.75	0.76	19
	Mean	**3.96**	**0.74**	**102**
Variation of Work	Target A	3.11	0.78	62
	Target B	2.50	0.76	21
	Target C	3.05	0.88	19
	Mean	**2.98**	**0.82**	**102**
Control over Working Time	Target A	2.58	0.64	62
	Target B	2.77	0.69	21
	Target C	3.00	0.61	19
	Mean	**2.70**	**0.66**	**102**
Predictability	Target A	3.69	0.91	62
	Target B	3.48	0.93	21
	Target C	3.37	0.72	19
	Mean	**3.59**	**0.89**	**102**
Autonomy	Target A	3.24	0.64	62
	Target B	3.06	0.69	21
	Target C	3.07	0.64	19
	Mean	**3.17**	**0.65**	**102**
Meaning of Work	Target A	4.68	0.44	62
	Target B	4.86	0.39	21
	Target C	4.21	0.95	19
	Mean	**4.63**	**0.59**	**102**
Recognition	Target A	3.97	0.84	62
	Target B	3.41	1.04	21
	Target C	3.46	0.91	19
	Mean	**3.76**	**0.93**	**102**
Emotional Social Support	Target A	3.73	0.73	62
	Target B	3.27	1.12	21
	Target C	3.43	0.76	19
	Mean	**3.58**	**0.84**	**102**
Instrumental Social Support	Target A	2.16	0.85	62
	Target B	2.17	0.76	21
	Target C	2.39	0.54	19
	Mean	**2.21**	**0.78**	**102**

Job-related Protective Factors

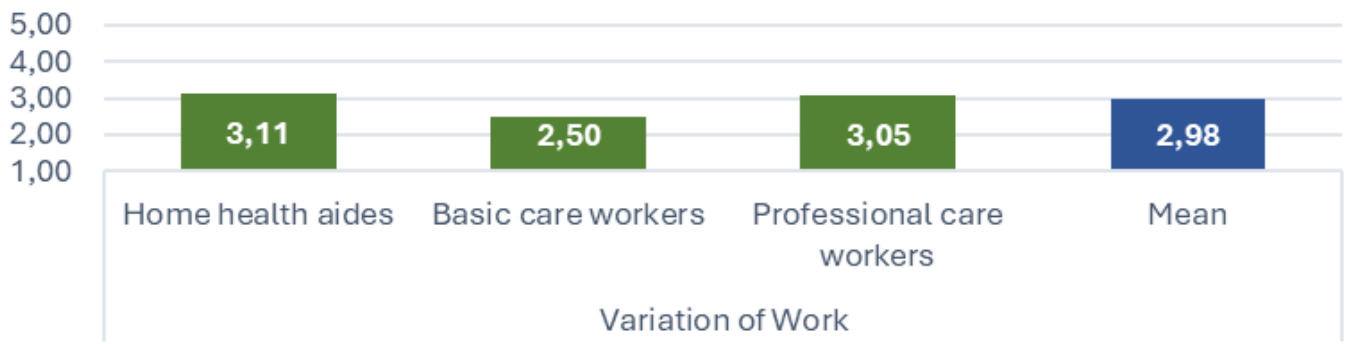
Possibilities for Development. The variable in question refers to the extent to which job performance provides opportunities for care workers to put their knowledge, skills and experience into practice and to acquire new knowledge, skills and experience. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. An illustrative item is "Do you have the possibility of learning new things through your work?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The mean score for development opportunities among French care workers was 3.96 (SD = 0.74) on a scale of 1 to 5, indicating that workers generally perceived that their jobs offered good opportunities to use and develop their knowledge, skills and experience. No significant differences were found between the groups, suggesting that perceptions of career development opportunities were consistent across care settings and levels of qualification.

Variation of Work. The construct refers to whether care work tasks are repetitive or, on the contrary, diverse or varied. Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. An illustrative item is "Do you have to do the same thing over and over again?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The mean score for job variety among French care workers was 2.98 (SD = 0.82) on a scale of 1 to 5, indicating a moderate level of task variety in their roles. Significant differences were observed between the groups: tasks were reported to be slightly more repetitive for basic care workers, whereas home health aides and professional care workers reported slightly more varied work.

Figure 40. *Cross-target variation of work comparative results*



Control over Working Time. The construct refers to care workers'' control over their working time in aspects such as starting and ending the working day, when to take breaks, days off, holidays, and control over whether, when and how much overtime to work. 5 items from the long version of the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) were selected to assess this resource. An illustrative item is "Can you decide when to take a break?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The average score for control over working time among French care workers was 2.70 (SD = 0.66) on a scale of 1 to 5, indicating a moderate level of autonomy in managing aspects of their work schedule, such as start and end times, breaks and days off. No significant differences were found between the groups, suggesting that this level of control was similar across care settings and levels of qualification.

Predictability. Work is predictable if the worker has adequate, sufficient and timely information to be able to perform the job correctly and to adapt to changes (future restructuring, new technologies, new tasks, new methods and the like). Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected for the assessment of this resource. One illustrative item is, "Do you receive all the information you need in order to do your work well?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The average score for predictability among French care workers was 3.59 (SD = 0.89) on a scale of 1 to 5, indicating that care workers generally felt they received sufficient and timely information to carry out their tasks and adapt to changes in the workplace. No significant differences were found between the groups, suggesting that predictability in the work environment was perceived similarly across care settings and levels of qualification.

Autonomy. The construct refers to the degree of influence or decision latitude that the care worker has in the day-to-day activities, particularly in relation to the tasks to be carried out and the manner in which they are to be carried out. The three-item scale from Bakker and Bal (2010), adapted from Karasek et al. (1985), was used to quantify this resource. An illustrative item is "I have a lot of freedom in the execution of my work". The responses ranged from 1 (strongly disagree) to 4 (strongly agree).

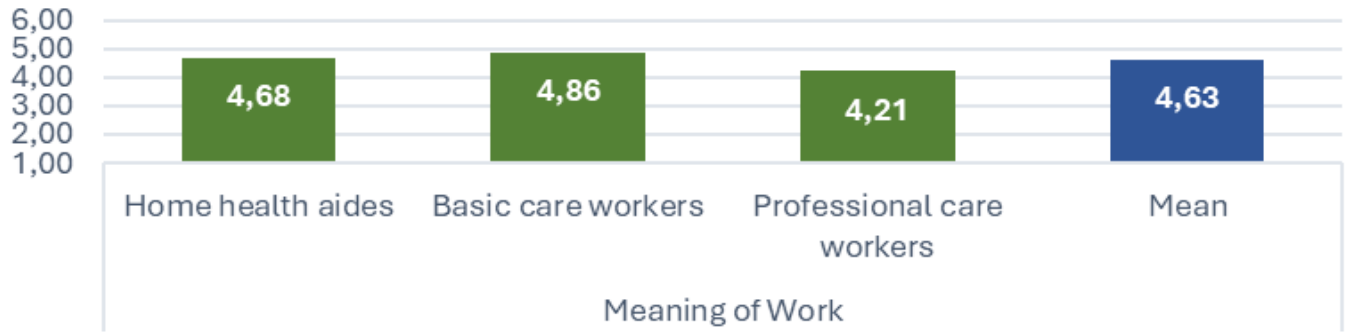
The mean autonomy score for French care workers was 3.17 (SD = 0.65) on a scale of 1 to 5, indicating a moderate degree of freedom to make decisions about how to carry out their daily tasks. No significant differences were found between the groups, suggesting that levels of autonomy were perceived similarly across different care settings and qualification levels.

Emotional Protective Factors

Meaning of Work. The variable is defined as the relationship that work has to values other than those associated with having a job and earning an income. These include the utility, importance or social value, or learning involved. Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected for the assessment of this resource. One illustrative item is, "Are you required to be kind and open towards everyone – regardless of how they behave towards you?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The mean score for meaning of work among French care workers was 4.63 (SD = 0.59) on a scale of 1 to 5, indicating a very high sense of purpose and perceived value in their work beyond financial rewards. Significant differences were observed between the groups: professional care workers reported slightly lower levels of perceived meaning in their work than home health aides and basic care workers. This suggests that although overall levels were high across the board, those in more specialised roles may feel less personally connected to the social or emotional value of their work compared to the other two groups.

Figure 41. *Cross-target meaning of work comparative results*



Relational Protective factors

Recognition. The term denotes the appreciation, respect and fair treatment afforded to care workers by their supervisors in the workplace. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. One illustrative item is, "Is your work recognised and appreciated by the management/supervisor?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The mean score for recognition among French care workers was 3.76 (SD = 0.93) on a scale of 1 to 5, indicating that workers generally felt valued, respected and treated fairly by their supervisors. No significant differences were found between the groups, suggesting that

perceptions of recognition were consistent across care settings and levels of qualification.

Social Support. The variable can be defined as the degree to which care workers receive emotional and instrumental (help with job tasks) support from the individuals with whom they interact at their place of work. The 8-item scale was adapted from that used by Peeters et al. (1995) for the purpose of measuring this resource. An example item is, "The people you interact with at work showed that they appreciated the way you do your work". The responses were measured on a scale ranging from 1 (not at all) to 5 (a lot).

French care workers reported moderate to high levels of emotional support (M = 3.58, SD = 0.84) and significantly lower levels of instrumental support (M = 2.21, SD = 0.78) on a scale of 1 to 5. This suggests that while they generally felt emotionally supported, they were less likely to receive help with practical or task-related matters. No significant differences were found between the groups, suggesting that these patterns of support were consistent across care settings and levels of qualification.

1.2.4. Summary: Main Differences Across Targets in France

Table 8. *Summary of prevalence results in France*

Dimension		Variable	Overall level	Cross-target differences
Well-being indicators	***Negative well-being indicators***	Burnout (Disengagement and Exhaustion)	Moderate-High	C > B > A
		Physical Exertion	Moderate	B > A > C
		Turnover Intentions	Low	C > B > A
		Work–Private Life Conflict	Moderate	No differences
	Positive well-being indicators	Work–Private Life Enrichment	Moderate-High	No differences
		Happiness	High	No differences
		Flourishing	High	No differences
Risk factors	***Job-related risk factors***	Physical Demands	Moderate-High	A > B, C
		Quantitative Demands	Moderate	C, B > A
		Work Pace Demands	Moderate-High	No differences
		Tasks Beyond Job Duties	Moderate	No differences
	Emotional risk factors	Emotional Demands	Moderate-High	No differences
		Demands for Hiding Emotions	High	No differences
	Relational risk factors	Exposure to Workplace Violence	Low-Moderate	B > A, C
		Exposure to Discrimination	Low	B > A > C
		Intragroup Conflict	Low-Moderate	C, B > A
		Workplace Incivility	Low	No differences
Protective factors	***Job protective factors***	Possibilities for Development	High	No differences
		Variation of Work	Moderate	A, C > B
		Control Over Time	Moderate	No differences
		Predictability	Moderate-High	No differences
		Autonomy	Moderate	No differences
	Emotional protective factors	Meaning of Work	High	B, A > C
	Relational protective factors	Recognition	Moderate-High	No differences
		Emotional Support	Moderate-High	No differences
		Instrumental Support	Low	No differences

Note: Consider the sample sizes for each group (62 home health aides - A; 21 basic care workers - B; and 19 professional care workers - C)

French care workers present a picture of resilience. Despite the many challenges they face, most report being satisfied with their lives and finding deep meaning in their work. Levels of flourishing are high. So is the sense that their work matters - not just to themselves, but to the people they care for. And yet this strong psychological foundation exists alongside important distress signals.

Care work is emotionally intense. This was clear: workers in all roles regularly face emotionally charged situations and feel pressured to manage or hide their reactions. These emotional demands are not isolated - they are coupled with other pressures that vary depending on where and how care workers work. For example, those working in institutions reported the highest workloads in terms of pace and volume. Home care workers, on the other hand, performed more physically demanding tasks but, interestingly, did not report higher levels of physical exertion. This may suggest that although the nature of their work is physically active, it is either more manageable, spread out or experienced differently.

Not all care workers experience their role in the same way. Professional care workers - those with the highest level of training - reported more burnout and greater intentions to leave the profession. At the same time, basic care workers were more likely to experience violence and discrimination at work. These findings point to different forms of vulnerability. Workers in institutional settings appear to be more exposed to interpersonal conflicts and role overload. Home health aides may be disadvantaged in other ways, such as working alone and having less access to lifting equipment.

In terms of protective factors, the picture was mixed. Care workers generally felt recognised by their managers and emotionally supported by those around them. But instrumental support - help with tasks - was lacking. Autonomy and predictability were moderate, and while there was some opportunity for development and learning, control over working hours was restricted. Daily task variety also diverged: it was lowest for basic care workers. Notably, professional care workers felt slightly less meaningful in their work, compared to the other two groups.

Overall, the data paint a complex picture. French care workers show a strong sense of commitment, purpose and personal well-being. But the structure of their work - in particular emotional strain, limited task support and diversity in the psychosocial risks across roles and settings - leaves them vulnerable. To support this essential workforce, interventions must reflect the real, varied and sometimes hidden pressures that French care workers navigate every day.

Chapter 2. Qualitative Data Set: Making Sense of the Findings Through Workers' Voices

2.1. Profile of the Care Workforce: Focus Group Sample

A total of 57 care workers from France participated in the study, 30 from Target A (in red, home health aides), 11 from Target B (in green, basic care workers) and 16 from Target C (in dark blue, professional care workers). Among home health aides who answered their work modality 3 (10%) were live-in home care workers while 27 (90%) were live-out home care workers.

The average age of the French participants was 40.82 years and the age group distribution was equal among young adults, adults and middle-aged adults (33.3%) .The majority were women (89.5%).

Figure 42. *Participants per target group*

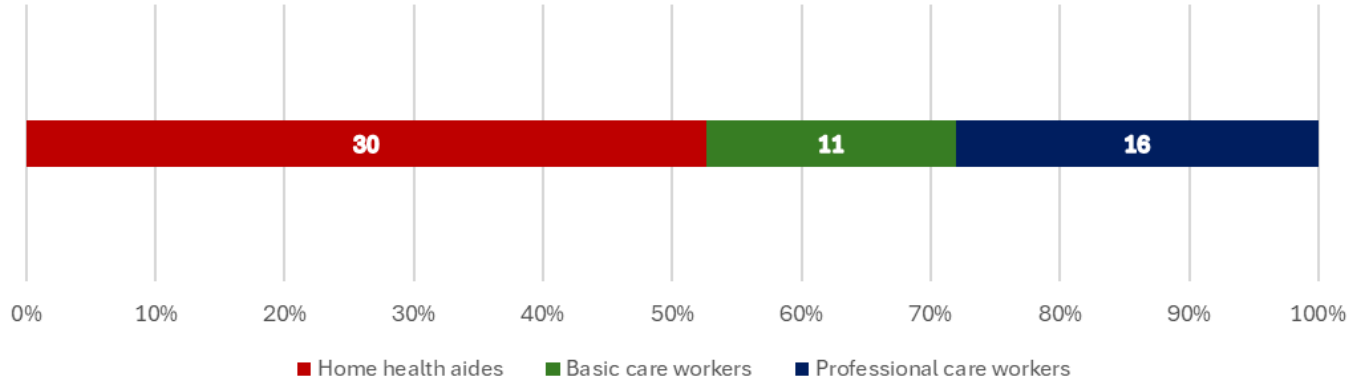


Figure 43. *Modality of home care*

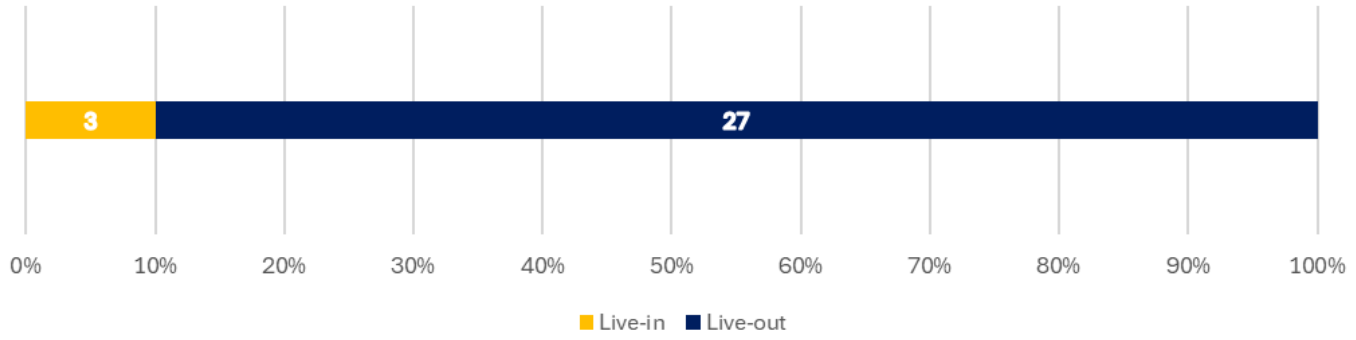


Figure 44. *Age groups*

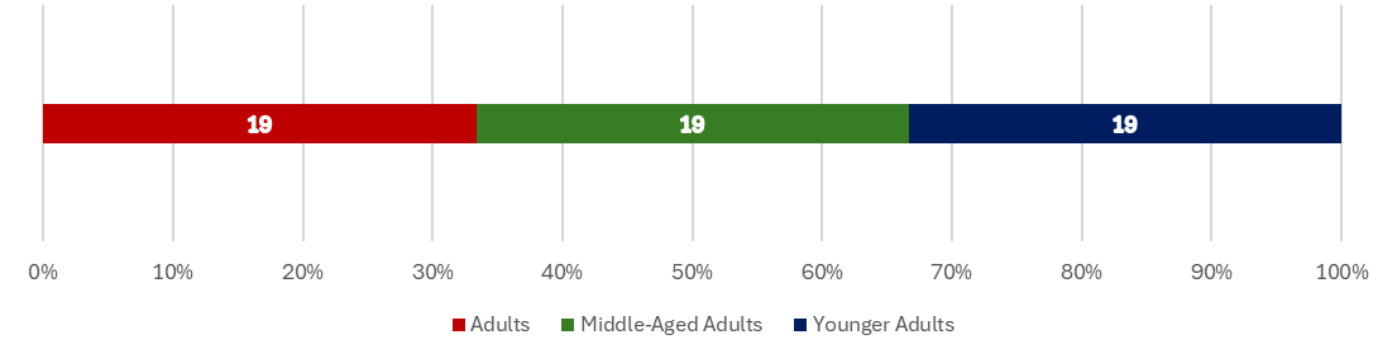
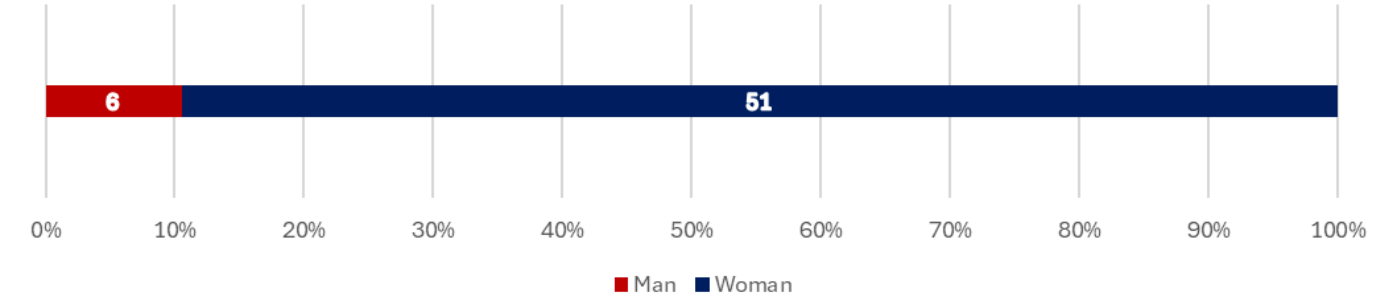


Figure 45. *Gender*



Most participants were French (98.2%). A small number of participants reported being from an African country: Cameroon (1.8%). Educational levels were diverse with 26.3% had no training in care sector activities, 35.1% had a short course in care activities, 15.8% were technicians and 22.8% had completed a university degree.

Table 46. *Country of origin*

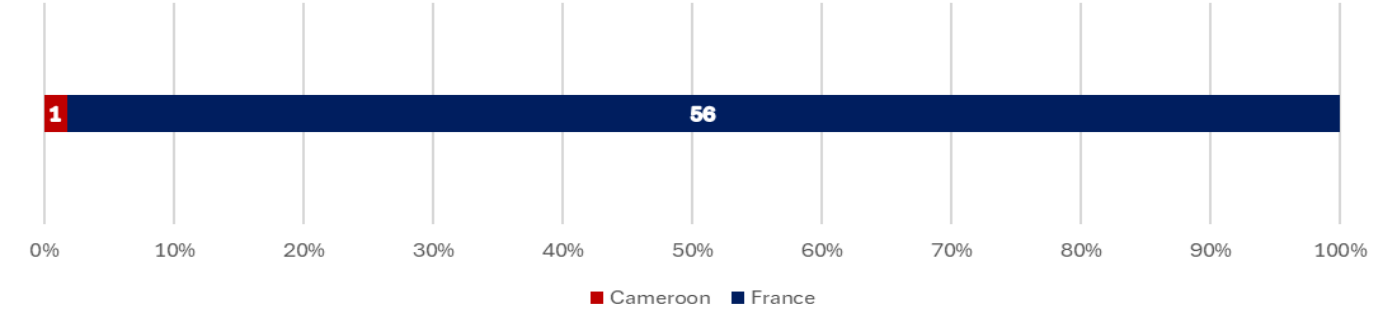
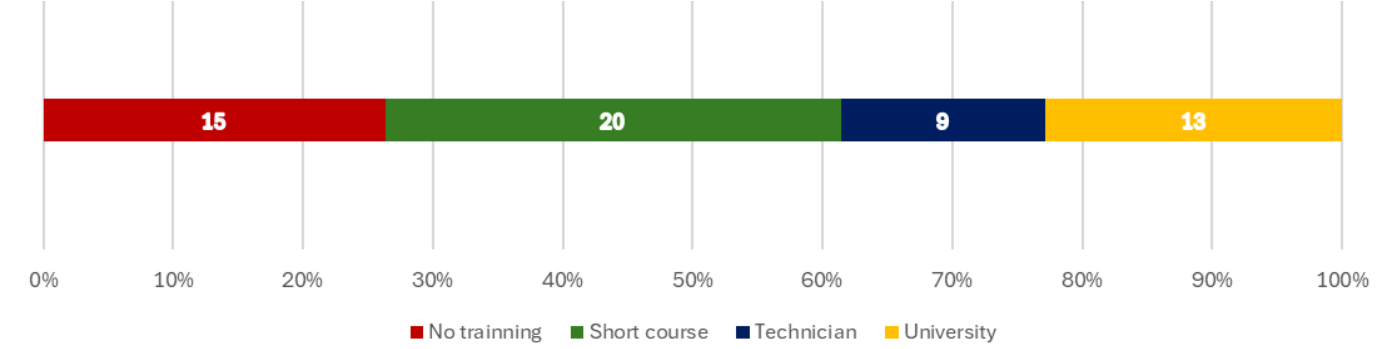


Figure 47. *Educational status*



2.2. Focus Group Findings: Understanding Risks and Protective Factors Across Worker Groups

Table 9. *French focus groups index*

Name of FG	Target	N	Gender		Age average	Country of origin
			F	M		
FG 1 FR B	B	6	5	1	43.16	Cameroon and France
FG 2 FR A	A	8	5	3	49.14	France
FG 3 FR B	B	5	5	0	42	Cameroon and France
FG 4 FR A	A	9	9	0	42.75	France
FG 5 FR C	C	5	5	0	37	France
FG 6 FR A	A	8	8	0	49.25	France
FG 7 FR AC	A (5) C (5)	10	8	2	35	France
FG 8 FR C	C	6	6	0	28.6	France

2.2.1. Home Care: Risk and Protective Factors

The information in the following section is based on the testimonies of home care workers. They are nursing and care professionals working in domestic and outpatient settings, lacking specific training, who provide care for elderly, sick or other individuals requiring home care.

The information in the following section is based on the testimonies of home care workers. They are nursing and care professionals working in domestic and outpatient settings, lacking specific training, who provide care for elderly, sick or other individuals requiring home care.

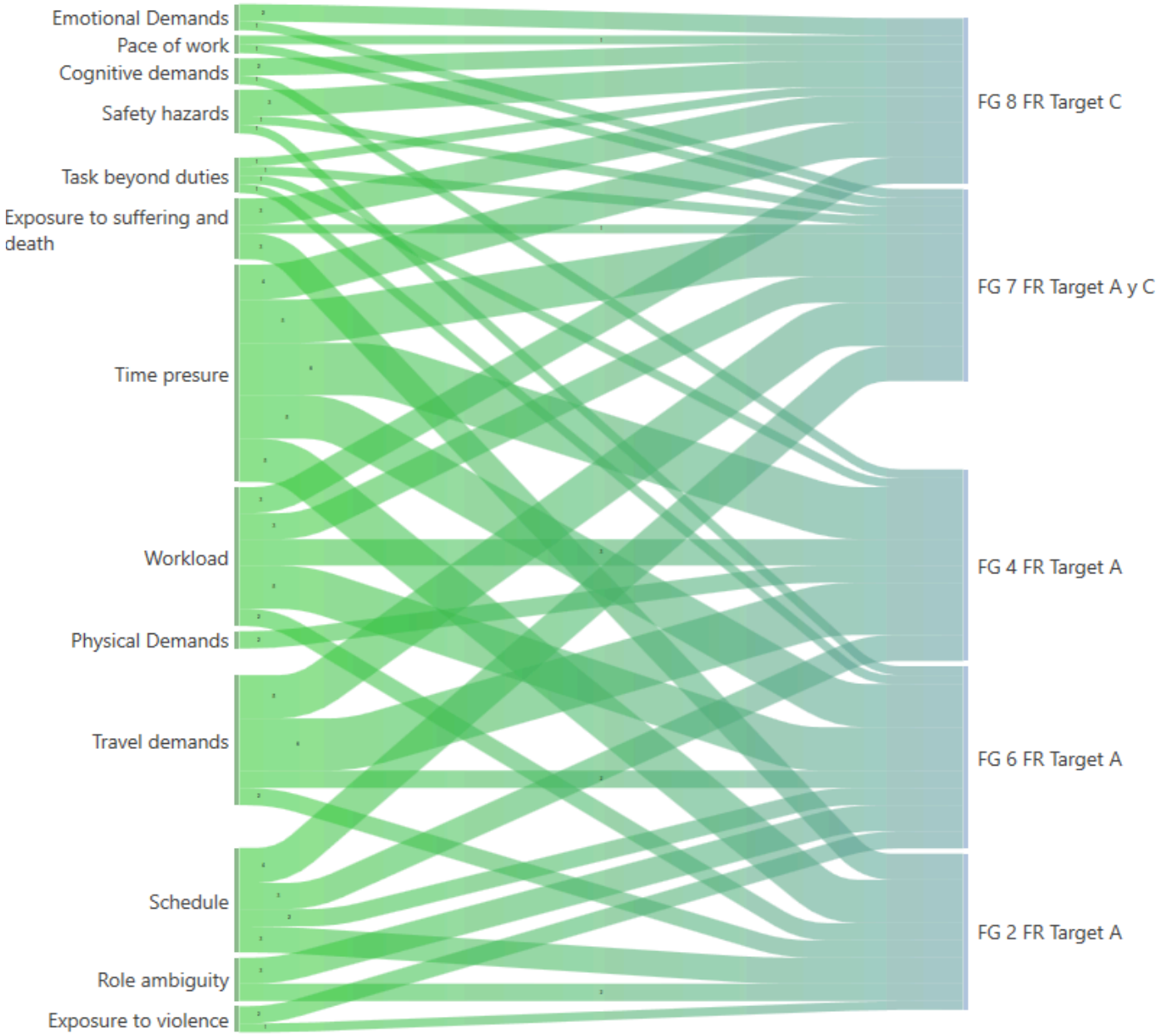
Risk Factors

Job-related Risk Factors

This Sankey diagram visualises the distribution and relative frequency of codes applied to the focus group with domestic care workers in France. Each flow represents how intensively a given code was used within this document. The thickest streams correspond to workload, time pressure, and emotional demands, indicating that these were the most frequently coded and discussed topics among participants. Medium–width flows such as pace of work, physical demands, and cognitive demands denote moderately recurrent themes. Thinner lines, including schedule, travel demands, safety hazards, role ambiguity, task beyond duties,

exposure to suffering and death, and exposure to violence, reveal issues mentioned only occasionally. Overall, the diagram highlights that the discussion was largely centred on the intensity, pace, and emotional weight of domestic care work, while other types of demands were present but less prominent.

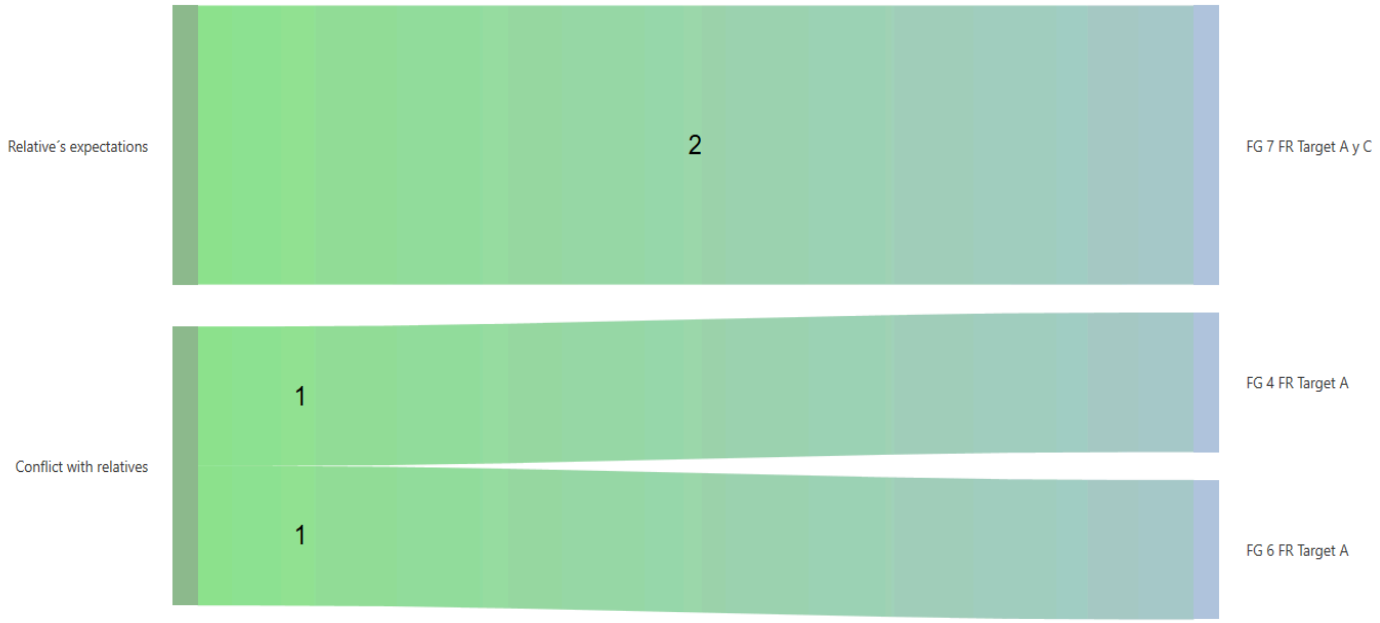
Figure 48. *Job-related risk factors among home care workers group in France*



Relational Risk Factors

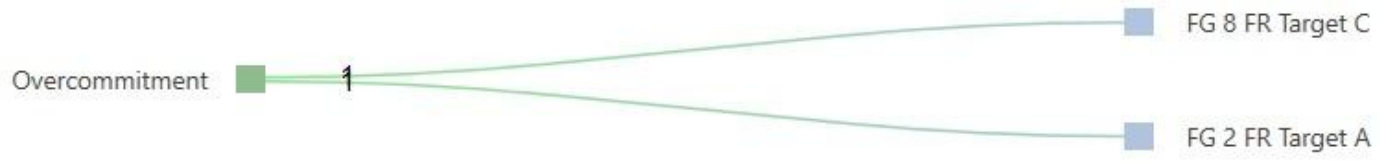
The diagram includes two main codes: relatives' expectations and conflict with relatives. The thickest flow corresponds to relatives' expectations, appearing twice across the datasets (*FG7 FR Target A, C*), suggesting that this theme was more frequently addressed. The code conflict with relatives appears once in *FG4 FR Target A* and once in *FG6 FR Target A*, with thinner streams that indicate less frequent mentions. Overall, the figure shows that references to relatives' expectations were more prominent than explicit conflict with relatives, though both themes were present in the French focus groups on domestic care.

Figure 49. *Relational risk factors among home care workers group in France*



Personal Risk Factors

Figure 50. *Personal risk factors among home care workers group in France*

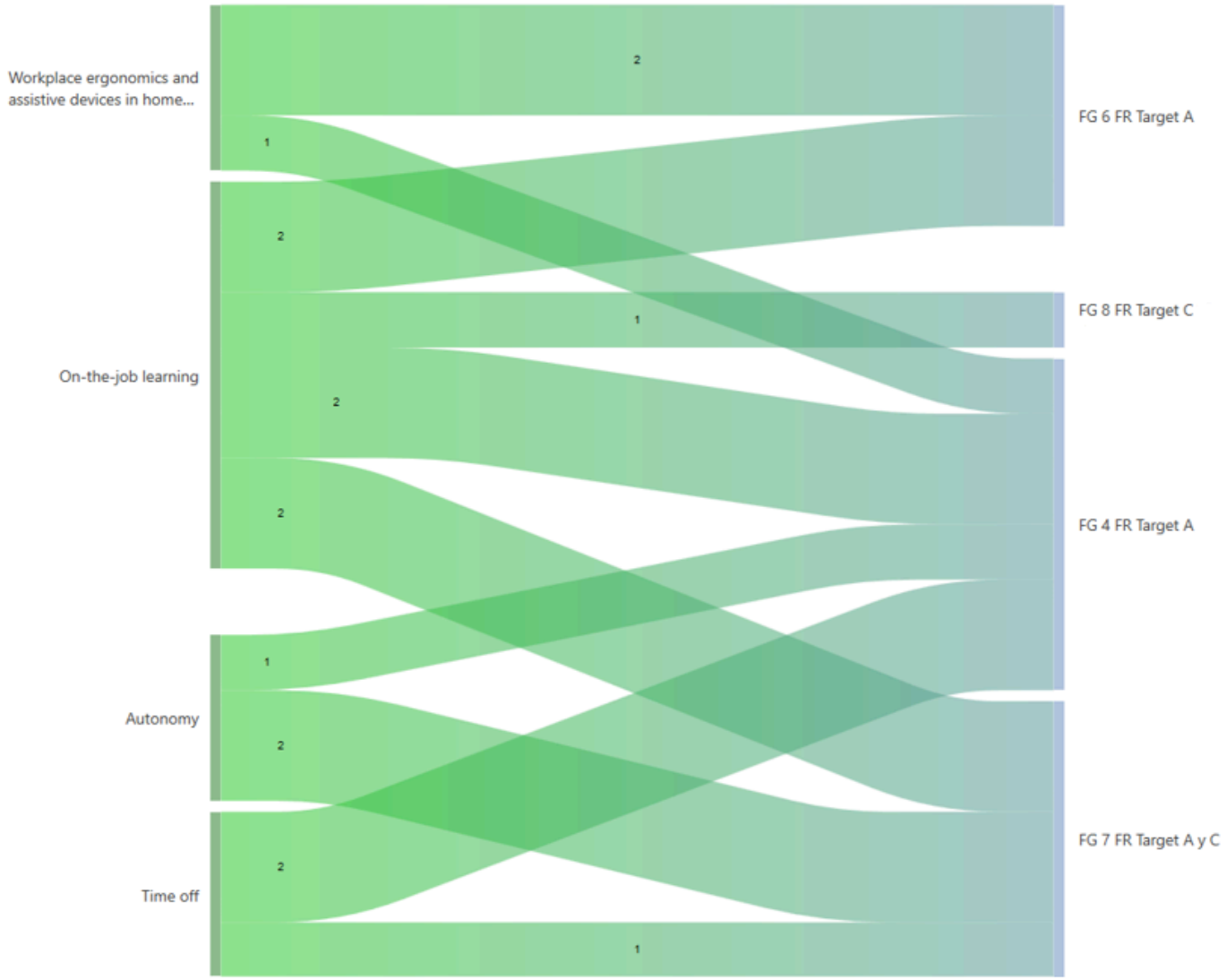


Protective Factors

Job-related Protective Factors

The most frequently coded themes are time off, on-the-job learning, and workplace ergonomics and assistive devices in homes, each connected to multiple focus groups, indicating recurring attention to rest periods, skill development, and practical tools for safer work. Autonomy also appears with several flows of medium width, suggesting that it was mentioned across different groups but less intensively than the previous themes. Overall, time off shows the thickest streams, particularly in *FG7 FR Target A y C*, while workplace ergonomics and assistive devices in homes and on-the-job learning are more evenly distributed across *FG4*, *FG6*, and *FG8*. This distribution indicates that the discussion focused mainly on opportunities for rest, learning, and ergonomic support, with autonomy emerging as a secondary but cross-cutting topic.

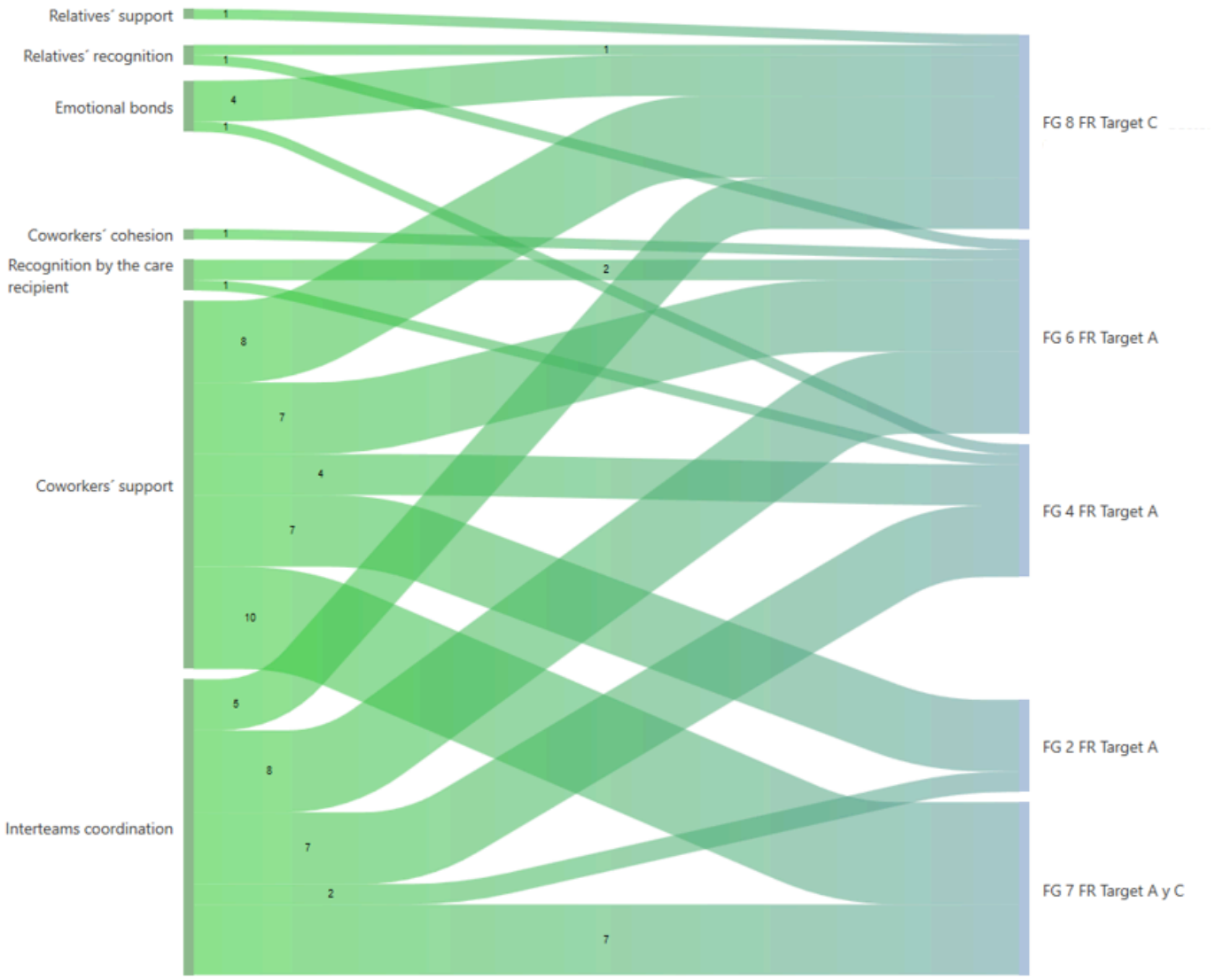
Figure 51. *Job-related protective factors among home care workers group in France*



Relational Protective Factors

The thickest streams correspond to coworkers' support and interteams coordination, which appear across several focus groups, particularly *FG2 FR Target A*, *FG4 FR Target A*, and *FG7 FR Target A y C*, suggesting that collaboration and mutual help among colleagues were central discussion points. Recognition by the care receiver and coworkers' cohesion also show multiple medium-width flows, indicating that positive feedback from users and team unity were recurrent but less dominant themes. Thinner lines represent less frequent mentions of emotional bonds, relatives' recognition, and relatives' support, mainly concentrated in *FG6 FR Target C* and *FG8 FR Target C*. Overall, the diagram highlights that the conversations among French domestic care workers focused mainly on peer support and coordination, while recognition and emotional ties—either from care receivers or families—appeared as secondary yet meaningful relational dimensions.

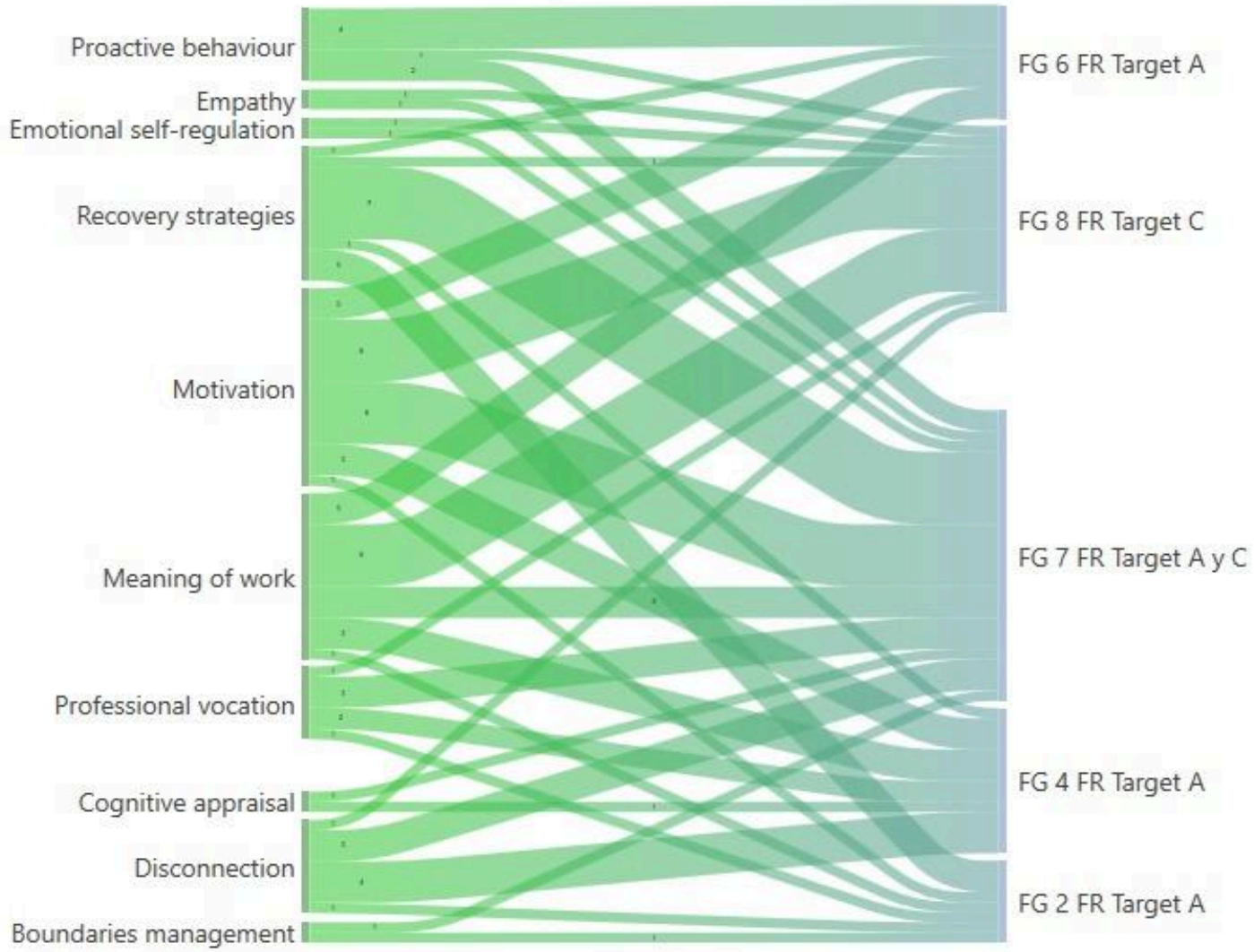
Figure 52. *Relational protective factors among home care workers group in France*



Personal Protective Factors

The thickest flows correspond to motivation, meaning of work, and coping strategies, which appear widely across *FG6 FR Target A*, *FG7 FR Target A y C*, and *FG8 FR Target C*, indicating that these were the most frequently discussed dimensions of personal resilience and engagement. Medium-width flows connect to recovery strategies, emotional self-regulation, and empathy, showing recurring but less dominant discussions about emotional balance and self-care. Thinner flows correspond to boundaries management, disconnection, cognitive appraisal, professional vocation, and proactive behaviour, suggesting that these topics were mentioned only occasionally or by specific participants. Overall, the figure reveals that conversations on individual resources among French domestic care workers centred mainly on motivation, coping, and the personal meaning of care work, while other aspects of emotional regulation and work–life boundaries were present but less emphasised.

Figure 53. *Personal protective factors among home care workers group in France*



Conclusion

Across all diagrams, the French home care workers focus groups reveal a clear predominance of discussions on workload, time pressure, and emotional demands, highlighting the demanding nature of domestic care work. In contrast, resources—whether organisational, relational, or personal—were mentioned less frequently but still provided important insights into how workers maintain balance and meaning in their roles. The strongest protective factors emerged around peer support, coordination, motivation, and coping strategies, while structural aspects such as time off and on-the-job learning were valued but inconsistently available. Together, these visual analyses depict a workforce facing intense pressures yet showing resilience through collaboration, motivation, and emotional management.

2.2.2. Institutional Care: Risk and Protective Factors

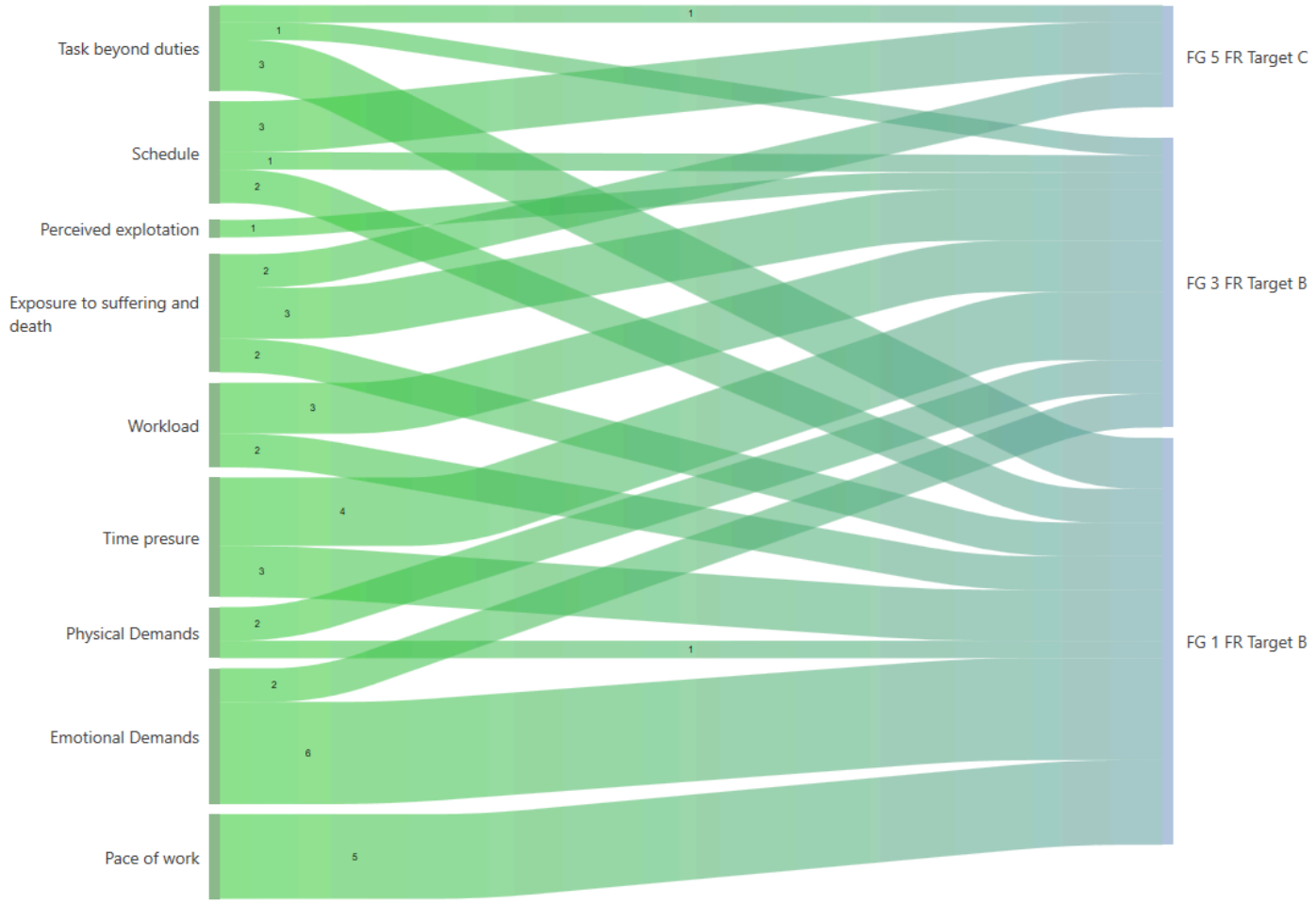
This part encompasses a mixed target: Basic care workers (target B: nursing and care staff who work in hospitals, retirement homes, nursing homes or day care centres and who have been trained in at least one short course) and Professional care workers (target C: specialists in the nursing or healthcare sector with vocational training or a Bachelor's degree).

Risk Factors

Job-related Risk Factors

This diagram visualises the distribution of job-related risk factors coded across French focus groups with both basic and professional care workers in institutional settings. The thickest flows correspond to emotional demands, workload, and time pressure, showing that these were the most recurrent topics in the discussions. These themes are present in several focus groups, indicating the centrality of emotional strain and excessive workload in daily care activities. Medium-width flows such as physical demands, exposure to suffering and death, and perceived exploitation reveal the frequent mention of physical exhaustion, contact with pain or loss, and a sense of being undervalued or overused. Thinner flows like schedule, pace of work, and tasks beyond duties appear less often, but they still illustrate the accumulation of responsibilities and organisational pressures. Overall, the diagram suggests that discussions about risks in care work were dominated by references to intense emotional and physical strain, reinforced by excessive workload and time constraints.

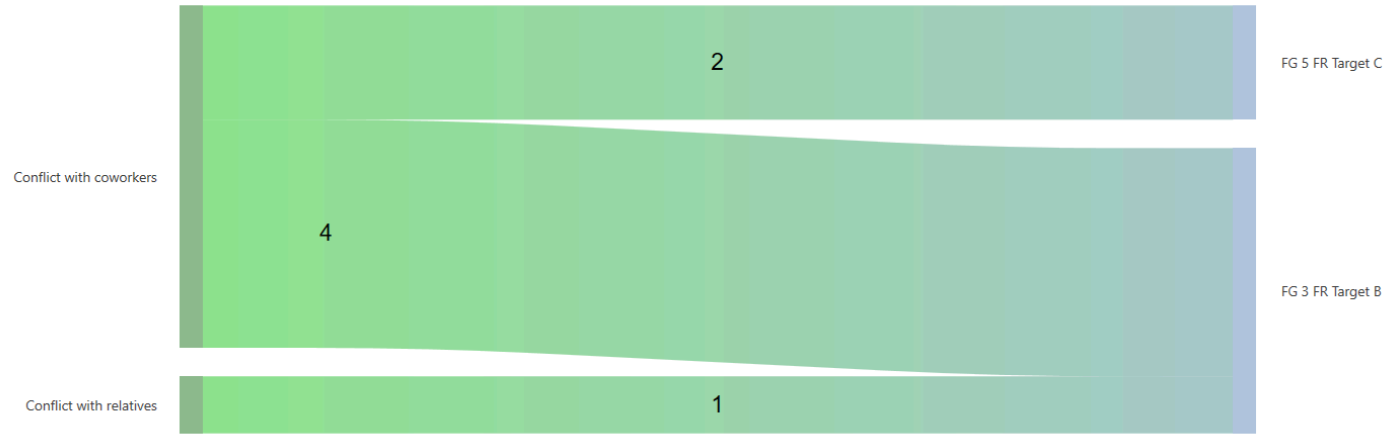
Figure 54. *Job-related risk factors among basic and professional care workers group in France*



Relational Risk Factors

The thickest flow corresponds to conflict with coworkers, appearing most prominently in *FG3 FR Target B*, indicating that tensions within teams were a significant concern. Smaller flows connect conflict with coworkers and conflict with relatives, suggesting that interpersonal friction occurs both among colleagues and with the families of care receivers. The thinner line representing conflict with relatives points to fewer but still meaningful instances where expectations or misunderstandings with families created stress for the workers. Taken together, the figure shows that intra-team conflict was more frequently discussed than conflict with families, yet both contribute to relational strain in the care environment.

Figure 55. *Relational risk factors among basic and professional care workers group in France*



Personal Risk Factors

The thickest flow corresponds to overcommitment, appearing mainly in *FG3 FR Target B*, which indicates that excessive personal dedication and difficulty in setting limits were the most recurrent self-related strain factors. A thinner flow connects to perceived exploitation, representing situations in which workers felt personally taken advantage of or insufficiently recognised for their effort. Overall, the figure highlights that personal risks among French care workers are closely linked to excessive self-involvement and the internalisation of work demands, leading to emotional exhaustion and a heightened sense of vulnerability.

Figure 56. *Personal risk factors among basic and professional care workers group in France*

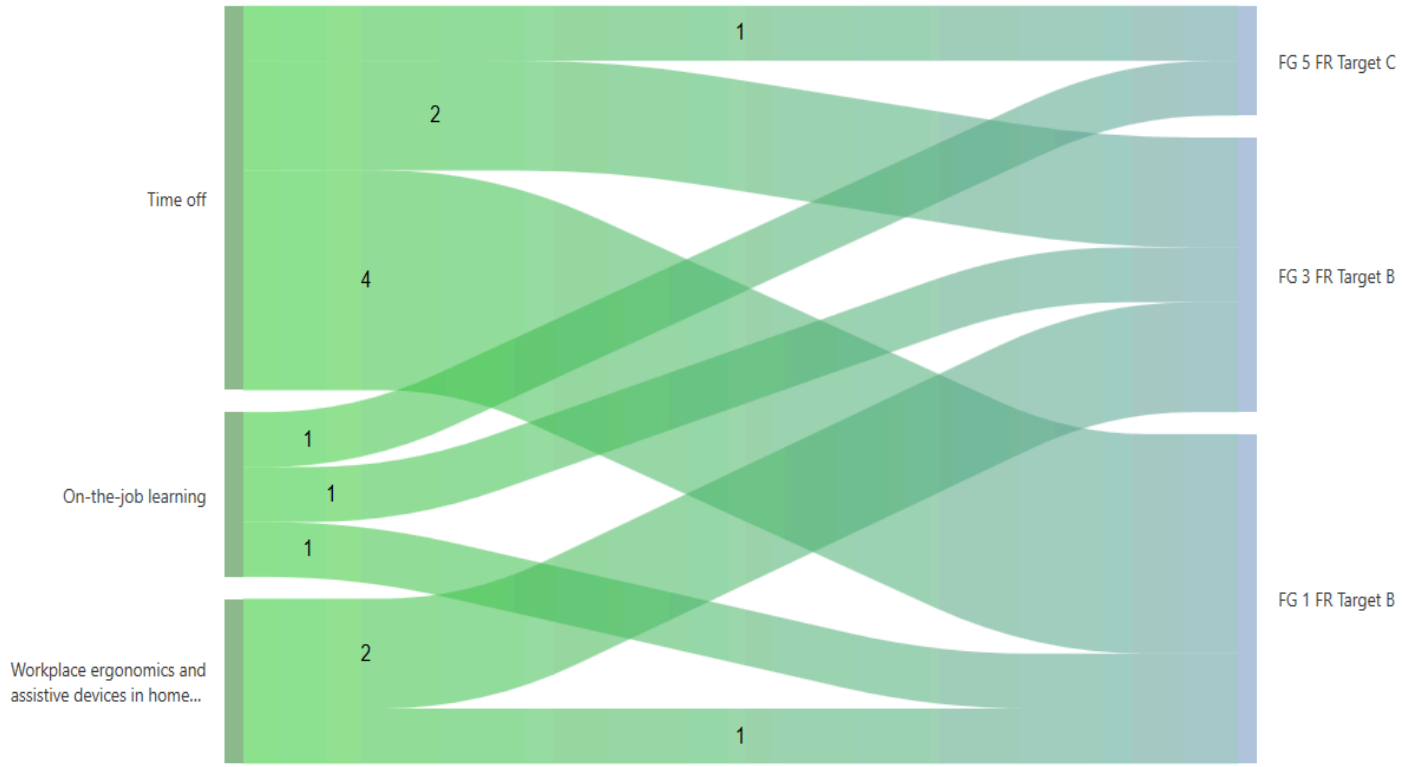
Protective Factors

Job-related Protective Factors

The most prominent flows are time off and workplace ergonomics and assistive devices in homes, appearing across multiple focus groups, particularly *FG3 FR Target B* and *FG8 FR Target B*. These indicate that workers view adequate rest and ergonomic tools as key supports for sustaining their work capacity. On-the-job learning also appears with several medium-width flows, revealing that opportunities for continuous training were valued as means of coping with demanding tasks. Thinner lines correspond to perceived exploitation and overcommitment, which are technically framed as protective elements here but likely

represent borderline areas between coping and risk. Overall, the figure shows that the main organisational buffers identified by French care workers were time for recovery, training, and ergonomic improvements, which together reduce strain and enhance safety.

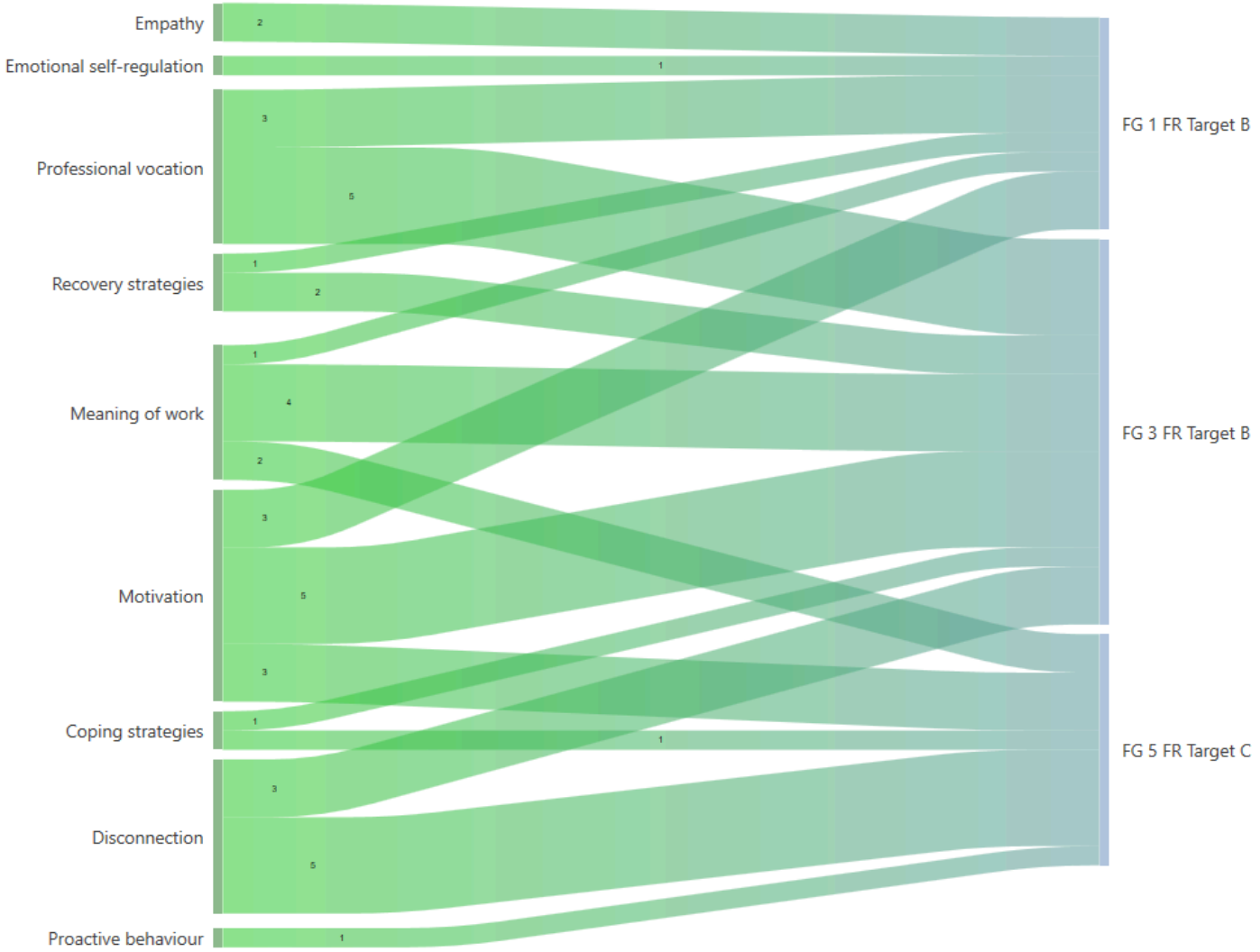
Figure 57. *Job-related protective factors among basic and professional care workers group in France*



Personal Protective Factors

This diagram visualises the individual and psychological resources that protect care workers from stress and burnout. The thickest flows correspond to motivation, coping strategies, and meaning of work, showing that intrinsic motivation, emotional adaptation, and a sense of purpose are central to personal resilience. Medium-width flows for recovery strategies, professional vocation, and emotional self-regulation suggest that these elements also play a recurrent but less dominant role. Thinner flows, including empathy, disconnection, and proactive behaviour, appear less frequently yet reveal complementary forms of emotional balance and self-preservation. Overall, the diagram indicates that French care workers rely primarily on internal motivation, coping mechanisms, and meaningfulness of care work as personal buffers against stress and fatigue.

Figure 58. *Personal protective factors among basic and professional care workers group in France*



Conclusion

The Sankey diagrams collectively portray a workforce under considerable pressure and emotional demand, yet demonstrating substantial capacity for adaptation and meaning-making. Structural and relational improvements—especially in workload management, team communication, and recognition—could enhance well-being and reinforce the personal and organisational resources already identified by the care workers themselves.

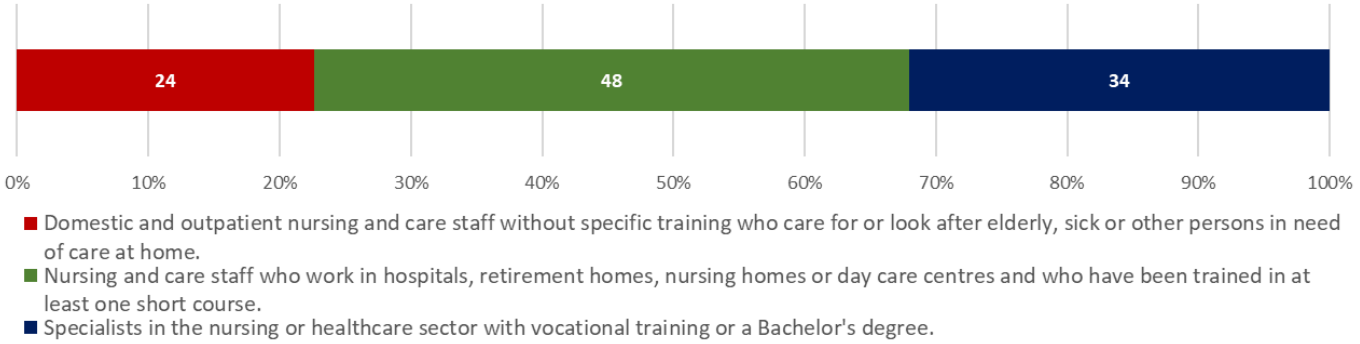
PART 2. CARE WORKERS IN ITALY

Chapter 3. Quantitative Data Set: What the Surveys Revealed About Care Work in Italy

3.1. Profile of the Care Workforce Sample

A total of 106 care workers from Italy participated in the study. 24 from target A (in red, home health aides), 48 B (in green, basic care workers) and 34 from target C (in dark blue, professional care workers).

Figure 59. *Participants per target group*



The mean age of the Italian participants was 42.76 years (SD = 11.32). The majority were women (83%), just over half (52.8%) were married, and most worked predominantly in urban areas (86.8%). While most participants were Italian nationals (82.1%), a smaller proportion came from other countries, including European countries (Moldova and Romania), African countries (Senegal, Somalia and Morocco), South America (Peru, Dominican Republic, Argentina, Ecuador and Brazil) and Asia (Sri Lanka).

Figure 60. *Age groups*

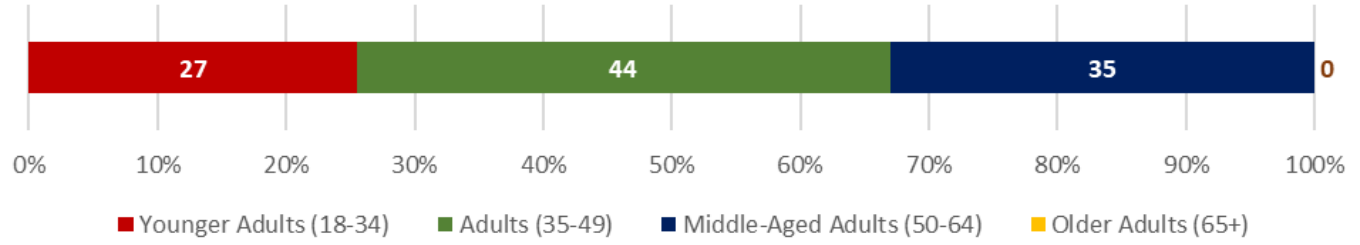


Figure 61. *Gender*

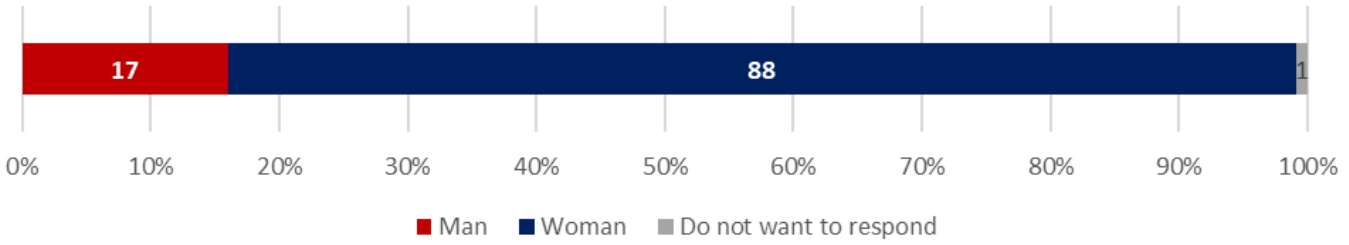


Figure 62. *Marital status*

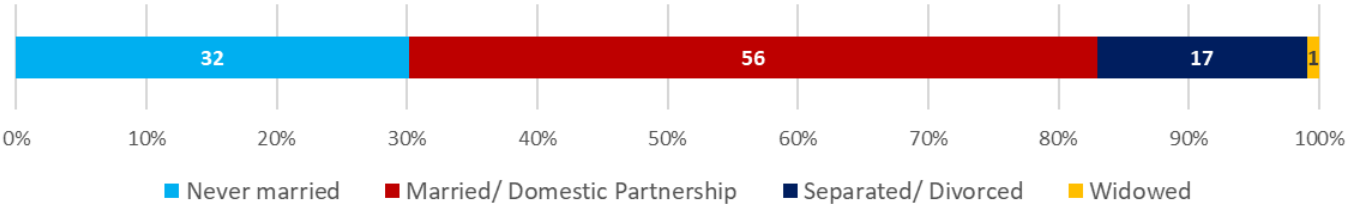


Table 10. *Descriptive statistics of the quantitative variables*

	N	Min	Max	Mean	SD
Age	106	22	63	42.76	11.32
Tenure in months	98	5	456	159.54	132.01
Monthly wages all participants	79	150	3500	1422.19	436.84
Monthly wages in Institutionalised care	65	570	1960	1455.12	308.22
Monthly wages in home based care	14	150	3500	1269.29	804.18
Hours worked in a week	105	2	54	33	11.78
Number of home care receivers in a week (HCWs)	28	1	54	8.46	14.90
Duration of stay (days in a week for live-in HCWs)	10	3	7	6.00	1.41
Months of residence (migrant workers)	11	15	264	119.64	98.41
Knowledge of benefits (out of 9)	106	0	9	2.48	1.93
Use of benefits (out of 9)	106	0	9	1.32	1.89

Figure 63. *Area of work*

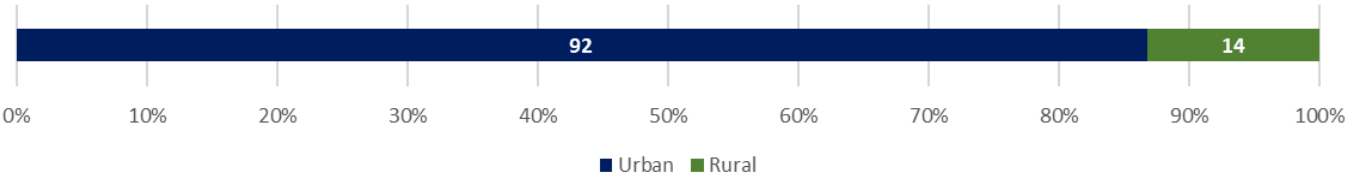


Figure 64. *Nationality*

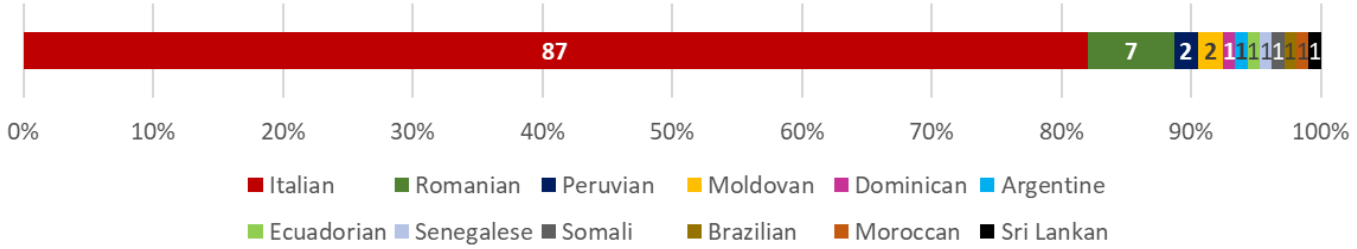
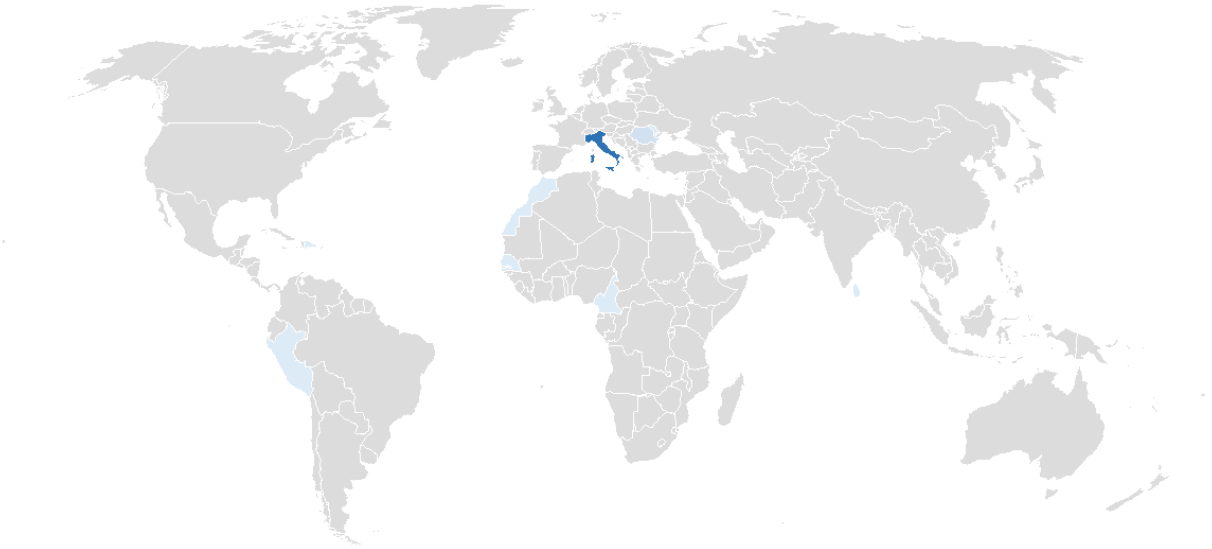


Figure 65. *Country of origin*



Most participants had completed some form of post-compulsory education (58.5%), with half (50%) having completed three or more years of higher education. The remainder had completed secondary education (34.9%), primary education (1.9%) or reported no formal education (2.8%). The majority (84%) had received specific formal education or training in care services. Regarding workplace safety training, 61.3% reported that their current employer had provided such training, 23.6% had received such training in a previous job or through a course taken independently, and 15.1% reported never having received such training. On average, participants had worked in the care sector for 159.54 months (approximately 13.3 years) (SD = 132.01).

Figure 66. *Educational status*

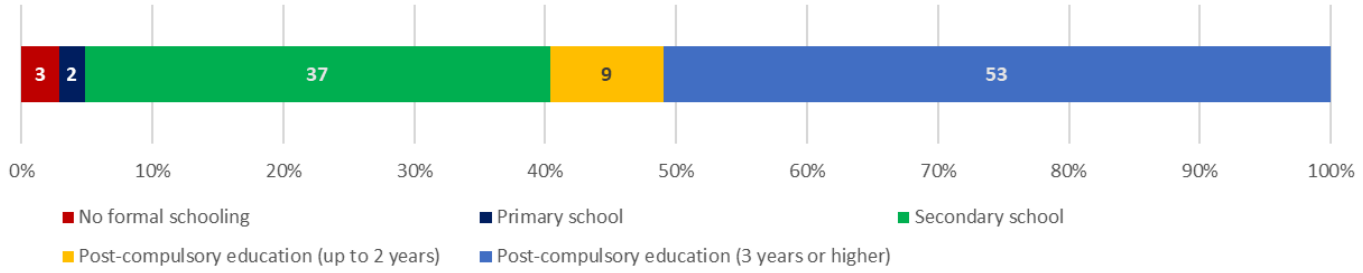


Figure 67. *Formal education in care services*

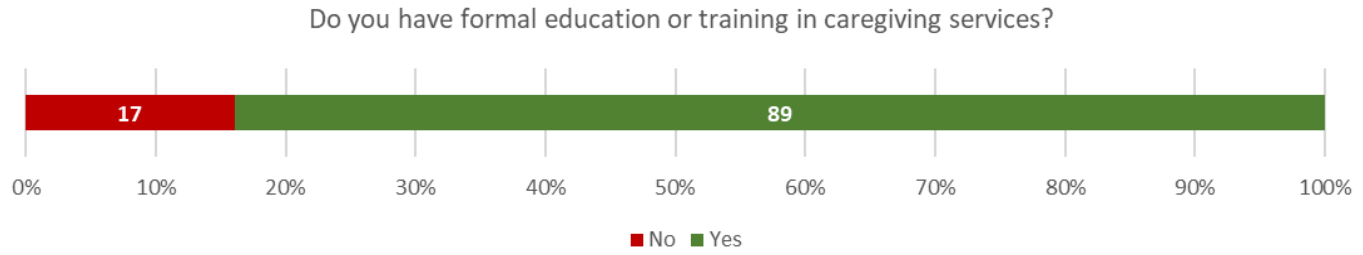
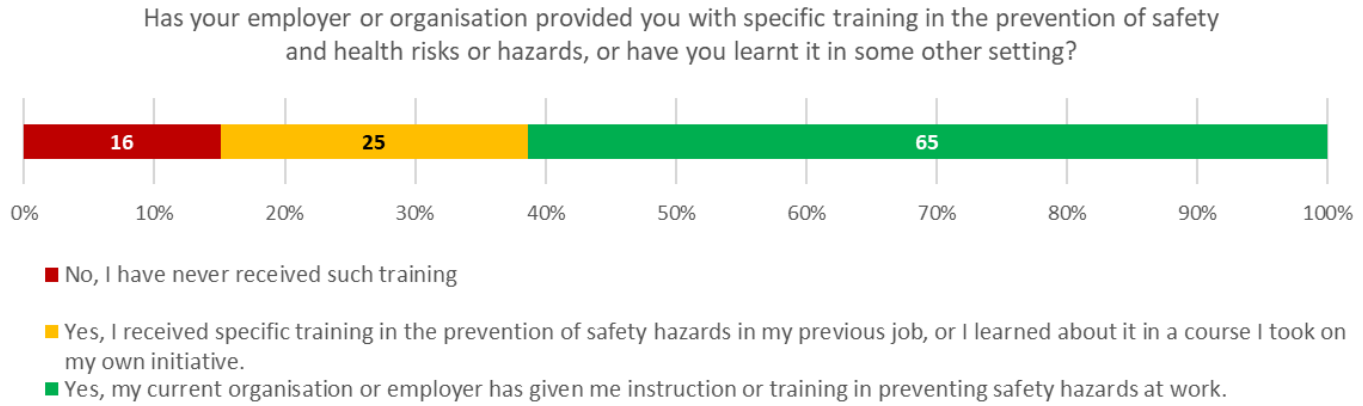


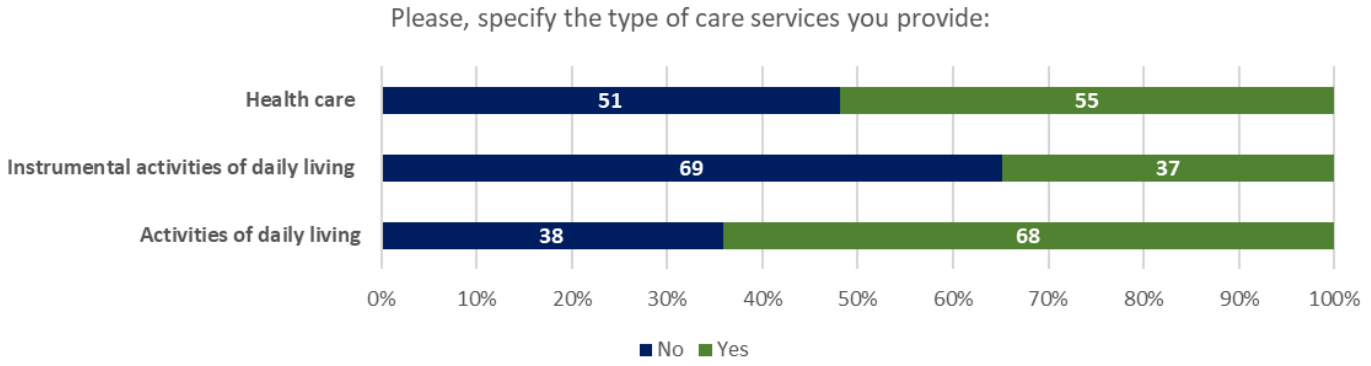
Figure 68. *Safety hazards training*



When asked about the types of tasks they performed, participants most often reported performing activities of daily living (ADLs), followed by health care tasks and instrumental activities of daily living (IADLs). The content of their training appeared to match their job responsibilities, as participants reported receiving more training for the tasks they performed most frequently. Although the majority (59.4%) had received specific training related to the care needs and health conditions of their care receivers, a significant proportion (40.6%) had not received such training. This is of concern as most care workers (93.4%) supported care receivers with specific diagnoses or health conditions, including mobility problems (84%),

behavioural or psychiatric disorders (79.2%), physical health conditions (74.5%), obesity (49.1%) and infectious diseases (42.5%).

Figure 69. *Type of care tasks they perform*



Note: **Activities of daily living or ADL** (dressing, toileting, mobility, bowel and bladder management, sleep time regulation, feeding, transferring from one position to another, personal hygiene, walking, caring for pets, personal care bathing, eating, toilet hygiene, grooming, ambulating, companionship and socialisation).
Instrumental activities of daily living or IADL (using the phone, shopping for groceries, managing medication, preparing meals, doing laundry, housekeeping, managing finances, assistance with using transportation).
Health services (nursing, auxiliary services, wound care, infusion therapy, physical or cognitive rehabilitation, injections, diagnostic services, prescriptions, treatment of injuries or illnesses, occupational therapy, hospice care, therapists and social workers.

Figure 70. *Type of formal education in care services*

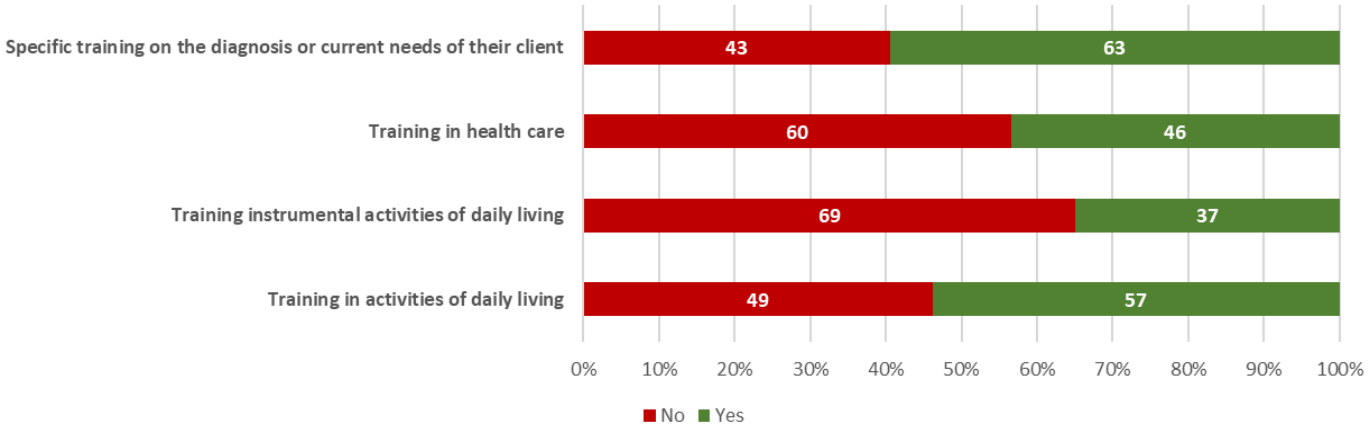
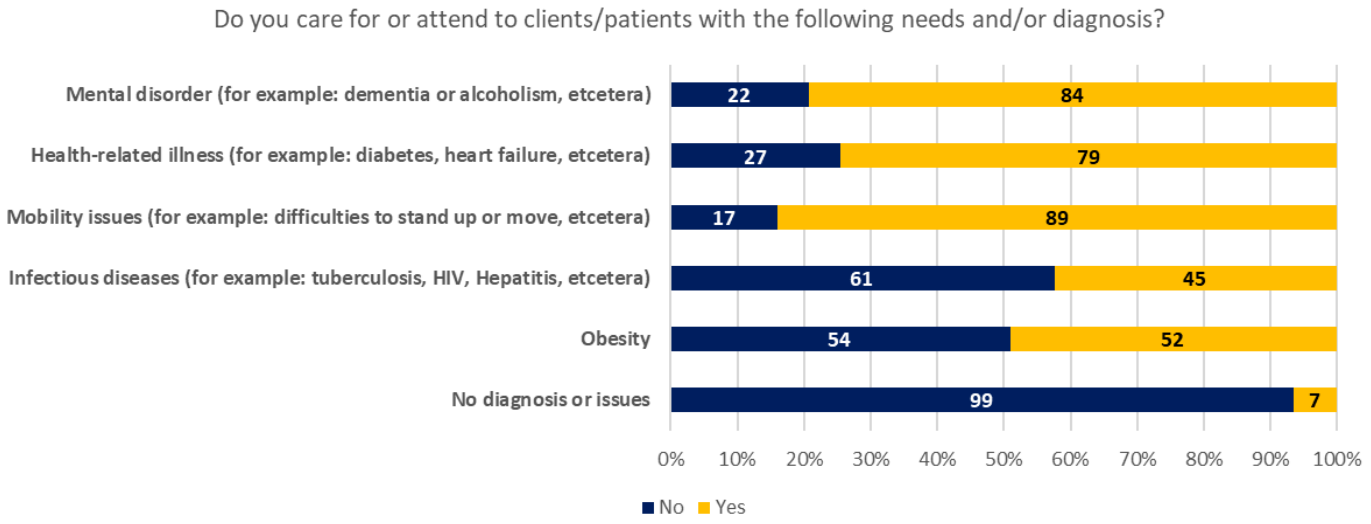


Figure 71. *Type of medical condition of the person receiving care*



The majority of participants (78.3%) reported receiving some form of supervision during their shifts. Most worked in teams with other colleagues (71.7%), while the remainder worked independently with their care receivers.

Figure 72. *Supervision*

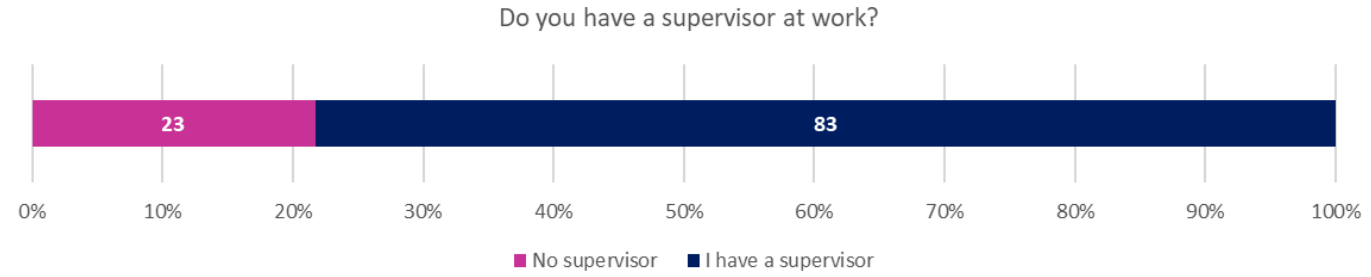
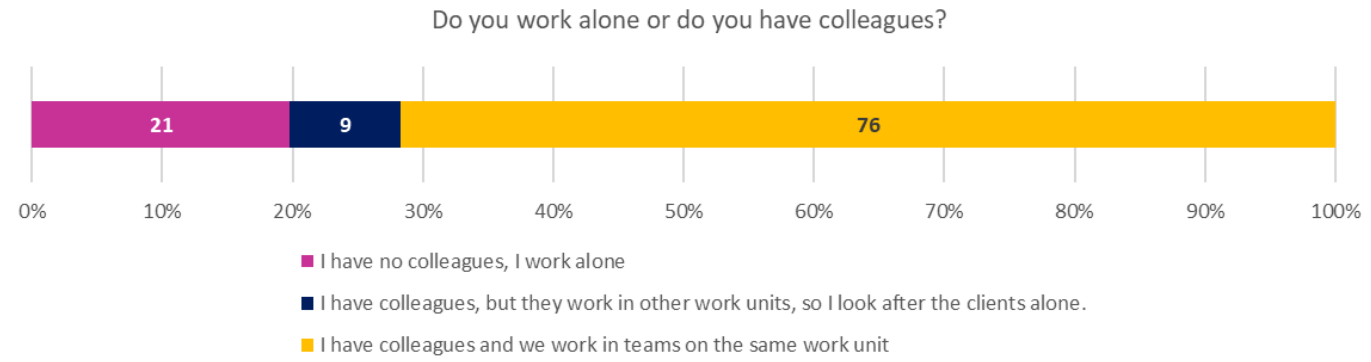


Figure 73. *Teamwork*



The majority of participants (75.5%) worked for private or for-profit organisations, while 14.2% were employed in the public sector and 13.2% were self-employed. A significant proportion (41.5%) reported being members of a trade union or similar organisation. In terms of employment contract, 61.3% had a full-time job, 25.5% worked part-time and 13.2% were employed on an hourly basis. Most participants (85.8%) had permanent contracts, 11.3% had temporary contracts and 3 people reported working without a legal contract. In terms of working hours, 55.7% worked shifts, 28.3% had fixed hours and 16% had flexible hours.

Figure 74. *Employment status*

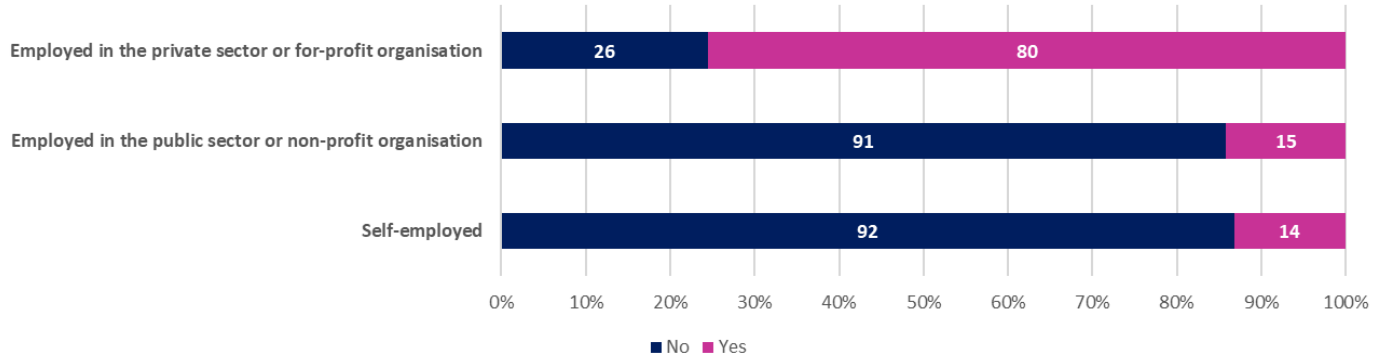


Figure 75. *Belonging to a union or association*

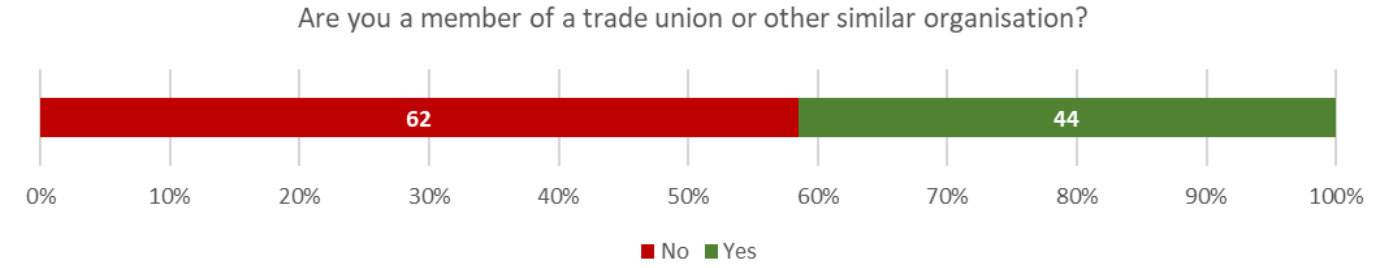


Figure 76. *Type and duration of contract*

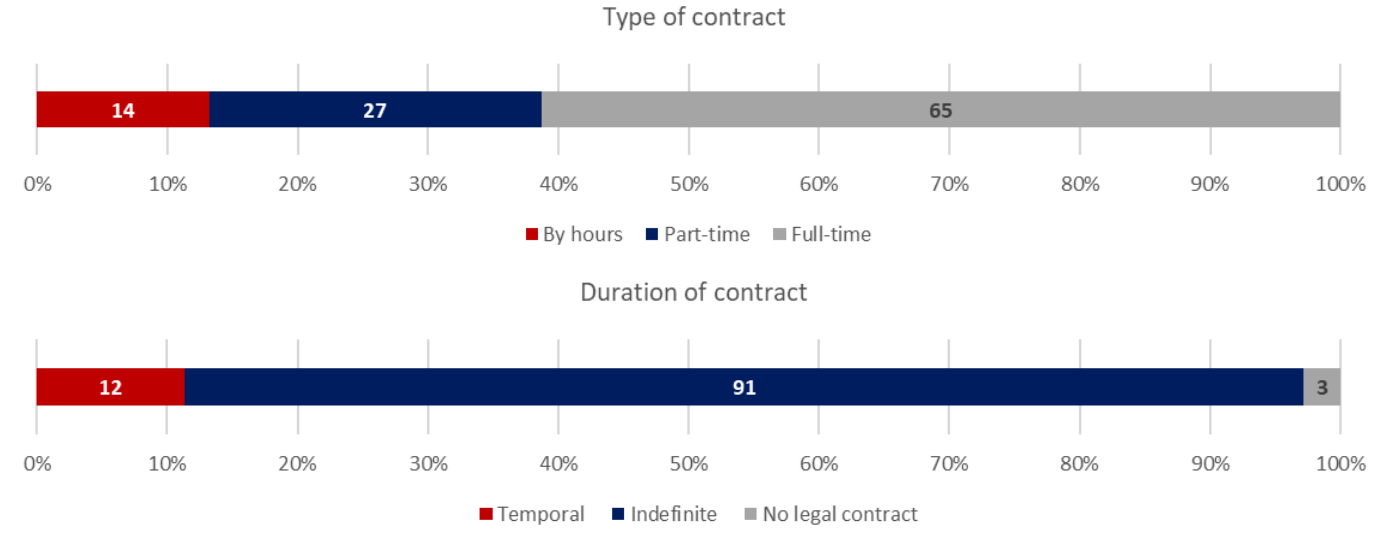
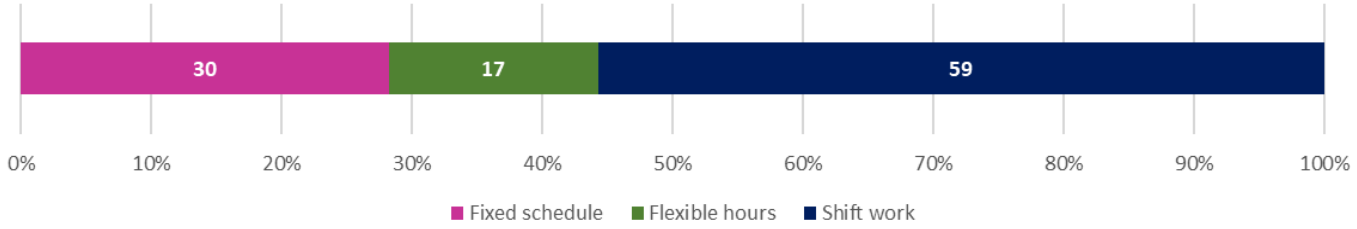
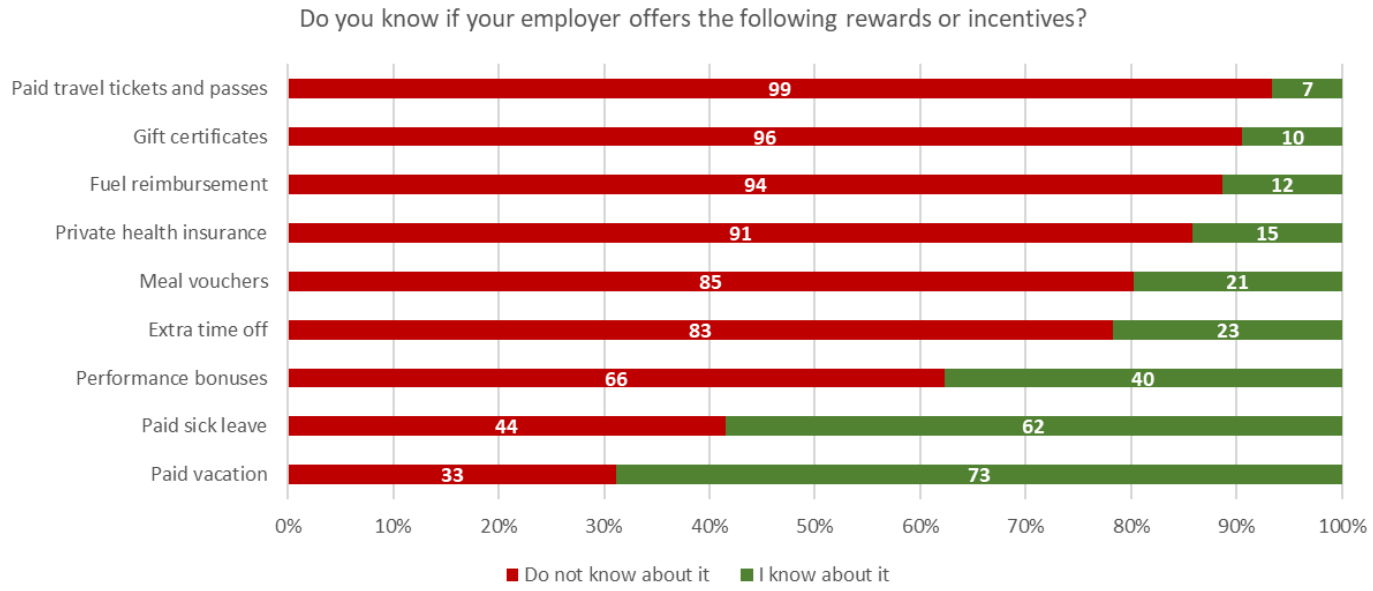


Figure 77. *Type of schedule or work shift*



Participants were asked whether they were aware of and had used any employer-provided rewards or incentives at their current workplace (e.g. meal vouchers, sick days or paid holidays). As shown in the figures below, care workers had limited access to or awareness of these benefits (mean = 2.48 out of 9, SD = 1.93). The most widely known benefit was paid leave (68.9%). However, overall use of benefits was low (mean = 1.32 out of 9, SD = 1.89), even for paid leave, which only 23.6% reported using. Awareness and use of the fuel reimbursement benefit was particularly low: only 11.3% knew about it and only 14.2% reported using it. This is notable given that the majority (79.2%) drive their own car to work. As homecare workers tend to have to travel more frequently than those employed in institutional care, these gaps suggest that a significant proportion of their wages may be spent on transport costs. This financial burden further disadvantages home care workers, who earn somewhat lower monthly wages (mean = €1,269.29; SD = €804.18) than those working in institutions (mean = €1,455.12; SD = €308.22). Most care workers (76.4%) reported having access to lifting equipment or mobility aids in their workplace.

Figure 78. *Knowledge and use of workplace benefits and/or rewards*



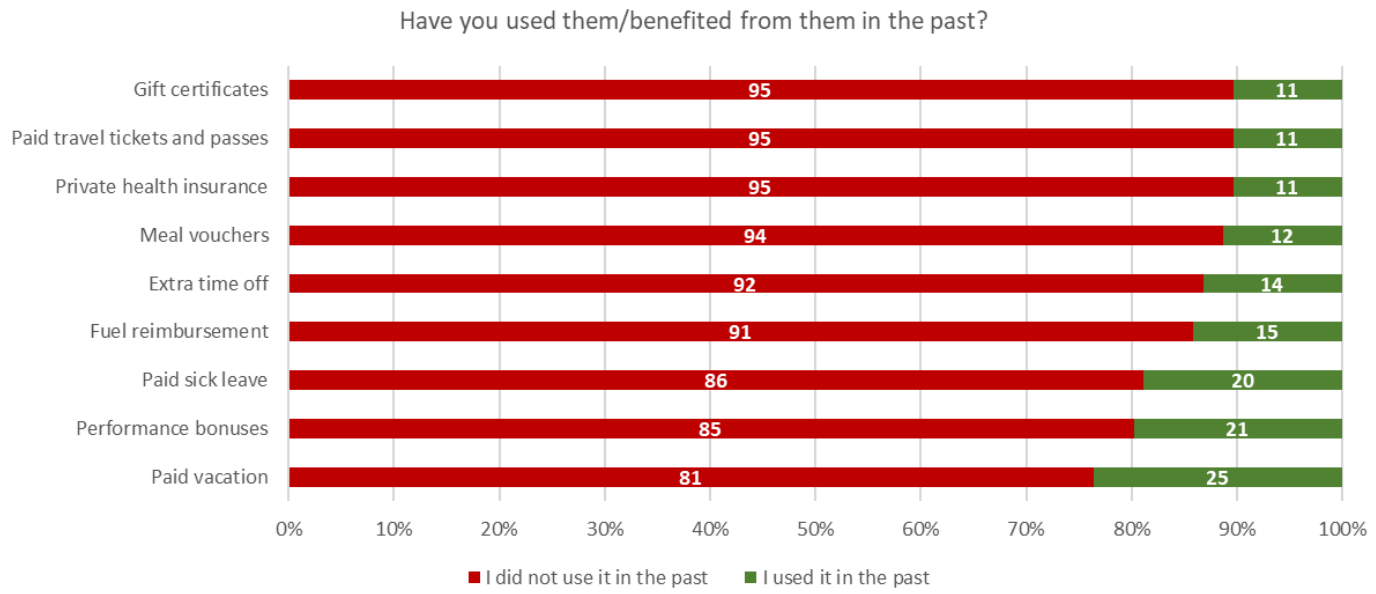


Figure 79. *Access to lifting aids or equipment*

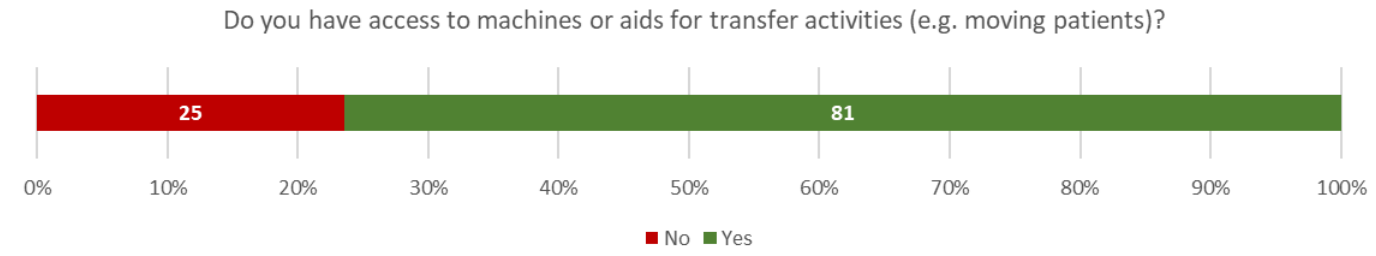
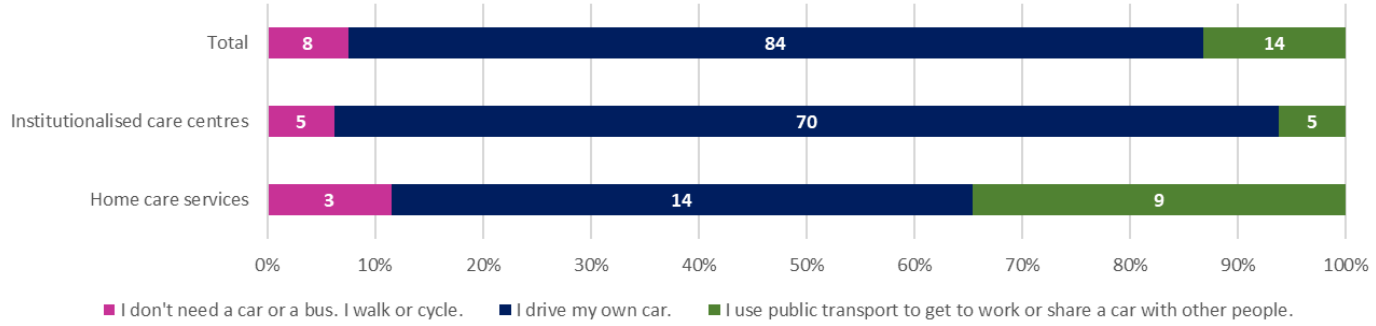


Figure 80. *Transport or commuting to work*



Participants worked an average of 33 hours per week (SD = 11.78). Among the Italian sample, 24.5% were employed in home care services, while 75.5% worked in institutional settings. Of those home care workers, the majority (60.7%) worked on a "live-out" basis, visiting care receivers in their homes, while 39.3% were "live-in" care workers, living with their care receivers. Home care workers often cared for the same care receivers for long periods: 28.6% provided care for 6 to 12 months and 53.6% for more than a year. On average, they cared for 8 care receivers per week (SD = 14.90). Live-in care workers typically spent an average of 6

days a week in their care receivers' homes (SD = 1.41). In terms of living conditions, although relatively few participants worked as live-ins, some reported not having access to a private room or wardrobe. Additionally, a few noted discomfort with indoor temperatures, reporting that it was too hot (2 participants) or too cold (1 participant) in the homes where they lived.

Figure 81. *Place of work*

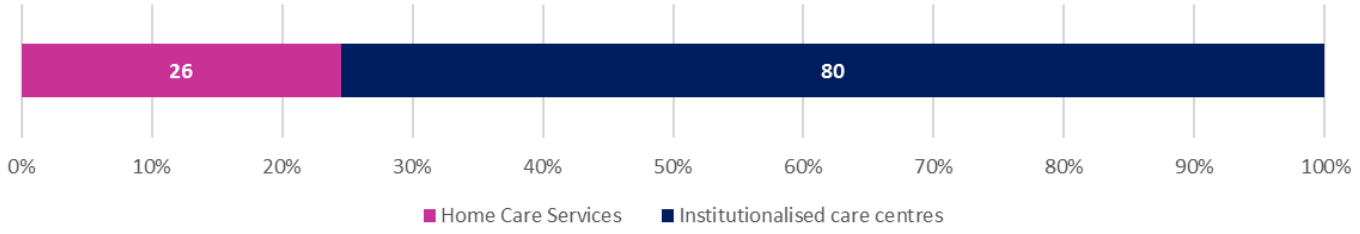


Figure 82. *Modality of home care work (HCWs)*

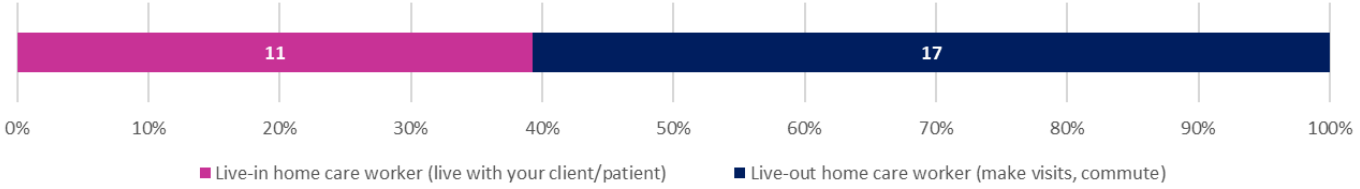


Figure 83. *Continuity of home care work (HCWs)*

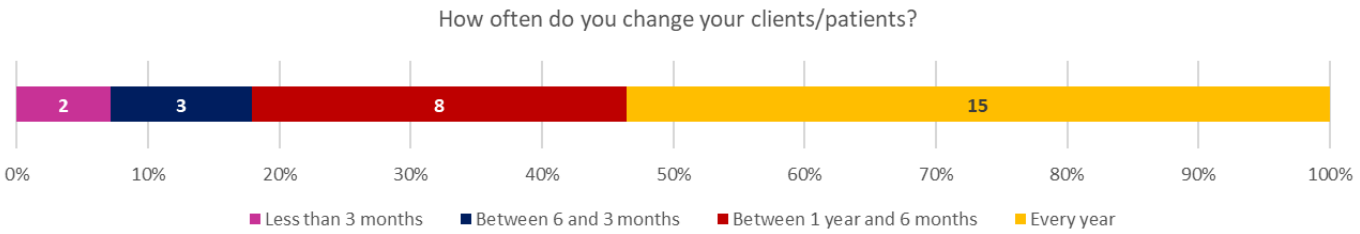
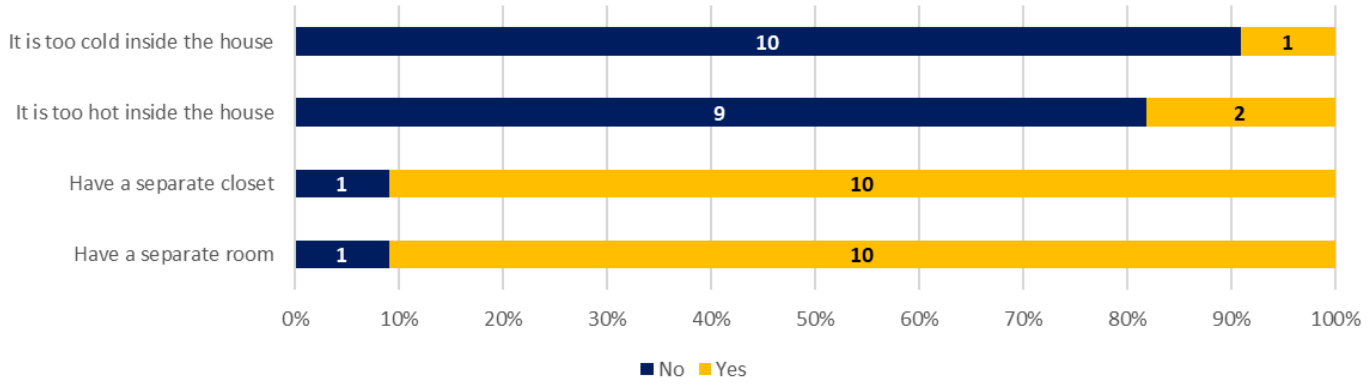


Figure 84. *Living conditions of live-in HCWs*



Only 13 participants (12.3%) were migrants, with an average of 119.64 months (approximately 10 years) of residence in Italy (SD = 98.41 months). All but two had legal permission to work in the country. Most migrant workers reported no difficulties with language use in the workplace, with only one participant reporting significant challenges with understanding and speaking Italian.

Figure 85. *Immigration status*

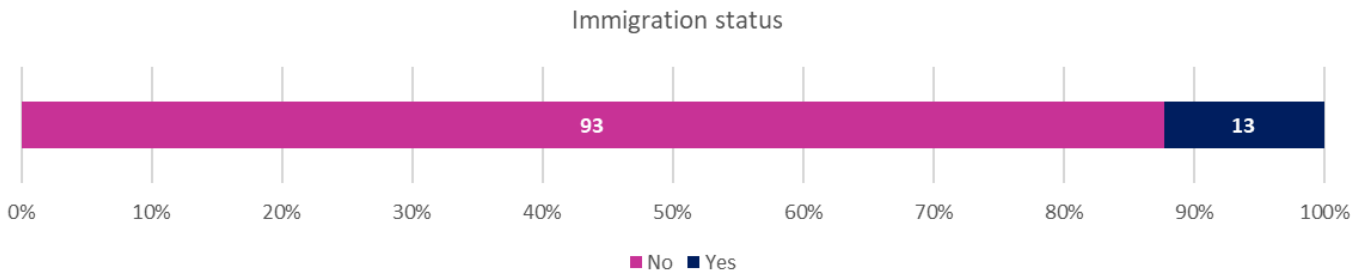


Figure 86. *Possession of work permit (migrant care workers)*

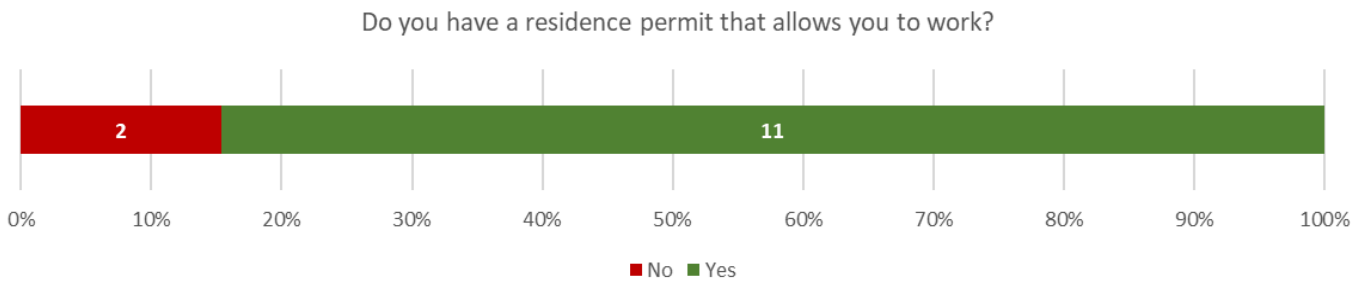
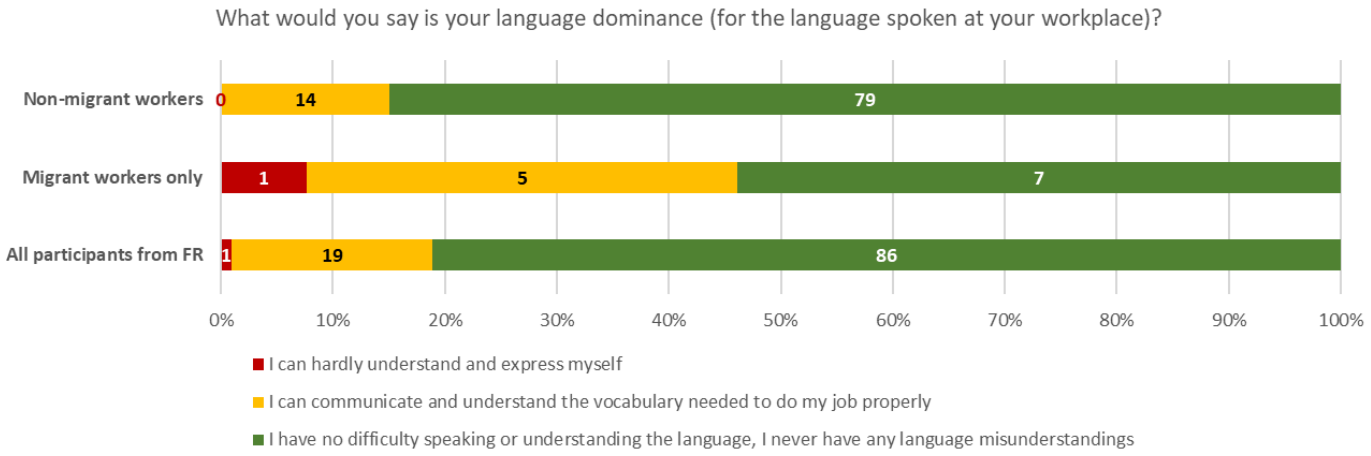


Figure 87. *Language dominance at the workplace*



3.2. Findings on Prevalence: Comparing Well-Being, Risks and Protective Factors Across Targets

3.2.1. Well-Being Results

In this section, the outcomes of work are examined, considering both its positive and negative dimensions. The positive dimension is captured through indicators of psychological well-being or flourishing, while the negative dimension focuses on burnout and perceived strain. The effects of work on personal life are also explored, concluding with a report on employees' expressed desire to leave their job if given the opportunity.

Table 11. *Main results of Wellbeing*

Outcomes	Target	Mean	S.D.	N
Burnout (Disengagement and Exhaustion)	Target A	2.70	0.43	24
	Target B	2.77	0.39	48
	Target C	2.78	0.48	34
	Mean	**2.76**	**0.42**	**106**
Perceived Exertion	Target A	6.63	3.29	24
	Target B	7.23	2.99	48
	Target C	6.21	2.84	34
	Mean	**6.76**	**3.02**	**106**
Turnover intentions	Target A	2.14	1.37	24
	Target B	2.10	1.16	48
	Target C	2.50	1.14	34
	Mean	**2.24**	**1.21**	**106**
Work-Private Life Conflict	Target A	2.31	1.06	24
	Target B	2.69	0.94	48
	Target C	2.69	0.80	34
	Mean	**2.60**	**0.93**	**106**
Work-Private Life Enrichment	Target A	3.52	1.04	24
	Target B	3.59	0.70	48
	Target C	3.50	0.75	34
	Mean	**3.55**	**0.80**	**106**
Happiness	Target A	7.67	2.20	24
	Target B	7.44	1.62	48
	Target C	7.06	1.77	34
	Mean	**7.37**	**1.81**	**106**
Flourishing	Target A	5.61	1.05	24
	Target B	5.62	0.98	48
	Target C	5.43	0.87	34
	Mean	**5.56**	**0.96**	**106**

Note: Target A: Home health aides; Target B: Basic care workers; Target C: Professional care workers.

Negative Indicators: Where Workers Are Struggling

Burnout Results. Burnout is a job-related syndrome that has been defined as a state of physical, emotional and mental exhaustion that results from prolonged exposure to chronic workplace stress that has not been successfully managed. This variable was assessed with the Oldenburg Burnout Inventory OLBI (Demerouti, et al. (2010). Two scales: disengagement (8 items) and psychological exhaustion (8 items). The responses ranged from 1 (strongly disagree) to 4 (strongly agree).

The average burnout score among Italian care workers was 2.76 (SD = 0.42) on a scale from 1 to 4, indicating a moderately high level of burnout, with frequent experiences of exhaustion and disengagement. No significant differences were found between the groups, suggesting that burnout levels were relatively consistent across home health aides, basic care workers, and professional care workers, regardless of their care setting.

Physical Exertion Results. This construct refers to the perceived level of physical effort required from care workers during their working hours. In other words, it quantifies the degree of exertion that care workers perceive themselves to be experiencing in relation to the physical demands of their work. This variable was measured using the Borg Rating of Perceived Exertion Scale (RPE) (1970). The scale ranges from 1 (no exertion) to 11 (maximal exertion).

The mean perceived physical strain score was 6.76 (SD = 3.02) on a scale of 1 to 11, indicating a moderate to high sense of physical strain associated with care work. No significant differences were found between the groups, suggesting that home health aides, basic care workers and professional care workers experienced similar levels of physical strain in their roles.

Turnover Intentions Results. This variable examined the intention or desire of care workers to leave or abandon their role within the care profession. It was measured using the Intention to Quit Questionnaire (ITQ), which was developed by Rahnfeld et al. (2016) and adapted from Price (1997). The ITQ comprises three items (example item 'despite the obligations I have made to my employer, I want to quit my job as soon as possible') that assess workers' intentions to quit their care job. Participants were asked to indicate the frequency of their intention to quit on a five-point Likert scale, with responses ranging from 1 (almost never) to 5 (almost always).

The mean turnover score was 2.24 (SD = 1.21) on a scale of 1 to 5, indicating a generally low to moderate intention among care workers to leave their current job. No significant differences were found between the groups, suggesting that home health aides, basic care workers and professional care workers had similar levels of intention to stay or leave their jobs.

Work-Private Life Conflict Results. This construct represents a form of inter-role conflict, characterised by a clash between the demands of one's professional role and those of their personal or familial responsibilities. The scale from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version, comprising five items (e.g., 'Do you feel that your work drains so much of your energy that it has a negative effect on your private life?'), was employed to measure the variable. The responses ranged from 1 (never) to 5 (always).

The mean work-life conflict score was 2.60 (SD = 0.93) on a scale of 1 to 5, indicating a moderate level of conflict between work responsibilities and personal or family life. No significant differences were found between the groups, suggesting that home health aides, basic care workers and professional care workers experienced similar challenges in balancing work and personal risk factors.

Positive Indicators: Signs of Strength

Work-Private Life Enrichment Results. This variable pertains to a process at the work-private life intersection, in which experience or involvement in one role enhances the quality or performance in the other role. The six-item scale Work-family enrichment, as originally proposed by Carlson et al. (2006) and subsequently abbreviated by Kacmar et al. (2014), was employed to assess the variable in question. Participants were invited to indicate their level of agreement with each item on a five-point Likert scale, with responses ranging from 1 (strongly disagree) to 5 (strongly agree).

The mean score for work-life enrichment was 3.55 (SD = 0.80) on a scale of 1 to 5, suggesting that care workers generally experienced a positive exchange between their work and personal lives, with involvement in one area enhancing experiences in the other. No significant differences were found between the groups, suggesting that home health aides, basic care workers and professional care workers reported similar levels of enrichment across roles and settings.

Happiness results. This construct was designed to assess care workers' general levels of happiness and their attitudes towards their own lives. The variable was assessed using a single item: ‘taken everything together, how happy are you with your life?’. Participants were instructed to indicate their level of satisfaction on a scale from 0 (totally unhappy) to 10 (extremely happy).

The average happiness score was 7.37 (SD = 1.81) on a scale from 0 to 10, indicating generally high levels of overall satisfaction with life among care workers. No significant differences were observed between the groups, suggesting that home health aides, basic care workers, and professional care workers reported similarly positive happiness, regardless of their role or care setting.

Flourishing results. The concept of flourishing can be defined as the combination of subjective and psychological well-being, in which the individual is in a positive emotional state, experiencing feelings of engagement, meaning (or purpose), having personal resources and positive interpersonal relationships. It is measured using a scale comprising eight statements (example items are 'I am optimistic about my future' and 'I lead a purposeful and meaningful life') (Diener et al., 2009), with respondents indicating their level of agreement on a scale from 1 (strongly disagree) to 7 (strongly agree).

The mean flourishing score was 5.56 (SD = 0.96) on a scale of 1 to 7, indicating that care workers generally reported high levels of psychological well-being, engagement, meaning, and strong personal and social resources. No significant differences were found between the groups, suggesting that home health aides, basic care workers and professional care workers experienced similarly strong foundations of well-being across these dimensions.

3.2.2. Risk Factors among Care Workers

Drawing on the Job Demands–Resources (JD-R) theory (Bakker & Demerouti, 2011), which serves as the theoretical framework for this research, this section examines key findings related to job demands or risk factors as perceived by care workers.

Table 12. *Job, emotional and relational risk factors*

Risk factors	Target	Mean	S.D.	N
Physical Demands	Target A	3.13	1.65	24
	Target B	3.77	1.45	48
	Target C	4.18	1.27	34
	Mean	**3.75**	**1.48**	**106**
Quantitative Demands	Target A	1.97	0.80	24
	Target B	2.53	0.83	48
	Target C	2.94	0.74	34
	Mean	**2.54**	**0.86**	**106**
Work Pace	Target A	3.10	1.21	24
	Target B	3.44	0.95	48
	Target C	3.69	0.80	34
	Mean	**3.44**	**0.98**	**106**
Tasks Beyond Care Workers' duties	Target A	2.46	1.22	24
	Target B	2.13	1.14	48
	Target C	2.82	1.31	34
	Mean	**2.42**	**1.24**	**106**
Emotional Demands	Target A	3.07	1.04	24
	Target B	3.54	0.73	48
	Target C	3.82	0.83	34
	Mean	**3.53**	**0.87**	**106**
Demands for Hiding Emotions	Target A	3.08	1.19	24
	Target B	3.59	0.75	48
	Target C	3.94	0.68	34
	Mean	**3.59**	**0.90**	**106**
Exposure to Workplace Violence	Target A	1.87	0.99	24
	Target B	2.15	1.07	48
	Target C	2.12	0.98	34
	Mean	**2.08**	**1.02**	**106**
Exposure to Discrimination	Target A	0.42	1.02	24
	Target B	0.35	0.91	48
	Target C	0.18	0.58	34
	Mean	**0.31**	**0.84**	**106**
Intragroup Conflict	Target A	1.81	0.91	24
	Target B	2.53	0.77	48
	Target C	2.75	0.78	34
	Mean	**2.44**	**0.87**	**106**

Continuation Table 12.

Risk factors	Target	Mean	S.D.	N
Workplace Incivility	Target A	1.69	0.78	24
	Target B	2.38	0.83	48
	Target C	2.36	0.73	34
	Mean	**2.22**	**0.83**	**106**

Job-related Risk Factors

Physical Demands. This variable pertains to the frequency of physical activity that care workers are required to perform in order to fulfil the duties inherent to their role. These activities may include, but are not limited to, walking, lifting, carrying, reaching, pushing and pulling. Participants were asked to respond on a 5-point Likert scale, from 1 (never) to 5 (everyday).

The mean score for physical demands was 3.74 (SD = 1.48) on a scale of 1 to 5, indicating that care workers frequently engaged in physically demanding tasks such as lifting, transferring and other forms of manual labour. Significant differences were found between the groups: professional care workers reported the highest levels of physical demands, while home health aides reported the lowest. This suggests that physical intensity increases with the level of professional qualification, even within similar institutional care settings (basic care workers and professional care workers both were employed in institutional settings).

Figure 88. *Cross-target physical demands comparative results*

Quantitative Demands. Defined as the psychological demands that arise from the amount of work that must be completed within a given timeframe. These demands are typically high when the volume of work exceeds the capacity to complete it within the specified period. Four items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were employed to assess the job demand in question. An illustrative item is "Is your workload unevenly distributed so it piles up?". The respondents

were asked to respond on a 5-point Likert scale, from 1 (never) to 5 (always).

The mean score for quantitative demands was 2.54 (SD = 0.86) on a scale of 1 to 5, indicating a moderate level of workload pressure to complete tasks within a set timeframe. Significant differences were observed between the groups: professional care workers reported the highest levels of quantitative demands, followed by basic care workers, while home health aides reported the lowest levels. This suggests that workload intensity increases with the level of professional qualification, even within similar institutional care settings.

Figure 89. *Cross-target quantitative demands comparative results*

Work Pace Demands. The term is defined as the psychological demand associated with the intensity of the work. To assess this job demand, three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were used. An illustrative item is, "Do you work at a high pace throughout the day?" Respondents were asked to indicate their level of agreement with the item on a 5-point Likert scale, from 1 (never) to 5 (always).

The mean score for work pace demands was 3.44 (SD = 0.98) on a scale of 1 to 5, indicating that care workers generally experienced a relatively high intensity of work that required them to maintain a steady and sometimes fast pace. No significant differences were found between the groups, suggesting that home health aides, basic care workers and professional care workers experienced similar work pace demands in all care settings.

Tasks Beyond Care Workers' Duties. The variable assessed the frequency of instances over the past year in which care workers were required to perform tasks that were not included in their job description or the care receivers' care plan (question taken from Karlsson et. al. (2020) study, in which 47% of home care aides agreed or strongly agreed with the statement. In our study, the response options were adapted to be coherent with the rest of the survey. They were instructed to indicate their response on a 5-point Likert scale, ranging from 1 (never or almost never) to 5 (a lot of the time).

The mean score for exposure to requests to perform tasks outside the formal care job was 2.42 (SD = 1.24) on a scale of 1 to 5, indicating that care workers occasionally experienced being asked to perform tasks outside their official job description. No significant differences were observed between the groups, suggesting that home health aides, basic care workers and professional care workers were exposed to similar levels of these extra-role requests in all care settings.

Emotional Risk Factors

Emotional Demands. The construct pertains to the psychological demands that arise from the interpersonal relationships involved in the work, which require care workers to engage in emotionally charged situations. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were employed to assess the aforementioned job demand. An illustrative item is "Do you have to deal with other people's personal problems as part of your work?" The respondents were requested to respond on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The mean score for emotional demands was 3.53 (SD = 0.87) on a scale of 1 to 5, indicating that care workers were frequently confronted with emotionally challenging situations in their daily work. Significant differences were found between the groups: professional care workers reported the highest levels of emotional demands, while home health aides reported the lowest. Basic care workers reported levels in between. This suggests that the emotional intensity of care work may be greater in roles with higher qualifications and in institutional settings.

Figure 90. *Cross-target emotional demands comparative results*

Demands for Hiding Emotions. The variable in question alludes to the psychological demand associated with the necessity of maintaining a neutral demeanour in the face of unpredictable behaviour exhibited by care receivers, colleagues, superiors, family members, and other individuals within the professional setting. Four items from the Copenhagen

Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this job demand. An illustrative item is, "Are you required to be kind and open towards everyone – regardless of how they behave towards you?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The mean score for demands to hide emotions was 3.59 (SD = 0.90) on a scale of 1 to 5, indicating that care workers often felt required to suppress or control their emotional reactions while performing their duties. Significant differences were observed between the groups: professional care workers reported the highest demands for hiding emotions, while home health aides reported the lowest, with basic care workers in between. This pattern suggests that higher skilled roles and institutional care settings may expose workers to more frequent demands for emotional self-restraint.

Figure 91. *Cross-target demands for hiding emotions comparative results*

Relational Risk Factors

Exposure to Workplace Violence. The variable in question was designed to assess the frequency of instances in which care workers were exposed to violent behaviours or attitudes directed towards them in the workplace. Specifically, respondents were asked to respond to one question - In the last year, how often have you been exposed at work to violence from patients and/or their family members?. The respondents were required to indicate their level of agreement with the statement on a five-point Likert scale, with 1 representing "never" and 5 representing "everyday".

The mean score for exposure to workplace violence was 2.08 (SD = 1.02) on a scale of 1 to 5, indicating that care workers occasionally encountered violent behaviour or attitudes from patients or their family members. No significant differences were found between the groups, suggesting that home health aides, basic care workers and professional care workers reported similar levels of exposure to workplace violence in all care settings.

Exposure to Discrimination. This variable assessed the frequency with which care workers had experienced discriminatory behaviour or attitudes that made them feel vulnerable because of their gender, ethnicity or colour in the past year. This was measured on a 4-point scale (0 - never; 1 - once; 2 - two or three times; and 3 - four or more times). The question was adapted from the Experiences of Discrimination Scale (EOD) developed by Williams et al. (1997).

A total of 14 out of 106 participants reported experiencing discrimination at work in the past year. The perceived reasons for this discrimination, listed from most to least frequent, were nationality, colour, height or weight, gender, ethnicity, age, religion, education or income level and disability.

Figure 92. *Exposure to discrimination variable results*

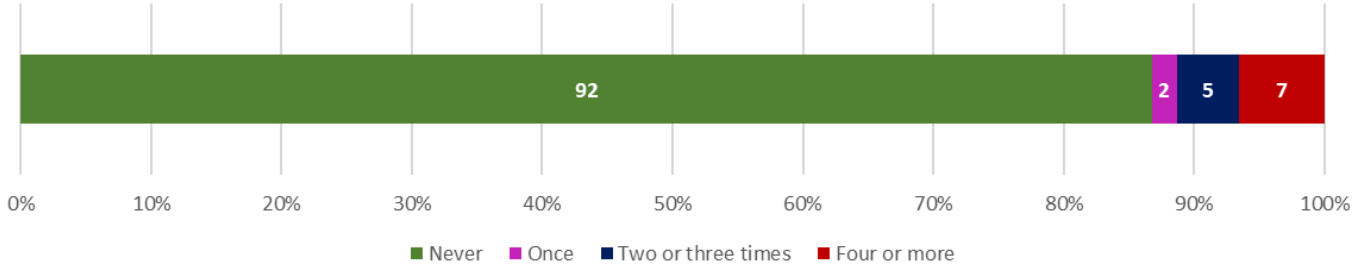
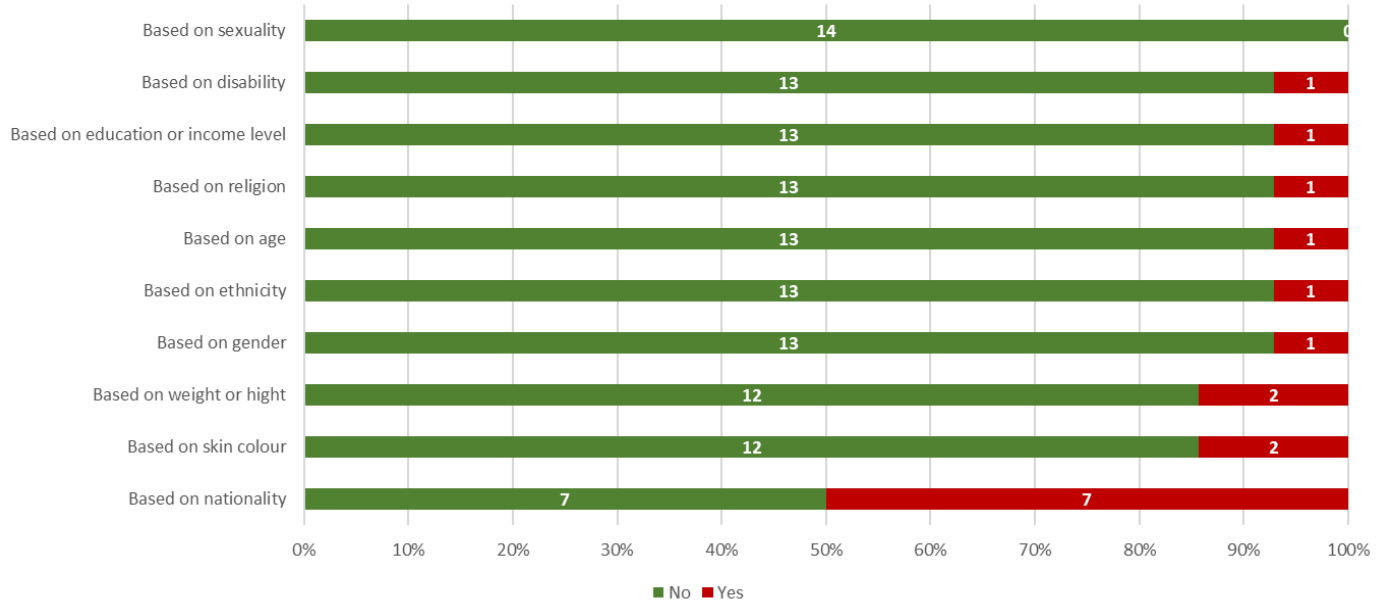


Figure 93. *Perceived motive of discrimination of those who experienced it*



The average score for exposure to discrimination was 0.31 (SD = 0.84) on a scale of 0 to 3, indicating that most care workers reported few or no incidents in the past year. However, this does not necessarily imply an absence of discrimination, but rather reflects the levels reported by participants. No significant differences were found between the groups, suggesting that home health aides, basic care workers and professional care workers reported similar experiences.

Intragroup Conflict. The construct refers to the frequency with which carers experience conflict within a team, with the care receiver, their family members or other people at work, where members clash over work procedures or due to personality clashes. The 8-item scale was adapted from Jehn (1995). Participants were asked to respond on a 5-point Likert scale from 1 (none) to 5 (a lot).

The mean score for intragroup conflict was 2.44 (SD = 0.87) on a scale of 1 to 5, indicating a moderate frequency of conflict or clashes within care teams or between workers and others in their immediate work environment. Significant differences were found between the groups: home health aides reported the lowest levels of intra-group conflict, while basic care workers and professional care workers reported higher - and statistically similar - levels. This suggests that conflicts may be more common in institutional care settings, where care is typically provided in teams.

Figure 94. *Cross-target intragroup conflict comparative results*

Workplace Incivility. The variable is defined as low-intensity deviant behaviour (by care receivers, family members, colleagues, etc.) with ambiguous intent to harm the target (the care worker), in violation of workplace norms of mutual respect. The 4-item scale shortened by Matthews & Ritter (2016) from Cortina et al. (2013) was used to assess this construct. An example item is "In the past year, have you been in a situation where people you interact with at work made jokes at your expense?" Participants were asked to respond on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The mean score for workplace incivility was 2.22 (SD = 0.83) on a scale of 1 to 5, indicating that care workers occasionally experienced disrespectful or inappropriate behaviour in their workplace. Significant differences were found between groups: home health aides reported the lowest levels of incivility, while basic care workers and professional care workers reported higher - and statistically similar - levels. This suggests that such behaviour may be more prevalent in institutional care settings, where interactions between staff, patients and families are more frequent.

Figure 95. *Cross-target workplace incivility comparative results*

3.2.3. Protective Factors in the Care Sector

This section focuses on the resources available to care workers to help them cope with the demands of their work. As in the previous section, both overall results and comparisons between different target groups are presented.

Table 13. *Job, emotional and relational protective factors*

Protective factors	Target	Mean	S.D.	N
Possibilities for Development	Target A	4.14	1.05	24
	Target B	3.94	0.77	48
	Target C	4.10	0.89	34
	Mean	**4.04**	**0.87**	**106**
Variation of Work	Target A	2.92	1.03	24
	Target B	3.17	0.87	48
	Target C	3.50	1.02	34
	Mean	**3.22**	**0.97**	**106**
Control over Working Time	Target A	2.72	0.78	24
	Target B	2.82	0.67	48
	Target C	2.99	0.61	34
	Mean	**2.85**	**0.68**	**106**
Predictability	Target A	4.10	1.06	24
	Target B	3.63	1.02	48
	Target C	3.15	0.91	34
	Mean	**3.58**	**1.05**	**106**
Autonomy	Target A	3.15	0.77	24
	Target B	2.79	0.71	48
	Target C	2.94	0.72	34
	Mean	**2.92**	**0.73**	**106**
Meaning of Work	Target A	4.58	0.93	24
	Target B	4.77	0.49	48
	Target C	4.43	0.86	34
	Mean	**4.62**	**0.74**	**106**
Recognition	Target A	4.19	1.09	24
	Target B	4.03	1.04	48
	Target C	3.86	0.92	34
	Mean	**4.01**	**1.01**	**106**
Emotional Social Support	Target A	3.93	1.16	24
	Target B	3.68	1.03	48
	Target C	3.67	0.83	34
	Mean	**3.73**	**1.00**	**106**
Instrumental Social Support	Target A	2.71	0.81	24
	Target B	3.08	0.98	48
	Target C	2.92	0.78	34
	Mean	**2.94**	**0.89**	**106**

Job-related Protective Factors

Possibilities for Development. The variable in question refers to the extent to which job performance provides opportunities for care workers to put their knowledge, skills and experience into practice and to acquire new knowledge, skills and experience. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. An illustrative item is "Do you have the possibility of learning new things through your work?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The mean score for development opportunities was 4.04 (SD = 0.87) on a scale of 1 to 5, indicating that care workers generally perceived strong opportunities to apply and develop their knowledge, skills and experience in their roles. No significant differences were found between the groups, suggesting that home health aides, basic care workers and professional care workers reported similarly positive perceptions of development opportunities across all care settings.

Variation of Work. The construct refers to whether care work tasks are repetitive or, on the contrary, diverse or varied. Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. An illustrative item is "Do you have to do the same thing over and over again?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The mean score for task variety was 3.22 (SD = 0.97) on a scale of 1 to 5, indicating that care workers generally experienced a moderate to good level of task variety in their daily responsibilities. No significant differences were found between the groups, suggesting that home health aides, basic care workers and professional care workers reported similar levels of task variety in different care settings.

Control over Working Time. The construct refers to care workers'' control over their working time in aspects such as starting and ending the working day, when to take breaks, days off, holidays, and control over whether, when and how much overtime to work. 5 items from the long version of the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) were selected to assess this resource. An illustrative item is "Can you decide when to take a break?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The mean score for control over working time was 2.85 (SD = 0.68) on a scale of 1 to 5, indicating that care workers generally reported a moderate level of autonomy in managing aspects of their schedule, such as start and end times, breaks and days off. No significant differences were found between the groups, suggesting that home health aides, basic care

workers and professional care workers experienced similar levels of control over their working hours.

Predictability. Work is predictable if the worker has adequate, sufficient and timely information to be able to perform the job correctly and to adapt to changes (future restructuring, new technologies, new tasks, new methods and the like). Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected for the assessment of this resource. One illustrative item is, "Do you receive all the information you need in order to do your work well?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The mean score for predictability was 3.58 (SD = 1.05) on a scale of 1 to 5, indicating that care workers generally felt they had a moderate to high level of timely and sufficient information to carry out their tasks and adapt to changes. Significant differences were found between the groups: home health aides reported higher levels of predictability, while professional care workers reported lower levels, with basic care workers falling in between. This suggests that the nature of the role and the care setting may influence how predictable workers perceive their tasks and environment to be.

Figure 96. *Cross-target predictability comparative results*

Autonomy. The construct refers to the degree of influence or decision latitude that the care worker has in the day-to-day activities, particularly in relation to the tasks to be carried out and the manner in which they are to be carried out. The three-item scale from Bakker and Bal (2010), adapted from Karasek et al. (1985), was used to quantify this resource. An illustrative item is "I have a lot of freedom in the execution of my work". The responses ranged from 1 (strongly disagree) to 4 (strongly agree).

The mean autonomy score was 2.92 (SD = 0.73) on a scale of 1 to 5, indicating that care workers experienced a moderate level of freedom to make decisions about how to carry out their daily tasks and responsibilities. No significant differences were found between the groups, suggesting that home health aides, basic care workers and professional care workers reported similar levels of autonomy across all care settings.

Emotional Protective Factors

Meaning of Work. The variable is defined as the relationship that work has to values other than those associated with having a job and earning an income. These include the utility, importance or social value, or learning involved. Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected for the assessment of this resource. One illustrative item is, "Are you required to be kind and open towards everyone – regardless of how they behave towards you?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The mean score for meaning of work was 4.62 (SD = 0.74) on a scale of 1 to 5, indicating that care workers strongly perceived their work as meaningful and valuable beyond its financial aspects, recognising its social importance and personal significance. No significant differences were found between the groups, suggesting that home health aides, basic care workers and professional care workers shared a similar sense of purpose and fulfilment in their roles.

Relational Protective Factors

Recognition. The term denotes the appreciation, respect and fair treatment afforded to care workers by their supervisors in the workplace. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. One illustrative item is, "Is your work recognised and appreciated by the management/supervisor?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The mean score for recognition was 4.01 (SD = 1.01) on a scale of 1 to 5, indicating that care workers generally felt valued, respected and treated fairly by their supervisors. No significant differences were found between the groups, suggesting that home health aides, basic care workers and professional care workers experienced similar levels of recognition across all care settings.

Social Support. The variable can be defined as the degree to which care workers receive emotional and instrumental (help with job tasks) support from the individuals with whom they interact at their place of work. The 8-item scale was adapted from that used by Peeters et al. (1995) for the purpose of measuring this resource. An example item is, "The people you interact with at work showed that they appreciated the way you do your work". The responses were measured on a scale ranging from 1 (not at all) to 5 (a lot).

Care workers reported an average score of 3.73 (SD = 1.00) for emotional support and 2.94 (SD = 0.89) for instrumental support on a scale of 1 to 5. These results suggest that while care workers generally felt they received strong emotional support - such as empathy and

understanding - from those they interacted with at work, practical help with tasks was perceived as less consistently available. No significant differences were found between the groups, suggesting that home health aides, basic care workers and professional care workers experienced similar patterns of emotional and instrumental support across all care settings.

3.2.4. Summary: Main Differences Across Targets in Italy

Table 14. *Summary of prevalence results in Italy*

Dimension		Variable	Overall level	Cross-target differences
Well-being indicators	***Negative well-being indicators***	Burnout (Disengagement and Exhaustion)	Moderate	No differences
		Physical Exertion	Moderate-High	No differences
		Turnover Intentions	Low-Moderate	No differences
		Work–Private Life Conflict	Moderate	No differences
	Positive well-being indicators	Work–Private Life Enrichment	Moderate-High	No differences
		Happiness	High	No differences
		Flourishing	High	No differences
Risk factors	***Job-related risk factors***	Physical Demands	Moderate-High	C > B > A
		Quantitative Demands	Moderate	C > B > A
		Work Pace Demands	Moderate-High	No differences
		Tasks Beyond Job Duties	Low-Moderate	No differences
	Emotional risk factors	Emotional Demands	Moderate-High	C > B > A
		Demands for Hiding Emotions	Moderate-High	C > B > A
	Relational risk factors	Exposure to Workplace Violence	Low	No differences
		Exposure to Discrimination	Low	No differences
		Intragroup Conflict	Low-Moderate	C, B > A
		Workplace Incivility	Low	C, B > A
Protective factors	***Job protective factors***	Possibilities for Development	High	No differences
		Variation of Work	Moderate	No differences
		Control Over Time	Moderate	No differences
		Predictability	Moderate-High	A > B > C
		Autonomy	Moderate	No differences
	Emotional protective factors	Meaning of Work	High	No differences
	Relational protective factors	Recognition	High	No differences
		Emotional Support	Moderate-High	No differences
		Instrumental Support	Moderate	No differences

Note: Consider the sample sizes for each group (24 home health aides - A; 48 basic care workers - B; and 34 professional care workers - C)

The findings from the general survey provide a detailed insight into the experiences of care workers living in Italy, showing a balance between positive well-being and the considerable risk factors of care work. Across all groups, workers reported high levels of psychological well-being, including a strong sense of purpose and flourishing in their role, as well as generally high levels of happiness. Turnover intentions were low to moderate, suggesting that while many workers are satisfied in their current roles, some may be considering making changes in the future. Burnout levels were moderate to high overall, reflecting a mixture of emotional strain and detachment from work, while moderate work-life conflict indicated challenges in balancing work and personal responsibilities.

The job-related risk factors faced by care workers in Italy were considerable. Physical and emotional demands were a regular part of their work, with professional care workers - those with the highest qualifications - reporting particularly high levels of physical demands, emotional demands and demands to hide their emotions. Although home health aides reported lower levels of demands, they were not exempt from challenges such as intergroup conflict and quantitative demands, although these tended to be less frequent than in institutional care. Reports of workplace violence and discrimination were relatively low overall, but it is important to note that lower reported incidents do not necessarily imply the absence of discriminatory experiences, but may reflect underreporting or the normalisation of such behaviour in care settings.

In terms of protective factors, the results are encouraging in many ways. Care workers strongly affirmed the meaning and value of their work and felt well recognised by their supervisors. Emotional support was also consistently reported, although practical help with tasks (instrumental support) was less readily available. Employees generally reported good opportunities for career development, with the variety of tasks also positively rated. The tasks and responsibilities were seen as highly predictable - particularly for home health aides - while autonomy and control over working time were moderate, suggesting room for improvement to allow greater flexibility and decision making authority.

In summary, Italian care workers described a working environment where personal well-being and a deep sense of meaning in their role coexist with high physical and emotional demands. Strengthening support systems - especially practical resources and opportunities for greater control over working time - could help alleviate some of these pressures and promote more sustainable working conditions in all care settings.

Chapter 4. Qualitative Data Set: Making Sense of the Findings Through Workers' Voices

4.1. Profile of the Care Workforce: Focus Group Sample

A total of 32 care workers from Italy participated in the study, 17 from Target A (in red, home health aides), 7 from Target B (in green, basic care workers) and 8 participants from Target C. Among home health aides who answered their work modality 15 (83.3 %) were live-in home care workers while 3 (16.7%) were live-out home care workers.

Figure 97. *Participants per target group*

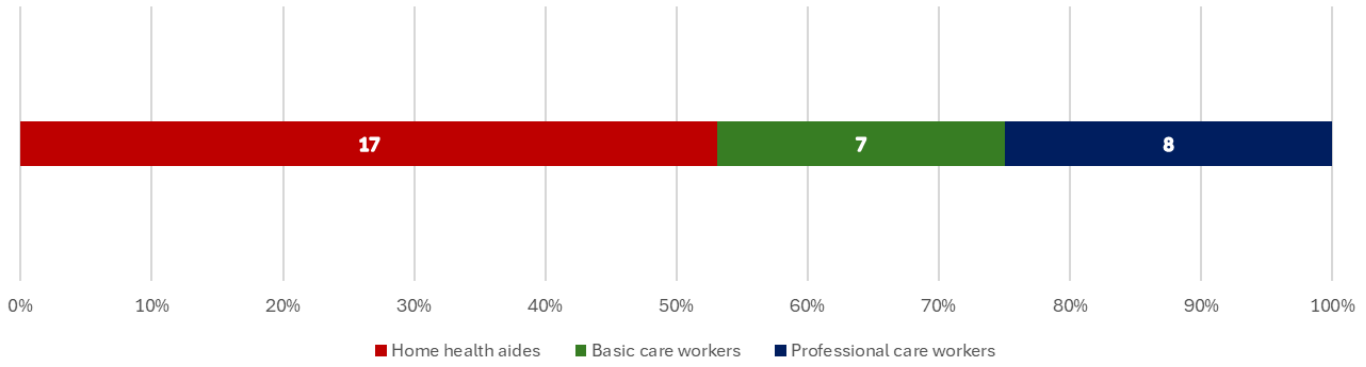
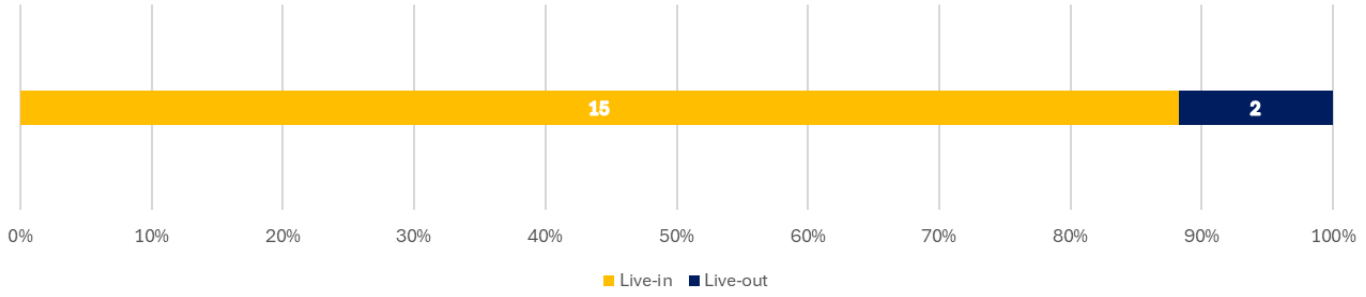


Figure 98. *Modality of home care*



The average age of the Italian participants was 46.71 years and the majority were women (84.5%). Among age groups 9.5% were younger adults, 46.8% were adults and 43.7% were middle-aged adults.

Figure 99. *Age groups*

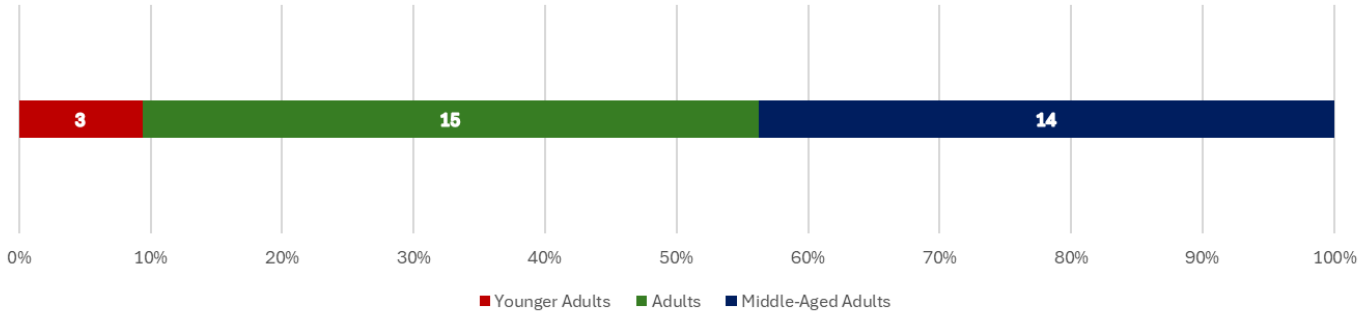
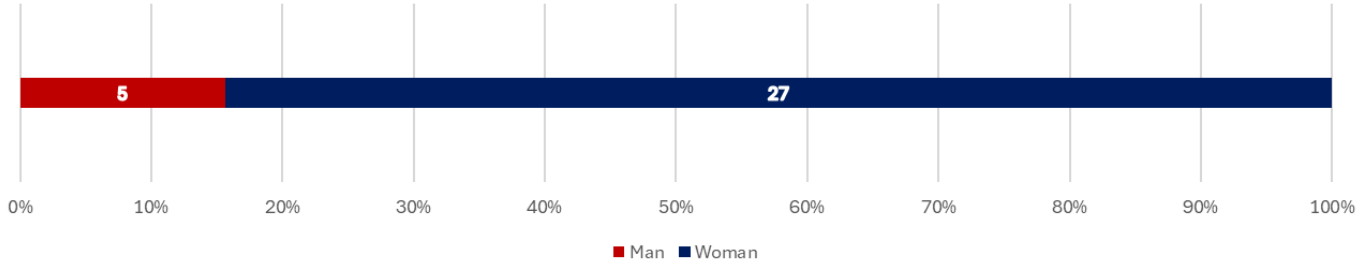


Figure 100. *Gender*



Most participants were Italian (48.4%). A small number of participants reported being from another EU country: Romania (16.9%) and Moldavia, also from African countries (Cameroon and Morocco) and Latin America (Brazil, Cuba and Ecuador).

Table 15. *Country of origin*

Country	Participants	Percentage
Italy	15	48.4
Brazil	2	6.7
Cameroon	3	9.6
Cuba	1	2.1
Ecuador	1	3.2
Morocco	1	3.2
Moldavia	1	3.2
Peru	2	6.7
Romania	5	16.9
Total	31	100

Figure 101. *Country of origin*

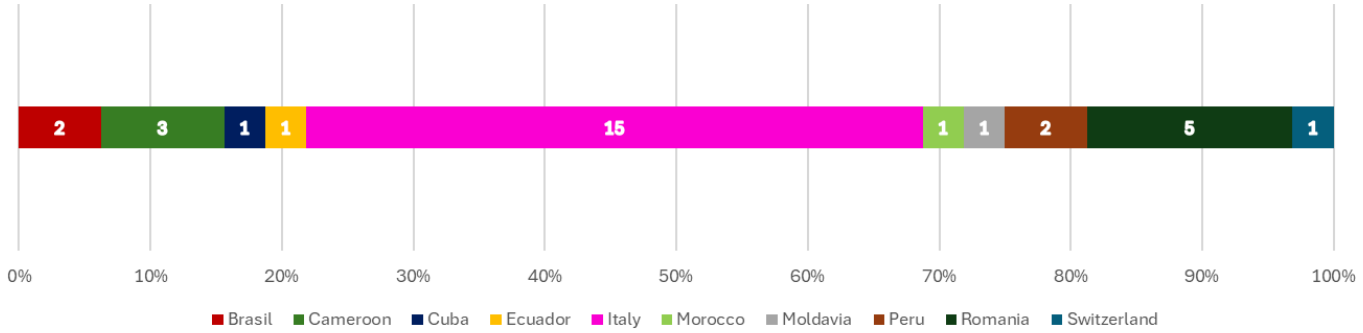
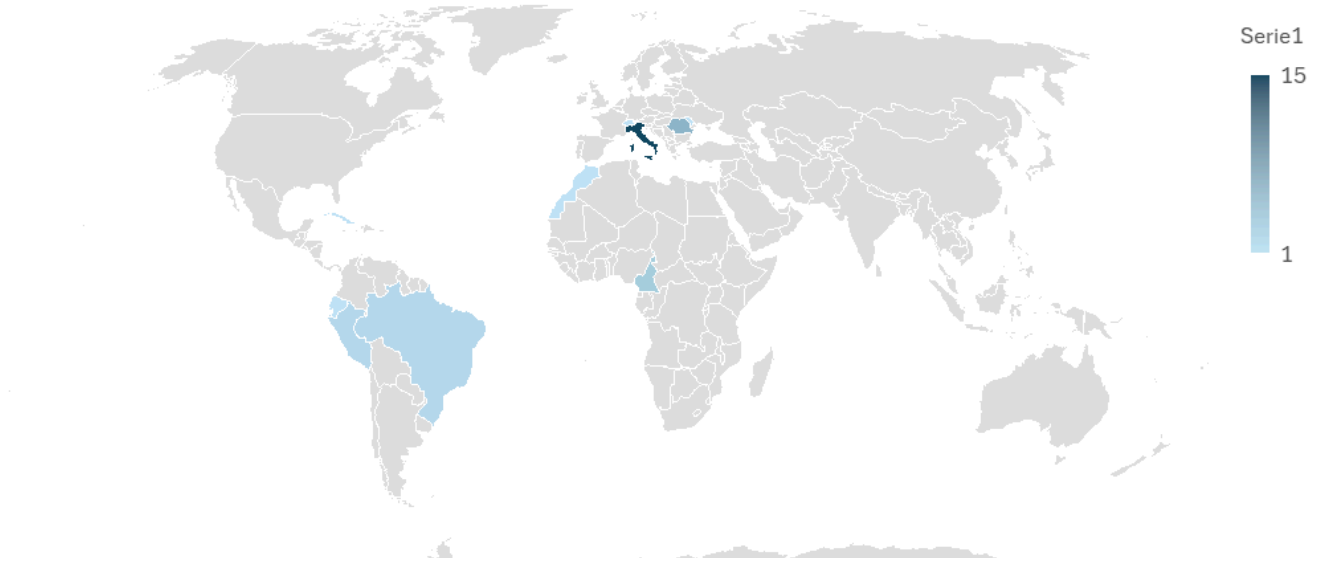
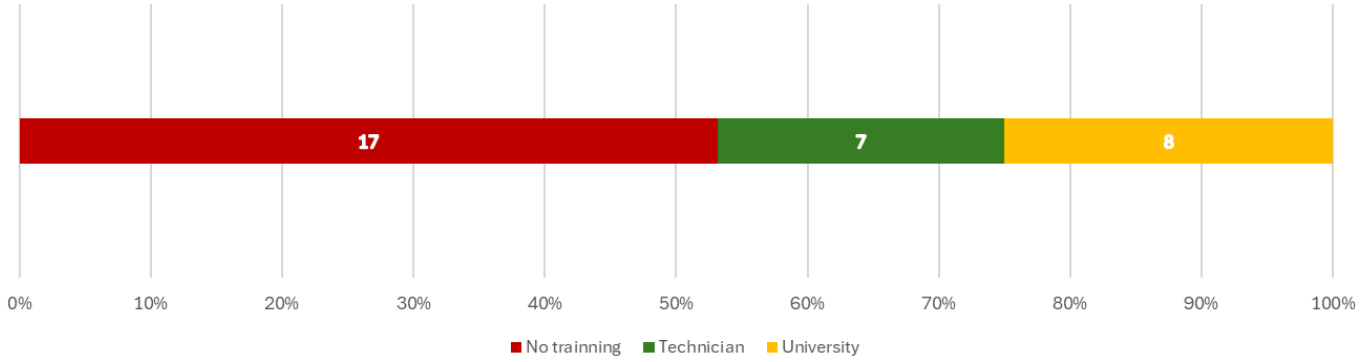


Figure 102. *Country of origin*



Educational levels were diverse: 53.1% had no training in care sector activities, there were no people with a short course in care activities, 21.8% were technicians and 25.1% had completed a university degree.

Figure 103. *Educational status*



4.2. Focus Group Finding: Understanding Pressures and Supports Across Worker Groups

The qualitative results are presented by the target group. Within each group, risk factors (demands) and protective factors (resources) have been identified. Three domains have been differentiated for both: job, relational (where applicable) and personal. The most salient codes are highlighted to ensure consistency with the quantitative results and clarify subjective experiences. Each domain is depicted using a Sankey diagram indicating code frequencies.

Table 16. Italian *Focus groups*

Name of FG	Target	N	Gender		Age average	Country of origin	Modality
			F	M			
FG 1 IT B	B	3	2	1	46.33	Italy	Face-to-face
FG 2 IT B	B	2	1	1	48.5	Cameroon and Italy	Face-to-face
FG 3 IT A	A	8	7	1	51	Brasil, Cuba, Moldavia, Morocco, Peru and Romania	Face-to-face
FG 4 IT B	B	2	1	1	44	Italy	Face-to-face
FG 5 IT A	A	9	9	0	48.66	Cameroon, Ecuador, Italy, Peru and Romania	Face-to-face
FG 6 IT C	C	8	7	1	40.62	Switzerland and Italy	Face-to-face

4.2.1. Home Care: Risk and Protective Factors

This section presents the results from the Italian focus groups with home care workers, based on the Sankey diagrams that visualise the frequency and distribution of coded risk and protective factors. Each flow represents how often a given code was applied across focus group discussions, illustrating the main sources of strain and resilience in the Italian home care sector.

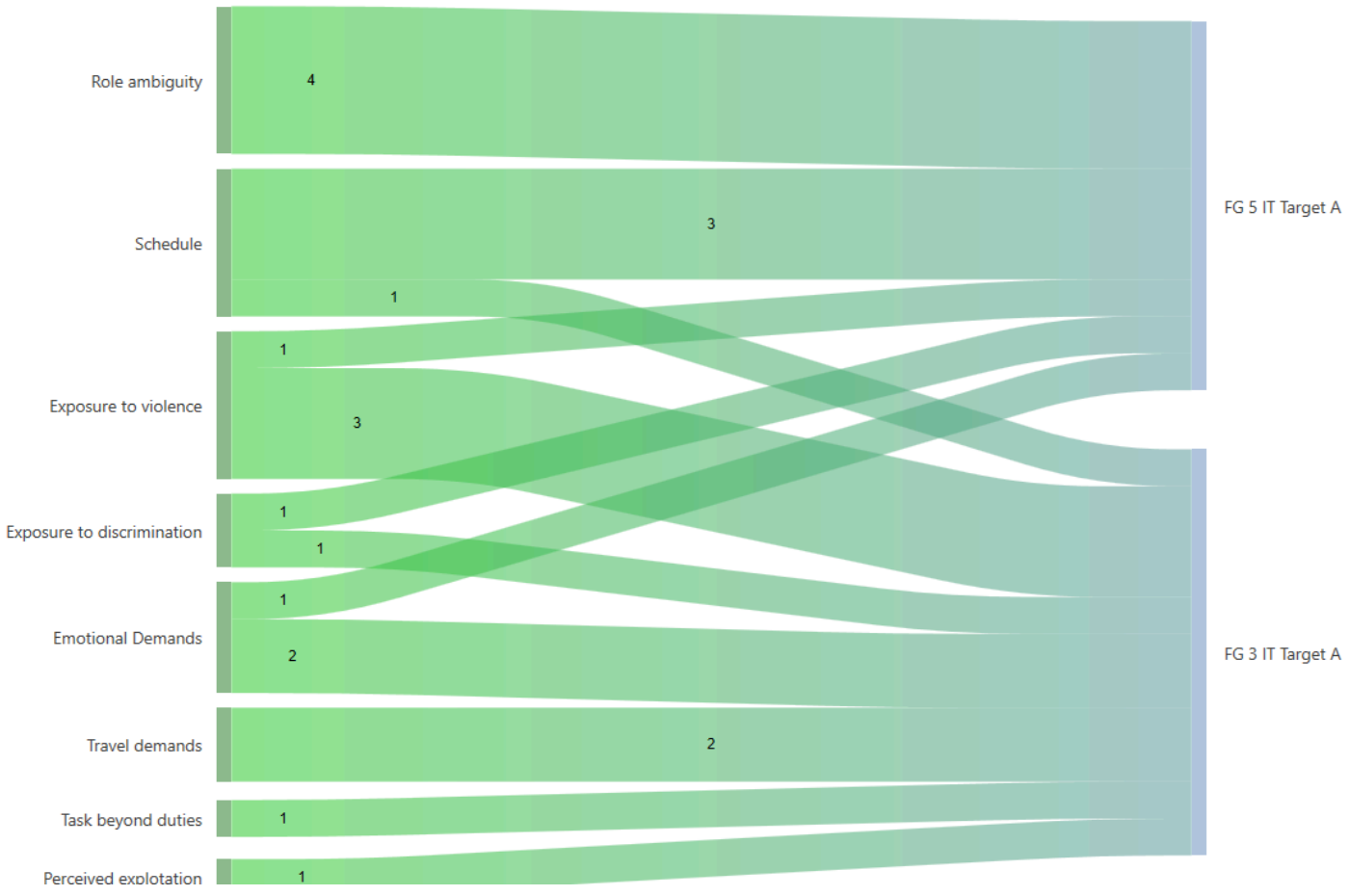
Home care workers are nursing and care professionals working in domestic and outpatient settings, lacking specific training, who provide care for elderly, sick or other individuals requiring home care.

Risk Factors

Job-related Risk Factors

This diagram shows that the most prominent job-related risks identified by Italian home care workers were role ambiguity, schedule, and exposure to violence. The thickest flow corresponds to role ambiguity, indicating that unclear job boundaries and overlapping responsibilities were the most frequent issues reported. Schedule and exposure to violence follow, revealing concerns about irregular or excessive working hours and instances of aggression or abuse in the workplace. Medium-width flows appear for emotional demands and travel demands, showing that the emotional burden of caring and the physical effort associated with mobility were also significant. Thinner flows such as perceived exploitation and task beyond duties reflect additional stress caused by unfair treatment or being asked to perform tasks outside their contractual role. Overall, the figure depicts a work context marked by unclear roles, unstable schedules, and exposure to risk, all contributing to job strain and insecurity.

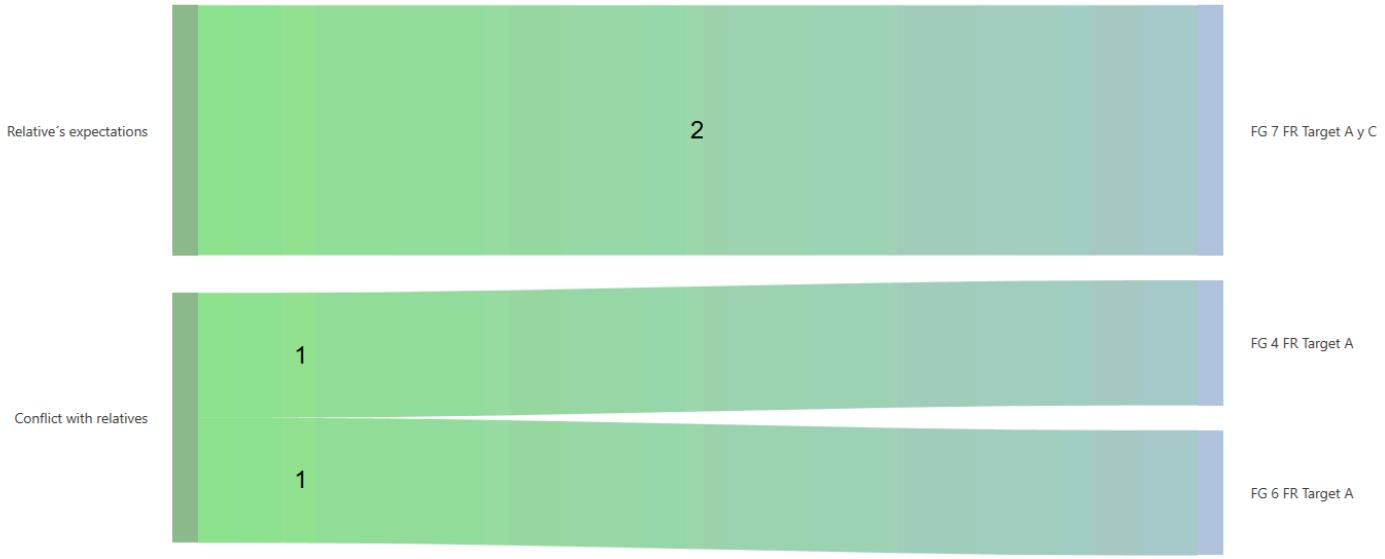
Figure 104. *Job-related risk factors among home care workers group in Italy*



Relational Risk Factors

The thickest flow corresponds to relatives' expectations, which appears mainly in *FG7 IT Target A, C*, indicating that excessive or unrealistic expectations from families represent the main relational pressure. Thinner flows link to conflict with relatives, suggesting that while open confrontation was less frequent, it emerged as a source of stress when workers felt criticised or mistrusted. The pattern highlights that Italian home care workers experience relational risk primarily through demanding family expectations, occasionally escalating into direct conflict.

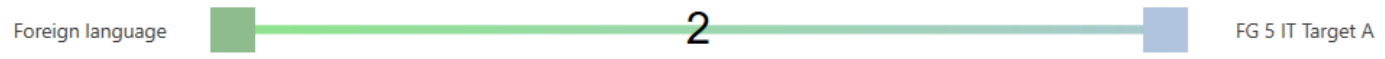
Figure 105. *Relational risk factors among home care workers group in Italy*



Personal Risk Factors

The personal risk factors diagram shows a single prominent flow for foreign language, representing communication difficulties as a key personal-level challenge. This code appears with moderate thickness, reflecting that language barriers—particularly for migrant care workers—often lead to misunderstandings and social isolation. Although no other major personal risks were identified, the presence of foreign language as a coded factor suggests that linguistic and cultural barriers indirectly amplify work-related stress and hinder effective communication with employers and families.

Figure 106. *Personal risk factors among home care workers group in Italy*



Protective Factors

Job-related Protective Factors

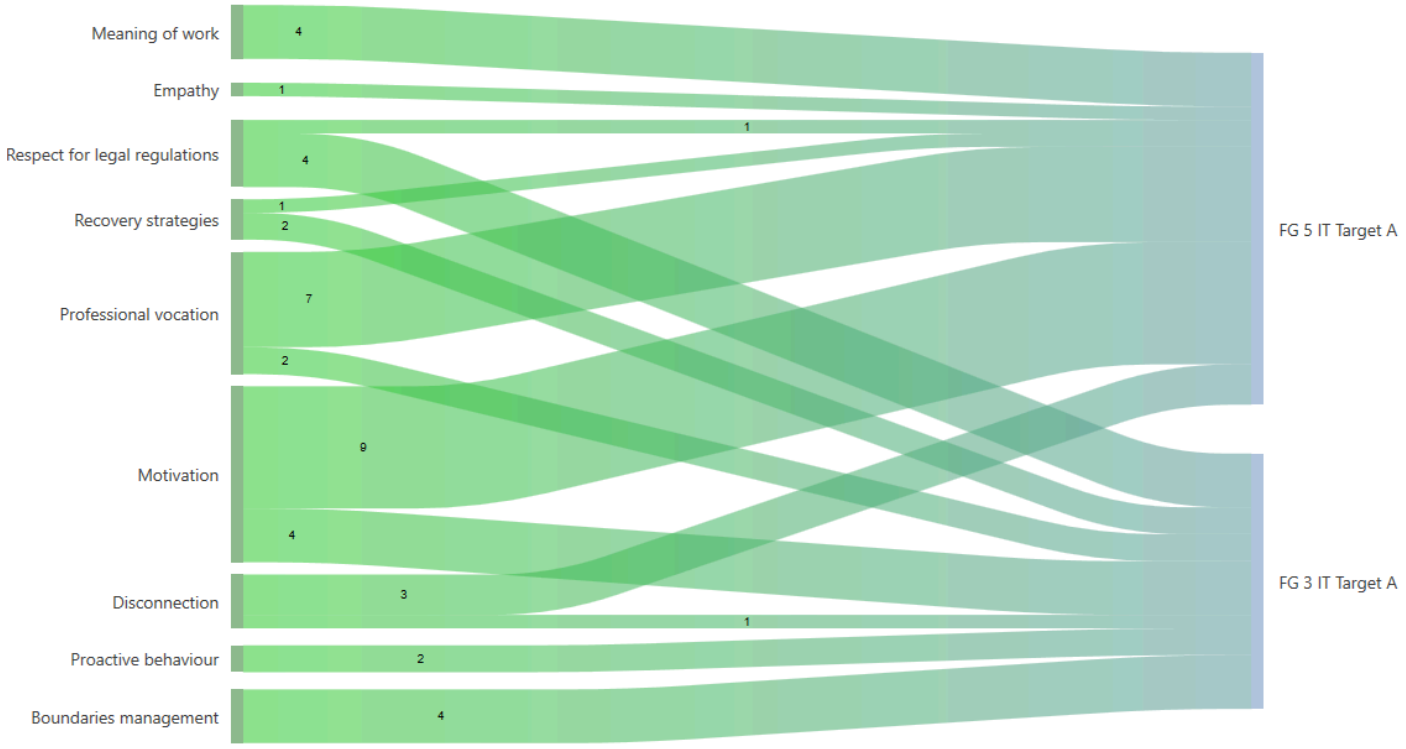
This diagram illustrates the organisational and structural elements that act as protective factors. The thickest flow corresponds to time off, showing that rest periods and days off are the most valued sources of recovery among Italian home care workers. A thinner but visible flow for workplace ergonomics and assistive devices in homes indicates that having proper equipment or physical support mechanisms also contributes to safety and well-being. On-the-job learning appears in several smaller flows, suggesting that opportunities for skill development and continuous training were recognised as important but not widely accessible. In summary, the figure reveals that adequate rest, ergonomic support, and training opportunities are essential job-related buffers against excessive workload and physical strain.

Figure 107. *Job-related protective factors among home care workers group in Italy*

Personal Protective Factors

This diagram visualises the individual and psychological resources that sustain Italian home care workers in demanding contexts. The thickest flows correspond to motivation, professional vocation, and meaning of work, reflecting that internal engagement and a strong sense of purpose are central to personal resilience. Recovery strategies, respect for legal regulations, and empathy appear with medium-width flows, indicating the presence of moral and emotional resources that reinforce professional identity and coping capacity. Thinner flows, such as disconnection, proactive behaviour, and boundaries management, show less frequent but meaningful references to self-care and the need to separate personal and professional life. Altogether, this figure demonstrates that Italian home care workers draw heavily on intrinsic motivation, ethical commitment, and emotional intelligence to sustain themselves in a context of precarious conditions.

Figure 108. *Personal protective factors among home care workers group in Italy*



In synthesis, the Italian home care sector reflects a paradoxical situation: high levels of vulnerability combined with strong personal resilience. While structural risks (e.g., unclear roles, long hours, and exposure to violence) remain significant, workers compensate through their commitment, emotional intelligence, and moral identification with care work. Enhancing institutional protections—such as formalised rest periods, clear job descriptions, and professional training—would be essential to sustain this workforce and reduce the reliance on individual coping capacities alone.

4.2.2. Institutional Care: Risk and Protective Factors

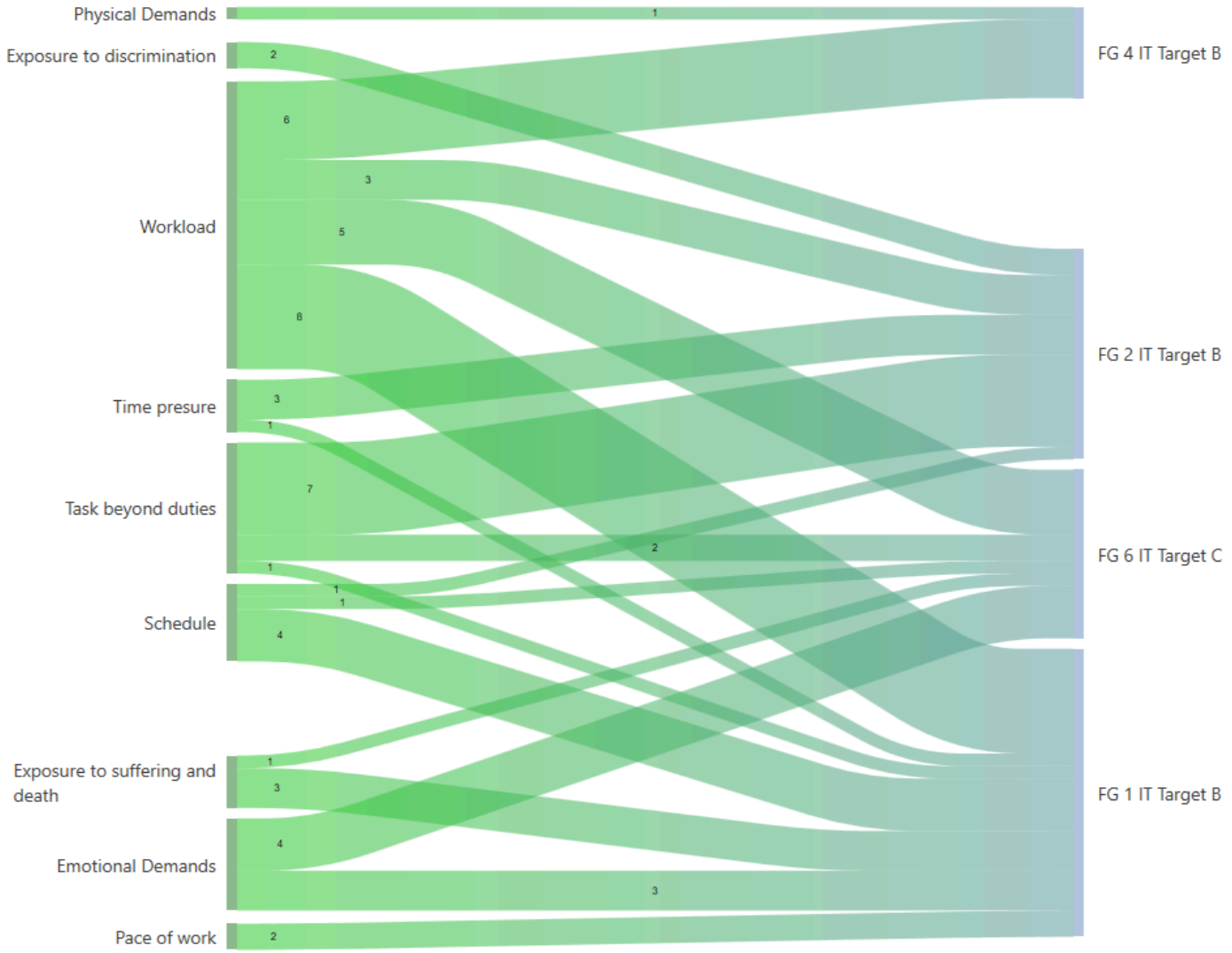
This part encompasses a mixed target: Basic care workers (target B: nursing and care staff who work in hospitals, retirement homes, nursing homes or day care centres and who have been trained in at least one short course) and Professional care workers (target C: specialists in the nursing or healthcare sector with vocational training or a Bachelor's degree).

Risk Factors

Job-related Risk Factors

This diagram highlights several overlapping sources of strain. The thickest flows correspond to workload, time pressure, and task beyond duties, indicating that the combination of heavy task demands and role expansion forms the core of job-related stress in institutional settings. Emotional demands also show prominent flows, revealing the psychological intensity of caring tasks. Schedule and exposure to suffering and death appear with medium-width lines, reflecting recurrent mentions of irregular working hours and emotional exhaustion associated with end-of-life care. Physical demands and exposure to discrimination are represented with thinner flows but still signal relevant stressors. Overall, the figure portrays a work environment characterised by excessive workload, role ambiguity, emotional burden, and irregular scheduling, with physical strain and occasional discrimination further compounding the pressure.

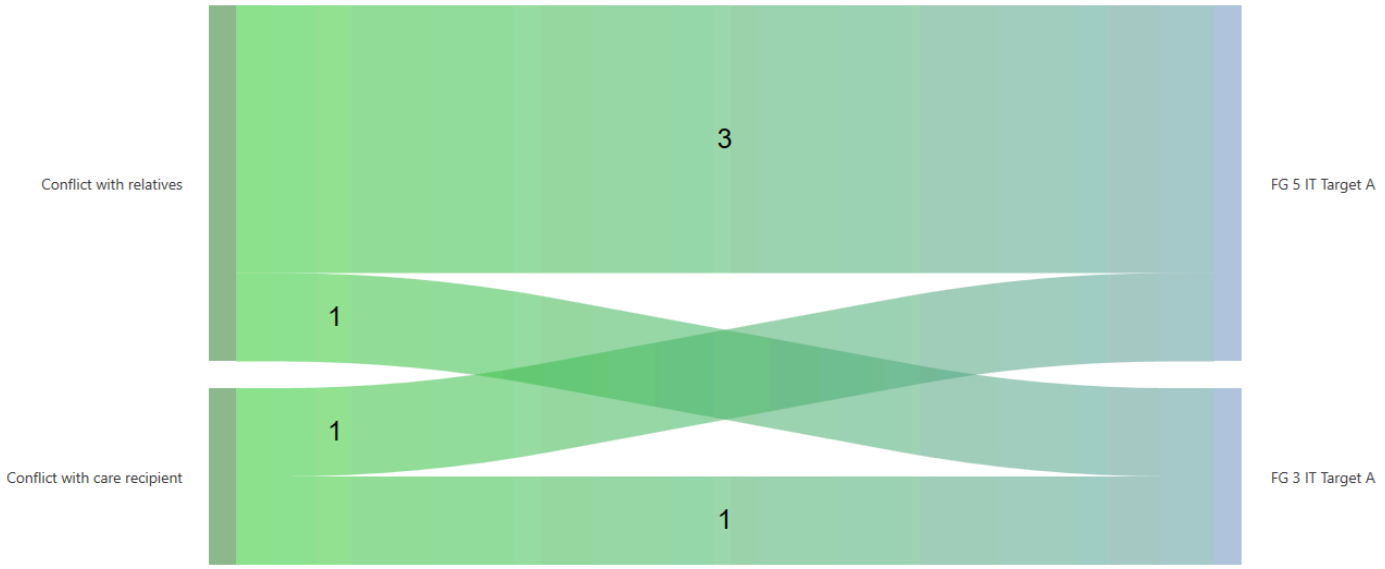
Figure 109. *Job-related risk factors among basic and professional care workers group in Italy*



Relational Risk Factors

This diagram focuses on interpersonal tensions within institutional settings. The thickest flow corresponds to conflict with relatives, mainly in *FG5 IT Target A*, highlighting that disputes with family members of patients or residents were the most frequently discussed relational difficulty. Thinner but visible flows link to conflict with coworkers and conflict with care receivers, suggesting that while intra-team and patient-related tensions occur, they were less central in the overall discourse. The figure thus reveals that external relational conflicts, especially with families, are perceived as the most stressful dimension of social interaction at work.

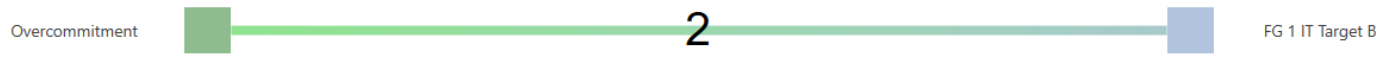
Figure 110. *Relational risk factors among basic and professional care workers group in Italy*



Personal Risk Factors

The personal risk factors diagram shows overcommitment as the main self-related vulnerability among Italian institutional care workers. This thick single flow, connected to *FG1 IT Target B*, indicates that excessive dedication and difficulty in maintaining personal boundaries were recurrent in the discussions. Workers often described putting too much of themselves into their roles, which intensified emotional fatigue. The absence of multiple additional codes in this figure suggests that overcommitment stands out as the dominant personal risk, representing the internalisation of work stress and an inability to detach from the caregiving role.

Figure 111. *Personal risk factors among basic and professional care workers group in Italy*



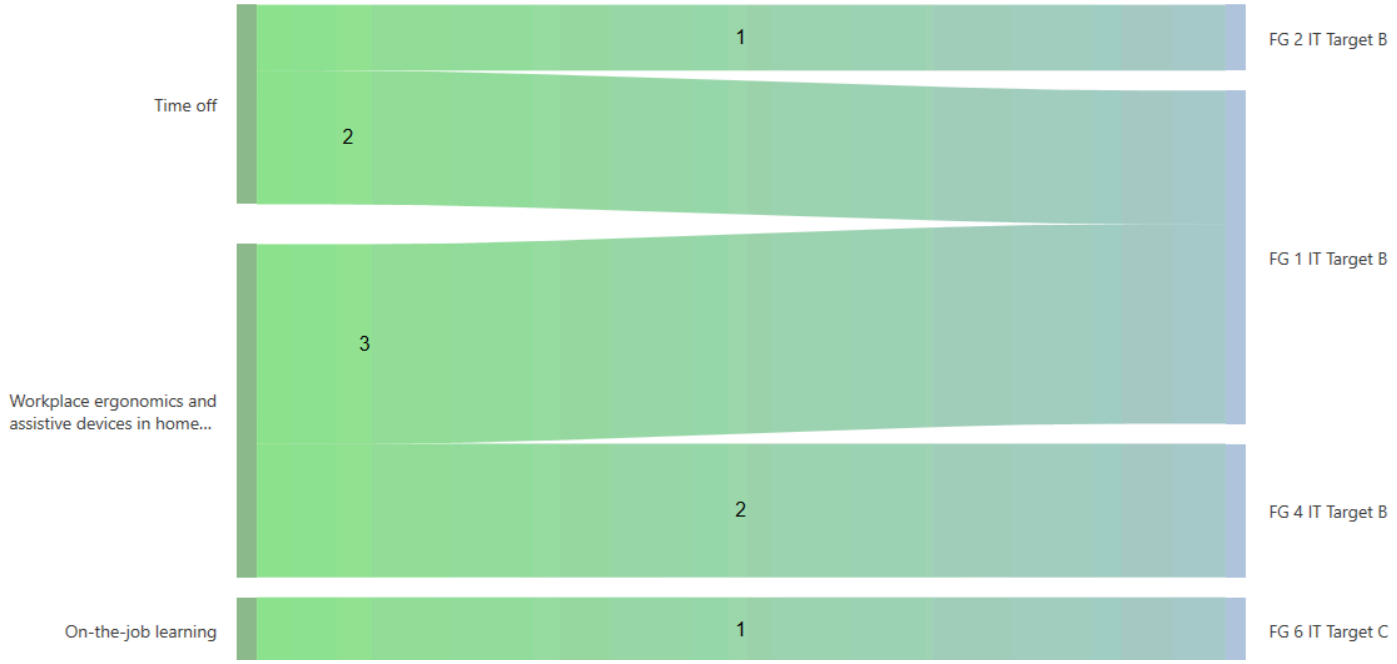
Protective Factors

Job-related Protective Factors

This diagram displays organisational resources that help mitigate stress. The thickest flows correspond to workplace ergonomics and assistive devices in homes and time off, both mentioned across several focus groups (*FG1 IT Target B*, *FG2 IT Target B*, *FG4 IT Target B*). These indicate that adequate rest periods and proper ergonomic tools are viewed as critical supports for preventing fatigue and injury. On-the-job learning appears with medium-width flows, showing that opportunities for continuous professional development are valued as a

way to increase competence and self-efficacy. Overall, the figure underscores that rest, training, and ergonomic support are seen as essential organisational buffers that improve safety and well-being.

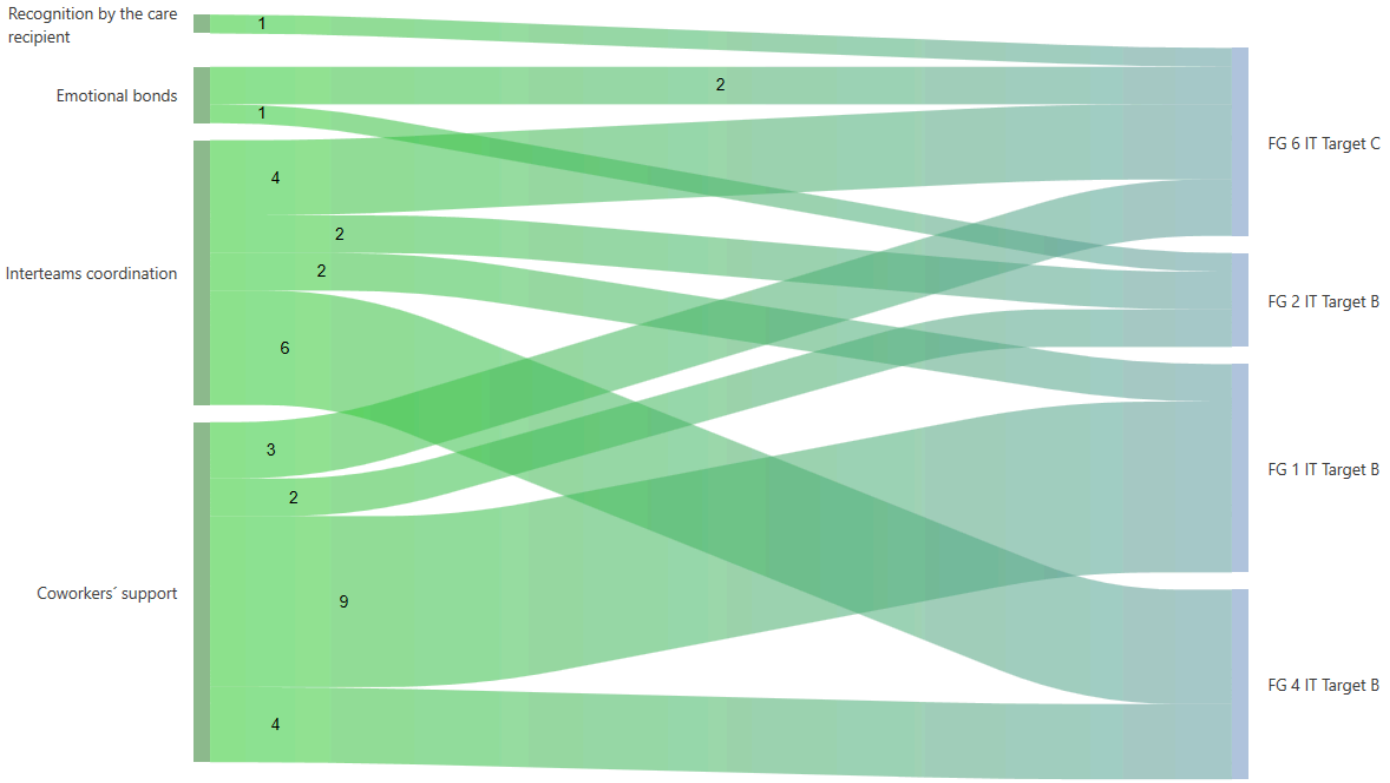
Figure 112. *Job-related protective factors among basic and professional care workers group in Italy*



Relational Protective Factors

This diagram visualises interpersonal support within institutional care settings. The thickest flow corresponds to coworkers' support, appearing strongly in *FG4 IT Target B*, which indicates that solidarity among colleagues is the most recurrent relational resource. Interteams coordination also displays a thick and consistent flow across groups, showing that collaboration between units is a key element of efficiency and mutual protection. Medium-width flows correspond to emotional bonds and recognition by the care receiver, which highlight the human and relational satisfaction derived from caregiving itself. Overall, the figure reveals that collegial support, coordination, and emotional connection form the main protective layer that counterbalances institutional stressors.

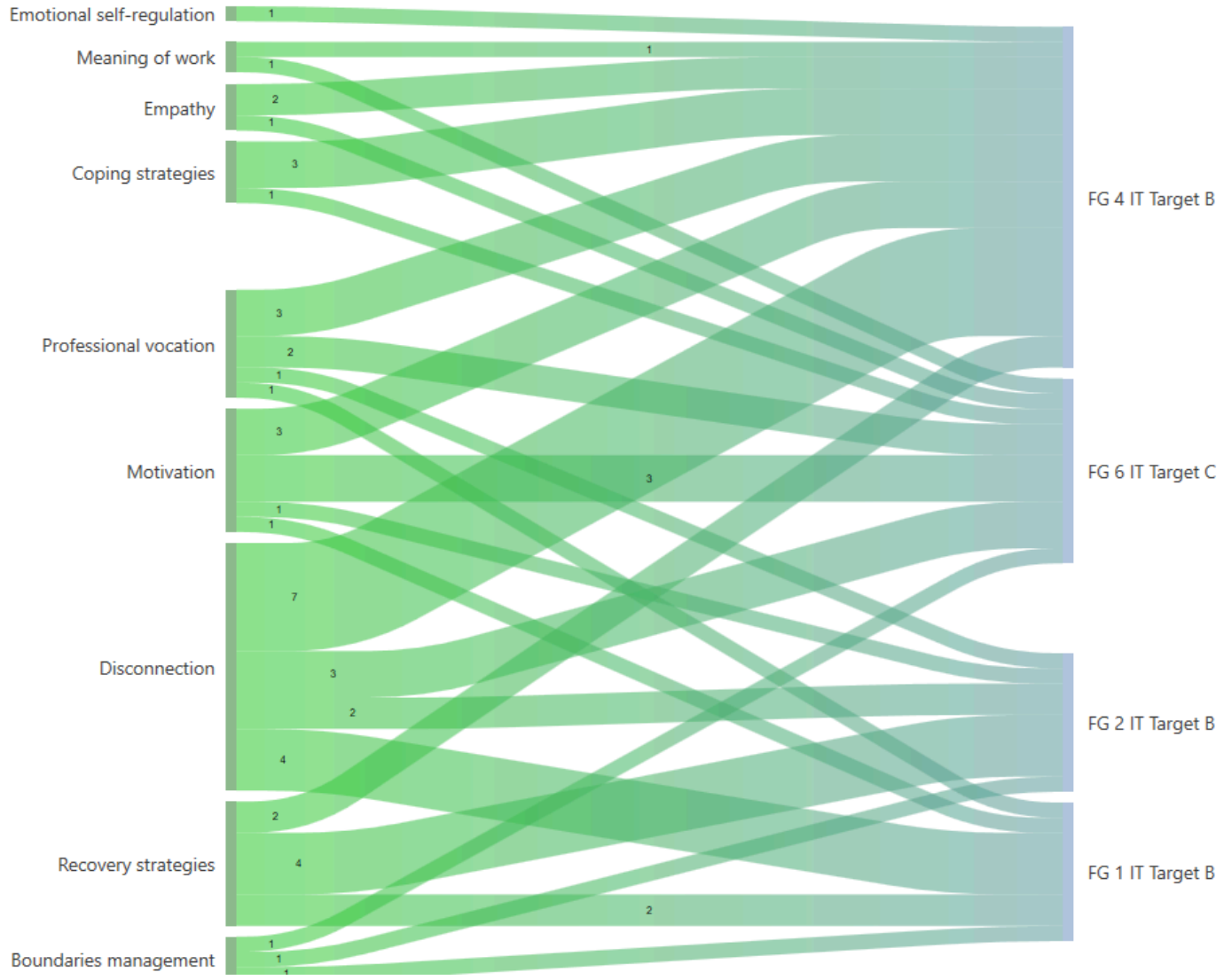
Figure 113. *Relational protective factors among basic and professional care workers group in Italy*



Personal Protective Factors

This diagram presents the individual and psychological strengths that help institutional care workers sustain engagement despite high stress. The thickest flows correspond to motivation, professional vocation, and coping strategies, suggesting that intrinsic drive, ethical commitment, and adaptive behaviour are core personal resources. Meaning of work, recovery strategies, and disconnection appear with medium-width flows, indicating the importance of reflection, self-care, and psychological distance to maintain balance. Thinner flows correspond to emotional self-regulation, empathy, and boundaries management, which complement the broader set of coping mechanisms. The figure as a whole depicts a resilient workforce relying primarily on motivation, vocation, and coping as the foundations of psychological endurance.

Figure 114. *Personal protective factors among basic and professional care workers group in Italy*



Italian institutional care workers face high workloads and emotional strain, yet they compensate through collaboration, motivation, and a strong sense of vocation. The Sankey diagrams collectively portray a professional culture where collective support and personal meaning act as key stabilising forces, balancing the pressures of an understaffed and emotionally intense care system.

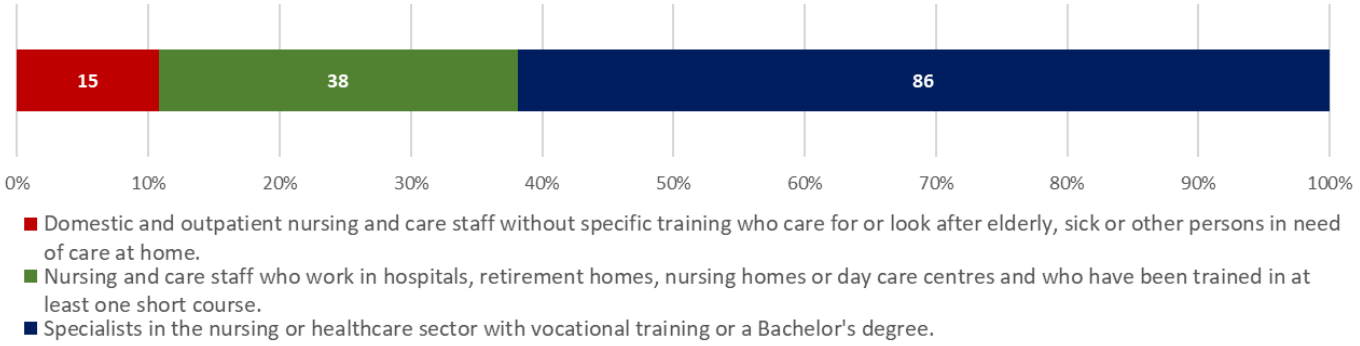
PART 3. CARE WORKERS IN GERMANY

Chapter 5. Quantitative Data Set: What the Surveys Revealed About Care Work in Germany

5.1. Profile of the Care Workforce Sample

A total of 139 care workers from Germany participated in the study: 15 from Target A (home health aides, represented in red), 38 from Target B (basic care workers, in green) and 86 from Target C (professional care workers, in dark blue). The mean age of the participants was 46.22 years (SD = 12.38). The majority were women (80.6%), most were married (56.1%) and a large proportion worked in urban areas (71.9%).

Figure 115. *Participants per target group*



Most participants were German nationals (94.2%), with a small number of care workers from other countries of origin, including Poland, Spain and Croatia (Europe), Colombia (South America) and Iran and the Philippines (Asia).

Figure 116. *Age groups*

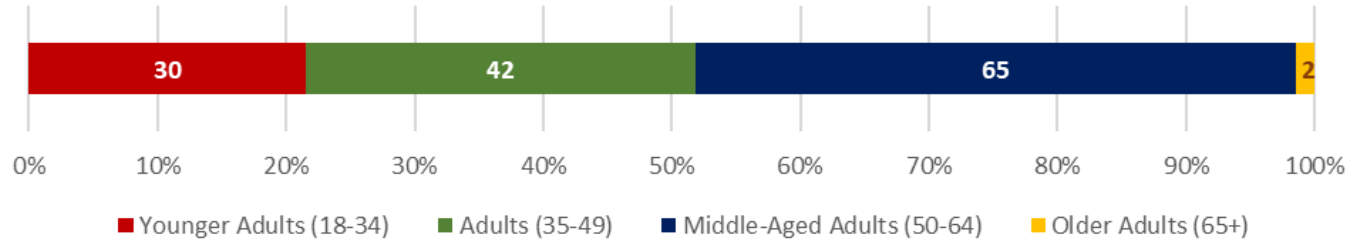


Figure 117. *Gender*

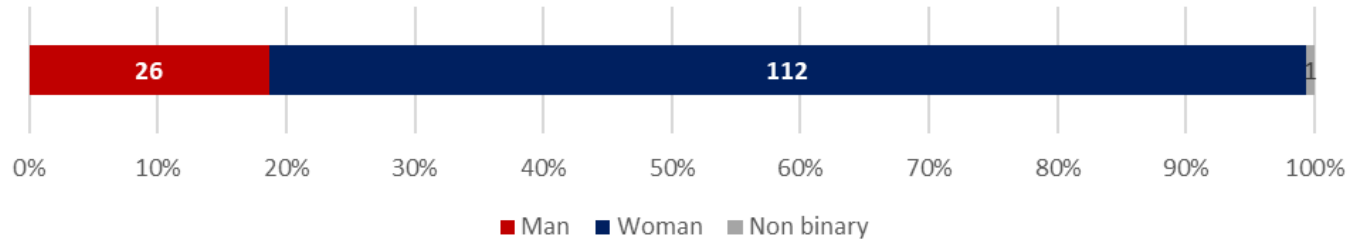


Figure 118. *Marital status*

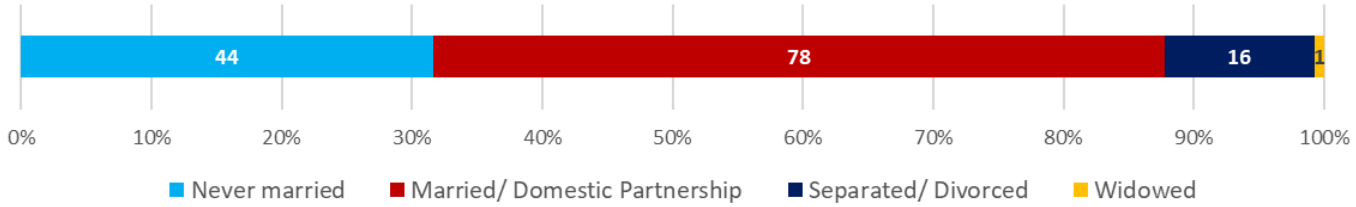


Table 17. *Descriptive statistics of the quantitative variables*

	N	Min	Max	Mean	SD
Age	139	22	77	46.22	12.38
Tenure in months	138	1	528	216.26	144.87
Monthly wages all participants	123	2.80	5900	2333.92	808.50
Monthly wages in Institutionalised care	88	2.8	5900	2288.19	819.22
Monthly wages in home based care	35	1300	4000	2448.88	780.54
Hours worked in a week	138	2	77	34.68	10.71
Number of home care receivers in a week (HCWs)	37	1	361	51.03	68.14
Duration of stay (days in a week for live-in HCWs)	2	7	7	7	0
Months of residence (migrant workers)	8	0	360	112.25	127.71
Knowledge of benefits (out of 9)	139	0	9	2.14	2.25
Use of benefits (out of 9)	139	0	7	1.96	1.59

Figure 119. *Area of work*

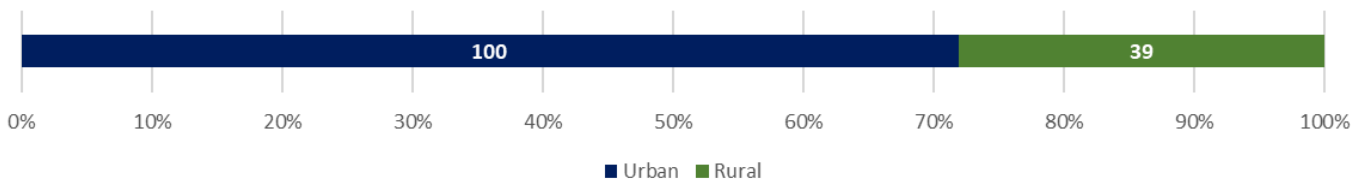


Figure 120. *Nationality*

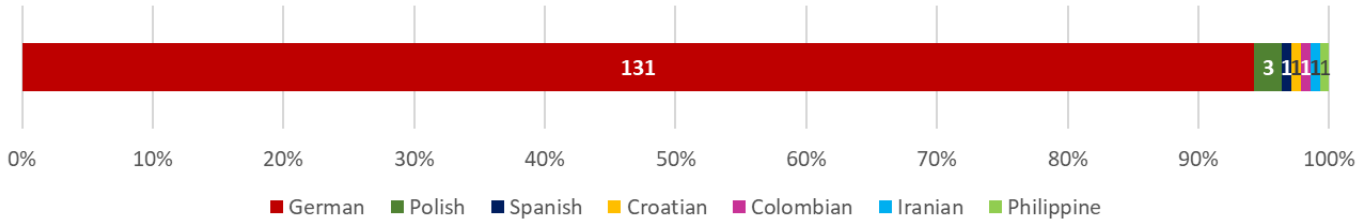
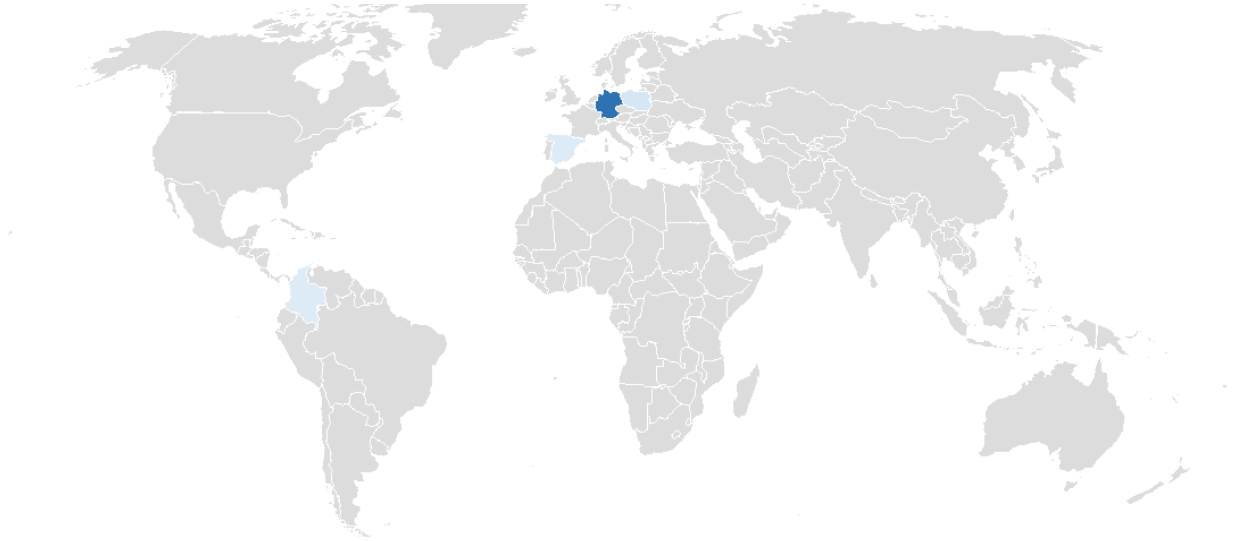


Table 121. *Country of origin*



Most participants (75.5%) had completed some form of post-compulsory education, with 70.5% having completed three or more years of higher education. The remainder had only completed secondary education (15.1%), primary education (8.6%) or no formal education (0.7%). The vast majority (87.8%) had received specific formal education or training in care services. Regarding safety in the workplace, 76.3% reported that their current employer provided training on safety hazards, 6.5% had received such training in a previous role or on their own initiative, and 17.3% had never received such training. Participants had an average of 18 years' experience in the care sector (SD = 144.87 months).

Figure 122. *Educational status*

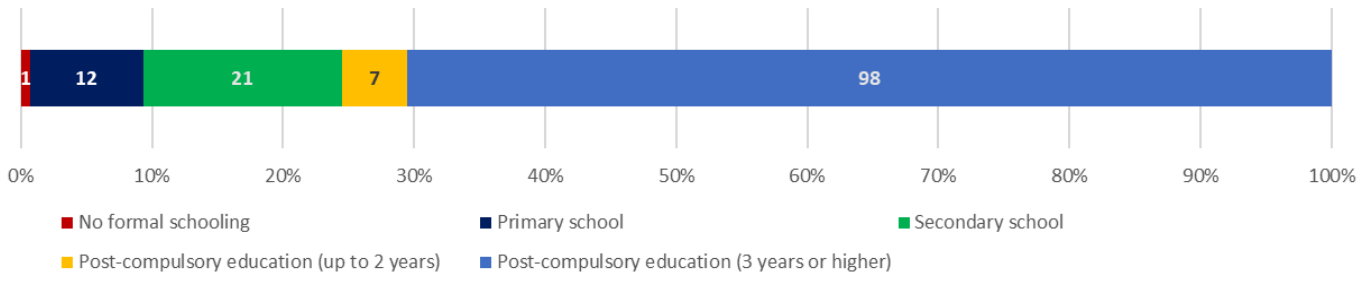


Figure 123. *Formal education in care services*

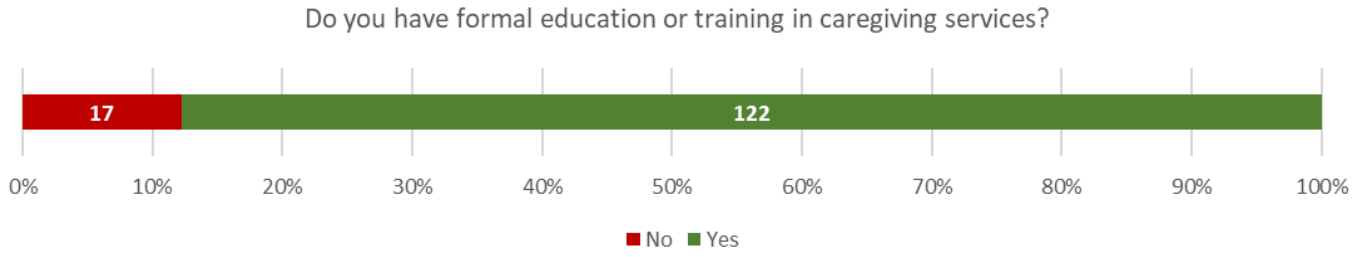
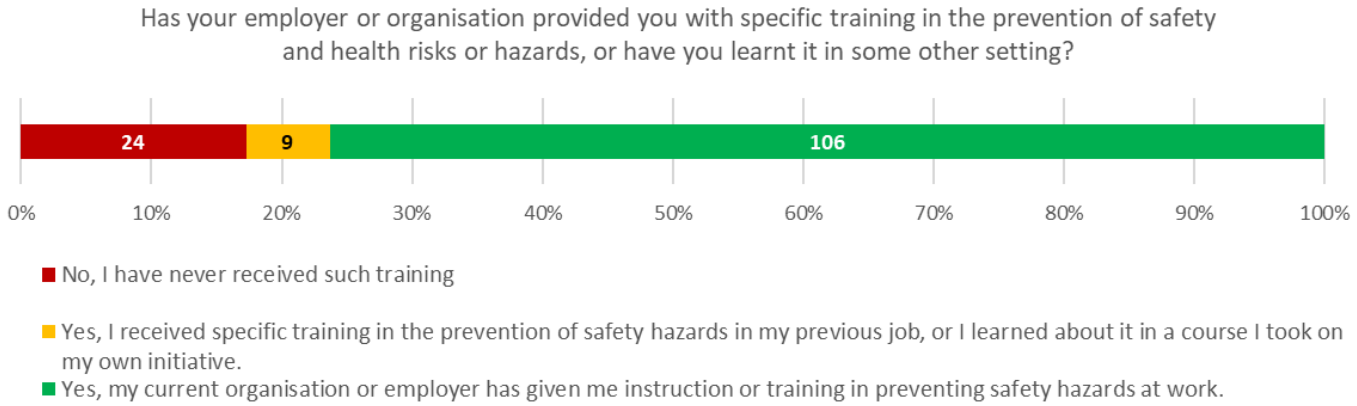
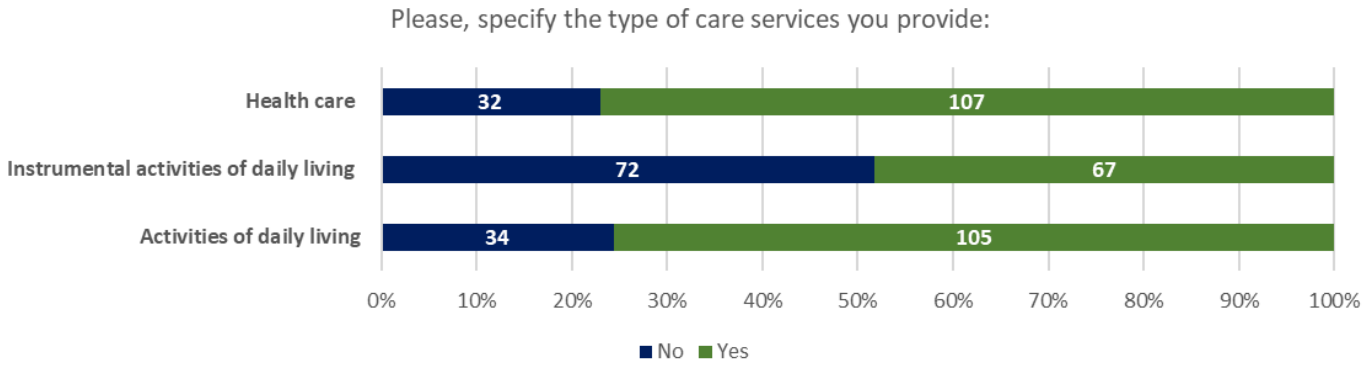


Figure 124. *Safety hazards training*



When asked about the types of tasks they performed, activities of daily living (ADLs) and health care tasks were most commonly reported. The specific training participants had received was generally related to the tasks they most frequently performed. However, a majority (59.7%) indicated that they had not received training specific to the care needs associated with their care receivers' diagnoses or health conditions. This gap is notable given that 77% of participants cared for care receivers with specific conditions, including physical health problems (97.1%), behavioural or psychiatric disorders (94.2%), mobility impairments (92.8%), obesity (81.3%) and infectious diseases (39.6%).

Figure 125. *Type of care tasks they perform*



Note: **Activities of daily living or ADL** (dressing, toileting, mobility, bowel and bladder management, sleep time regulation, feeding, transferring from one position to another, personal hygiene, walking, caring for pets, personal care bathing, eating, toilet hygiene, grooming, ambulating, companionship and socialisation).
Instrumental activities of daily living or IADL (using the phone, shopping for groceries, managing medication, preparing meals, doing laundry, housekeeping, managing finances, assistance with using transportation).
Health services (nursing, auxiliary services, wound care, infusion therapy, physical or cognitive rehabilitation, injections, diagnostic services, prescriptions, treatment of injuries or illnesses, occupational therapy, hospice care, therapists and social workers.

Figure 126. *Type of formal education in care services*

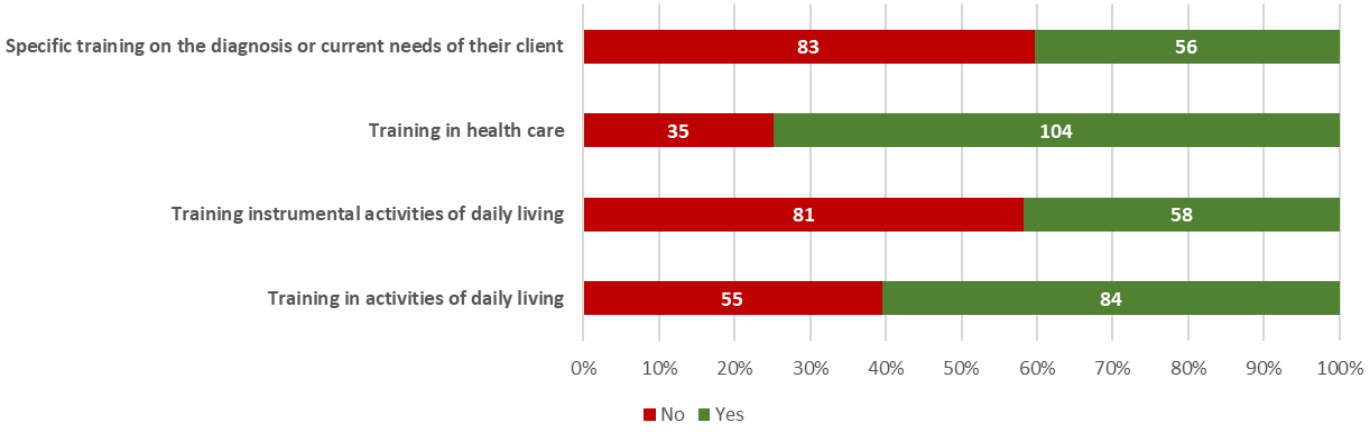
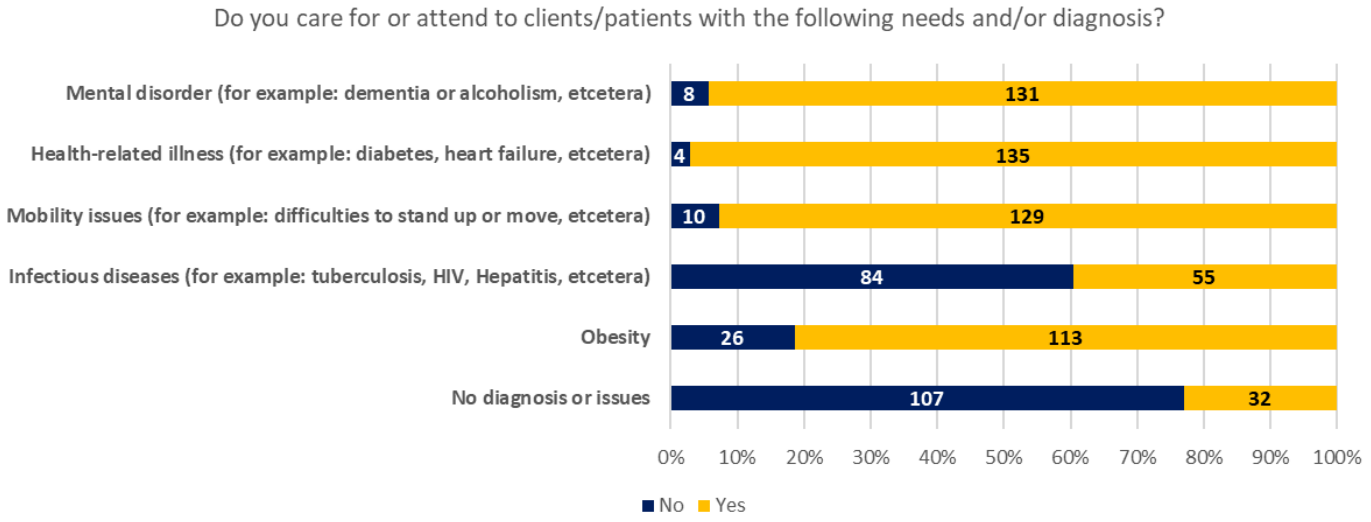


Figure 127. *Type of medical condition of the person receiving care*



Nearly all participants (96.4%) reported receiving some form of supervision during their shifts. Most worked in teams (74.8%), with the remainder working independently with their care receivers. Patterns of teamwork varied between groups: among home health aides, 10 out of 15 worked alone. In contrast, only 5 out of 38 basic care workers and 20 out of 86 professional care workers reported working alone. These figures reflect a tendency for home based care workers to work more independently, whereas in institutional care, team-based work was more common.

Figure 128. *Supervision*

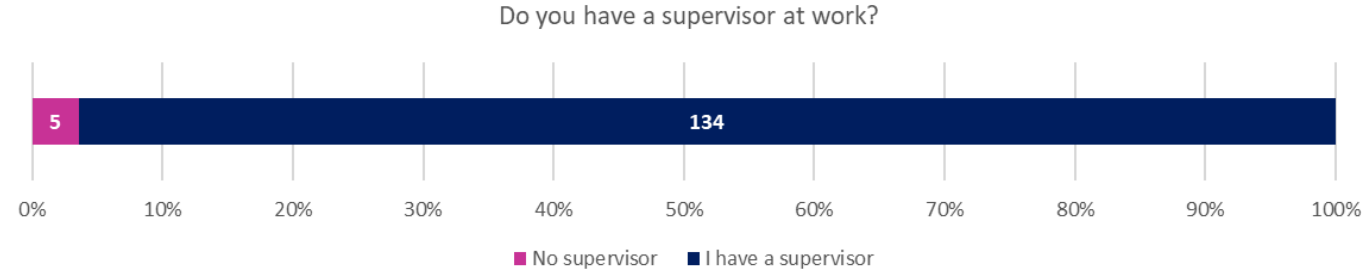
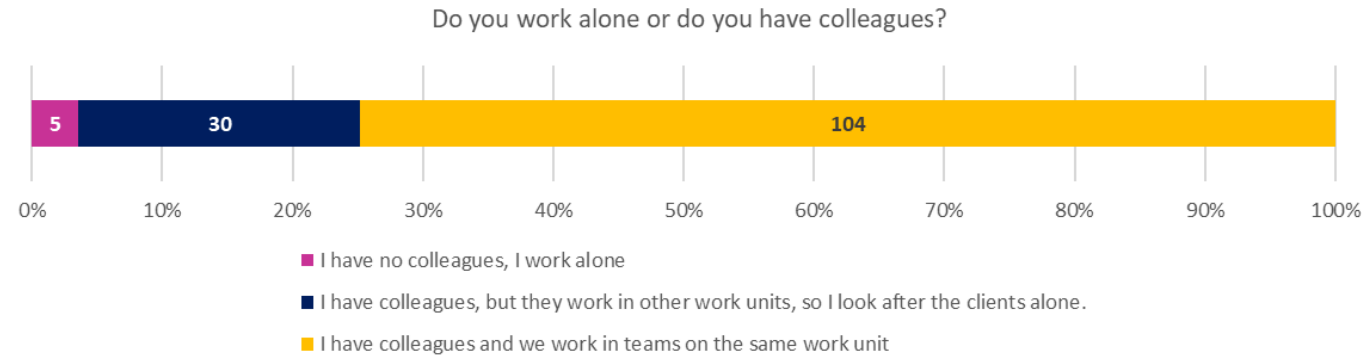


Figure 129. *Teamwork*



In terms of the employment sector, 53.2% worked for public or non-profit organisations, 54.3% worked in the private sector (note: there may be some overlap due to dual roles or reporting) and only 2.9% were self-employed. Contract types were mostly full-time (56.1%), with the remainder part-time (43.9%). Almost all employees (93.5%) had permanent contracts, with only 6.5% having temporary contracts. In terms of working schedules, 59.7% worked shifts, 17.3% had fixed hours and 23% reported flexible hours. About half (50.4%) reported being members of a trade union or similar organisation. Union membership varied between care settings: home health aides were less likely to be union members, while professional care workers were the most likely to be unionised.

Figure 130. *Employment status*

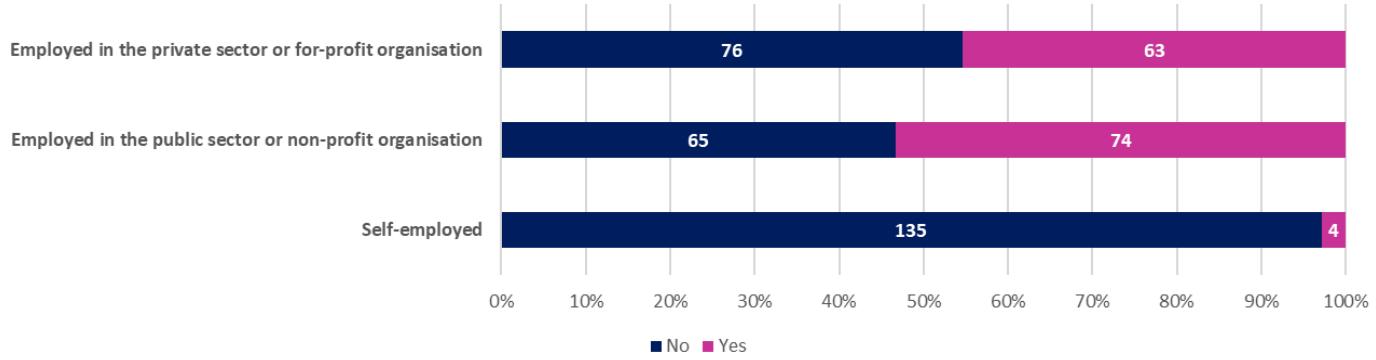


Figure 131. *Belonging to a union or association*

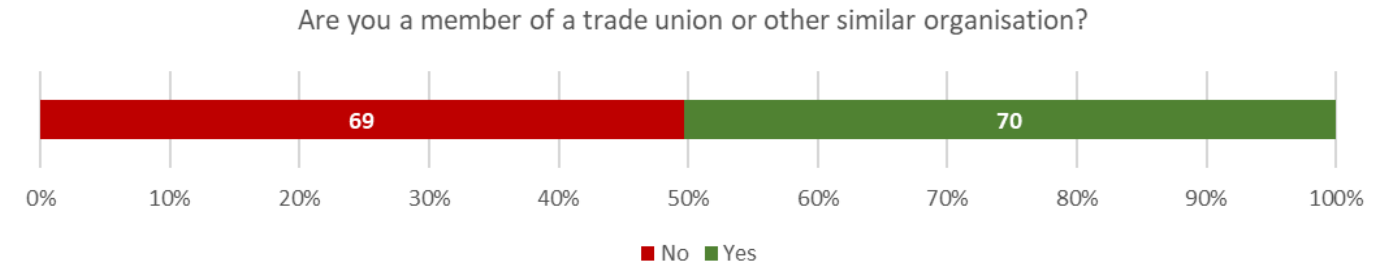


Figure 132. *Type and duration of contract*

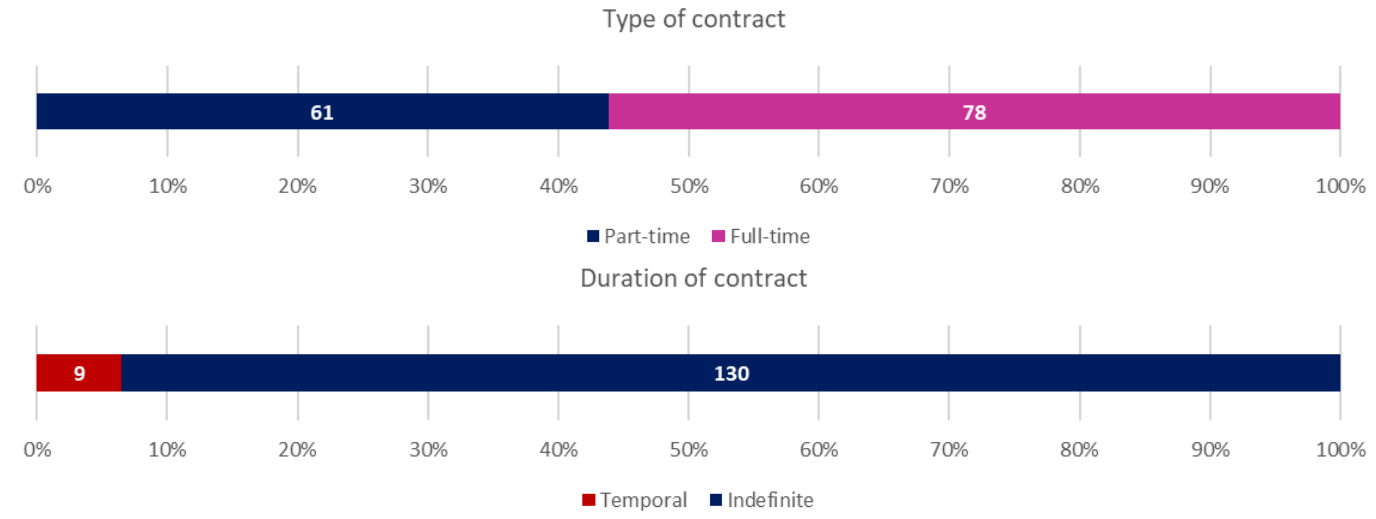
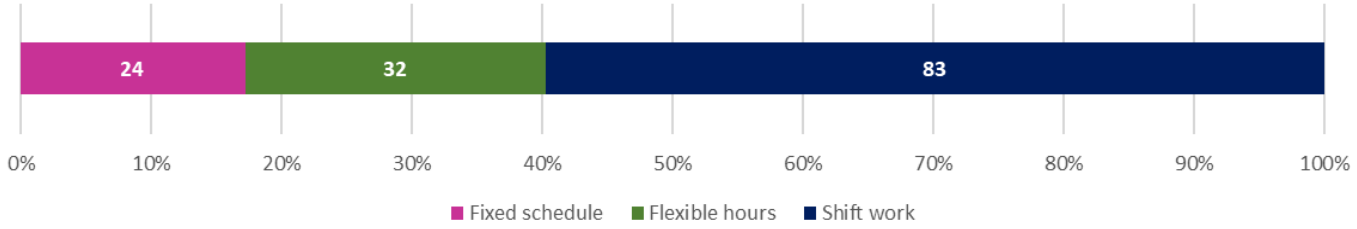


Figure 133. *Type of schedule or work shift*



Participants were also asked about their awareness and use of employer-provided benefits or incentives (e.g. meal vouchers, paid leave). Overall, care workers had limited awareness of and access to benefits (mean = 2.14 out of 9; SD = 1.94). The most commonly known benefits were paid vacation (32.4%), performance bonuses (31.7%) and paid travel tickets or passes (30.9%). Reported use of benefits was also low (mean = 1.96 out of 9; SD = 1.59), although benefits such as paid holidays and sick leave were used by most employees. Awareness of fuel reimbursement was particularly low (13.7%), with only 7.9% actually using this benefit - an interesting finding given that 68.3% of participants reported using their own car to get to work. This is likely to be an additional financial burden for home care workers as they tend to travel more frequently.

Figure 134. *Knowledge and use of workplace benefits and/or rewards*

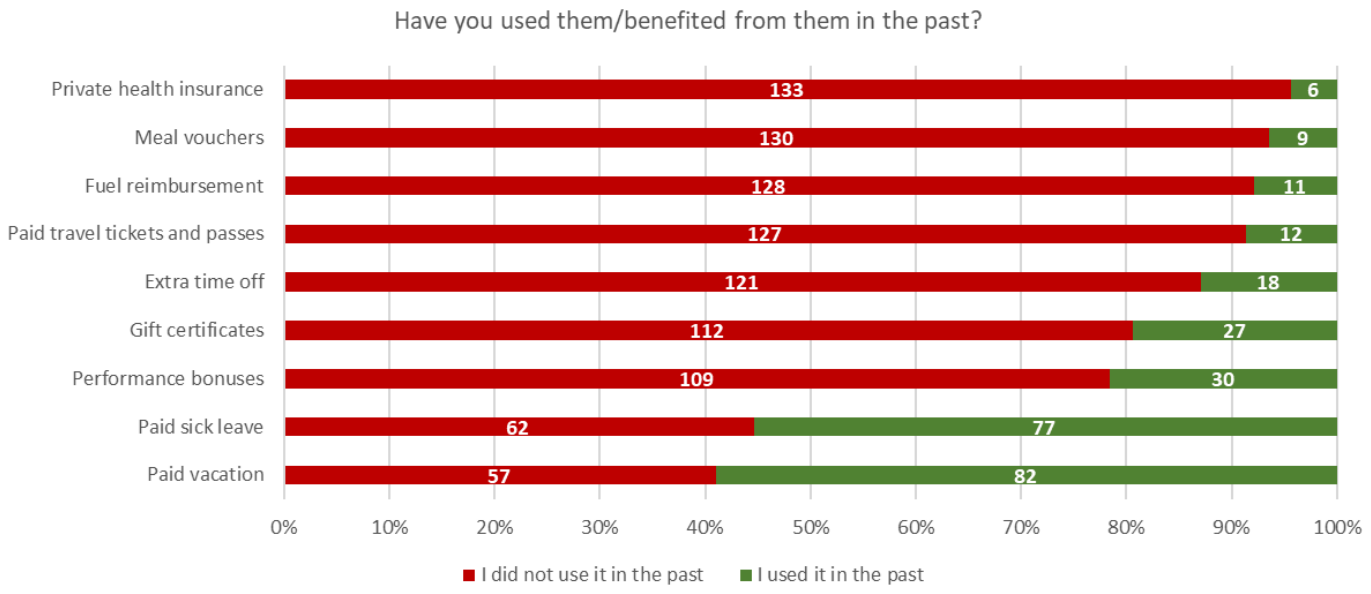


Figure 135. *Access to lifting aids or equipment*

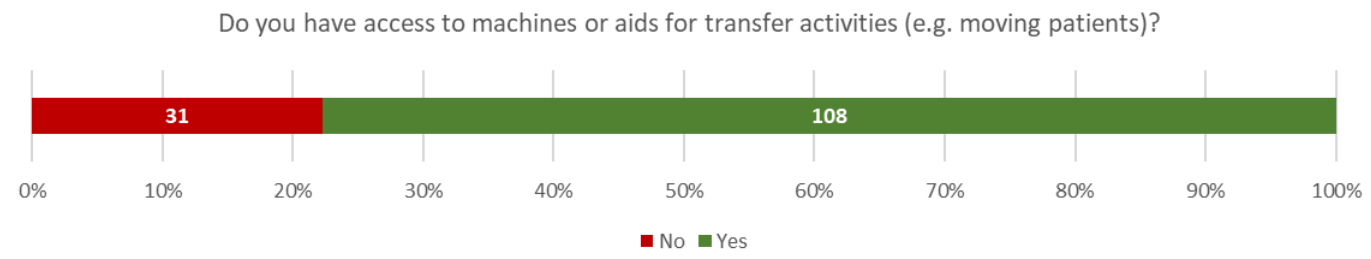
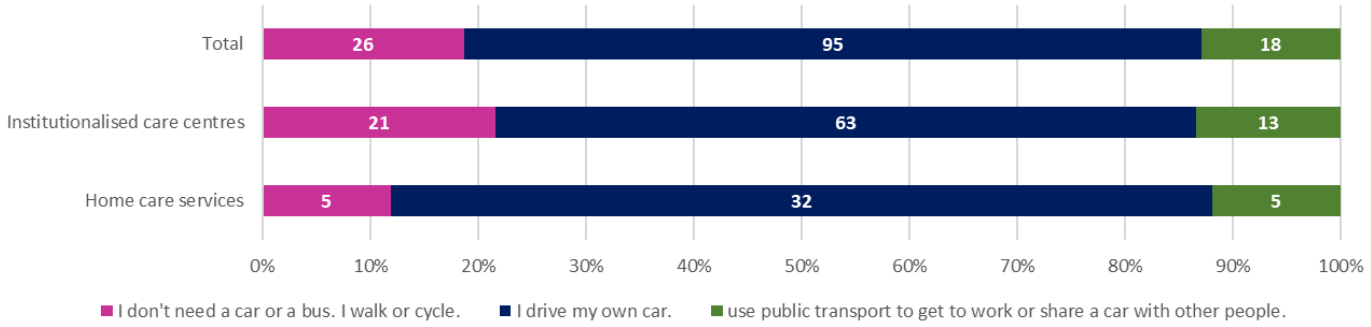


Figure 136. *Transport or commuting to work*



Access to lifting equipment or mobility aids was relatively high, with 77.7% of care workers reporting that such resources were available at their workplace. Participants worked an average of 34.68 hours per week (SD = 10.71). Of the total sample, 30.2% worked in home care and 69.8% in institutional care. Within home care, the vast majority (94.6%) worked on a live-out basis (visiting care receivers' homes) and a small proportion (5.4%) worked as live-in carers (living in care receivers' homes). These two live-in carers were Polish migrant workers.

Home care workers tended to establish long-term relationships with their care receivers: 27% cared for the same care receivers for 6 to 12 months and 29.7% for more than a year. They cared for an average of 51 care receivers per week (SD = 68.14), which probably reflects multiple visits or high caseload turnover. Live-in care workers - although few in number - reported staying in their care receivers' homes 7 days a week (SD = 1.41). Notably, both live-in carers reported having their own room, a personal wardrobe and comfortable living temperatures.

Figure 137. *Place of work*

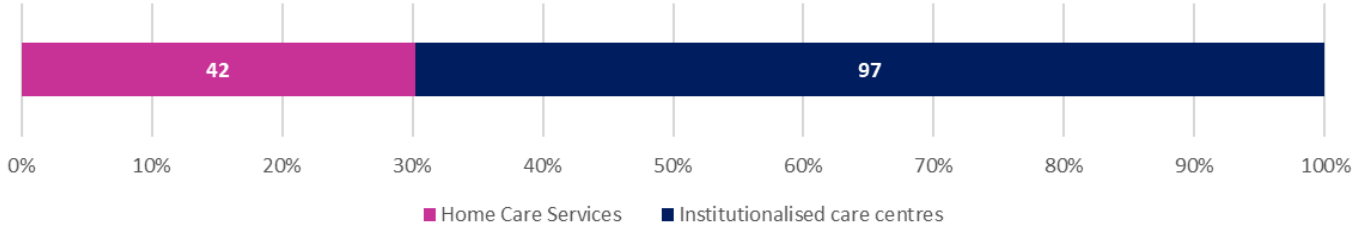


Figure 138. *Modality of home care work (HCWs)*

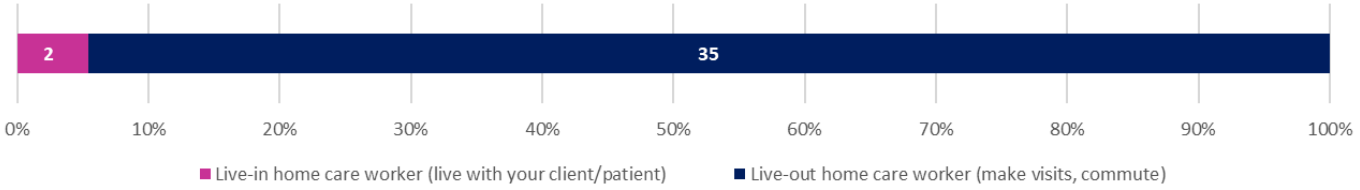


Figure 139. *Continuity of home care work (HCWs)*

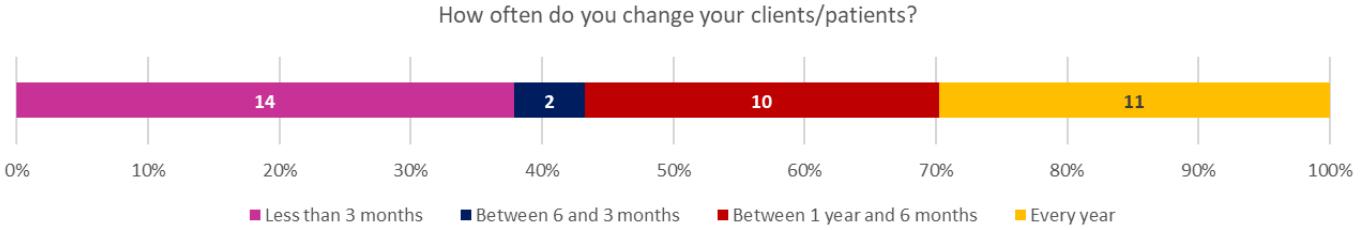
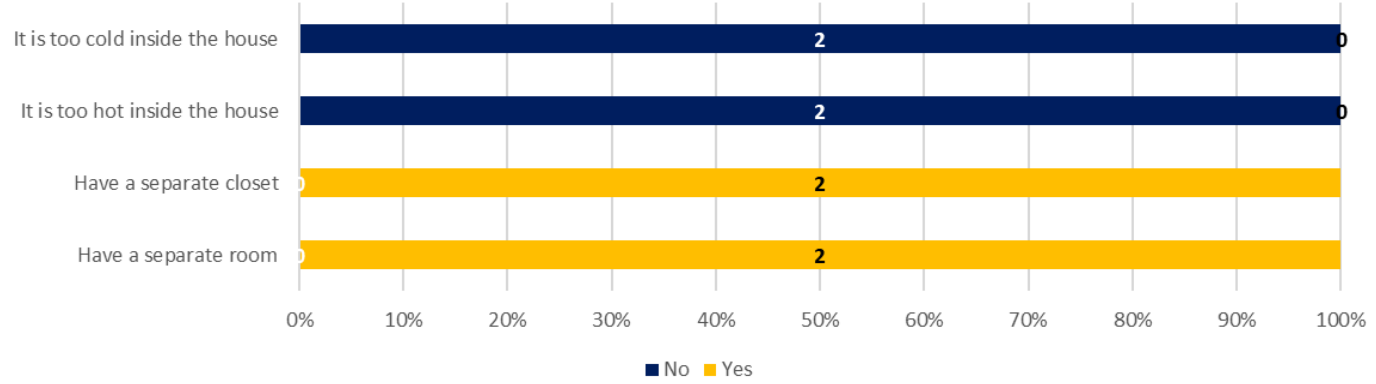


Figure 140. *Living conditions of live-in HCWs*



Finally, the sample of migrant workers was small (N = 8; 5.8%), with an average of 9.35 years of residence in Germany (SD = 127.71 months). All but two had legal permission to work in the country. No significant language barriers in the workplace were reported by the majority of migrant workers.

Figure 141. *Immigration status*

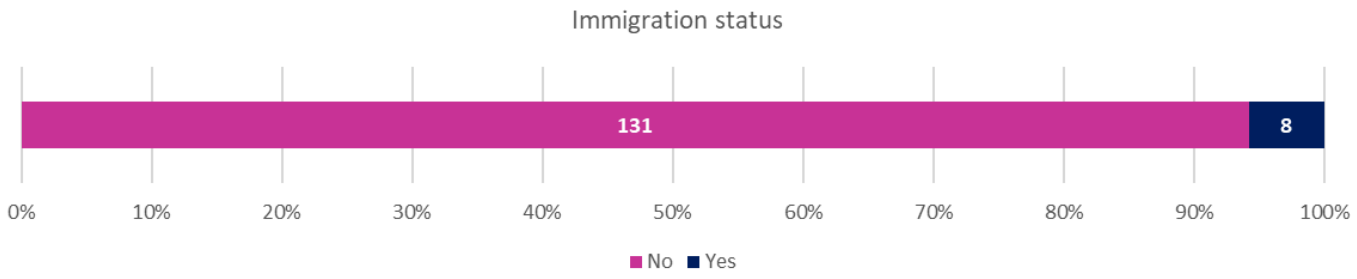


Figure 142. *Possession of work permit (migrant care workers)*

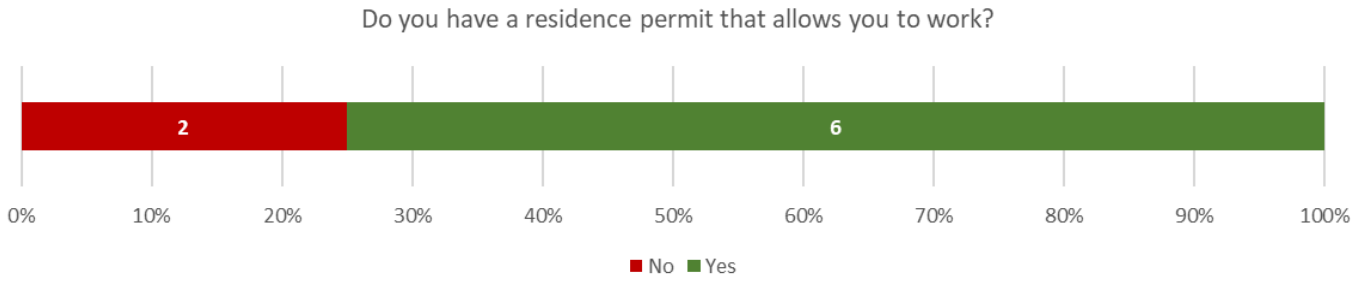
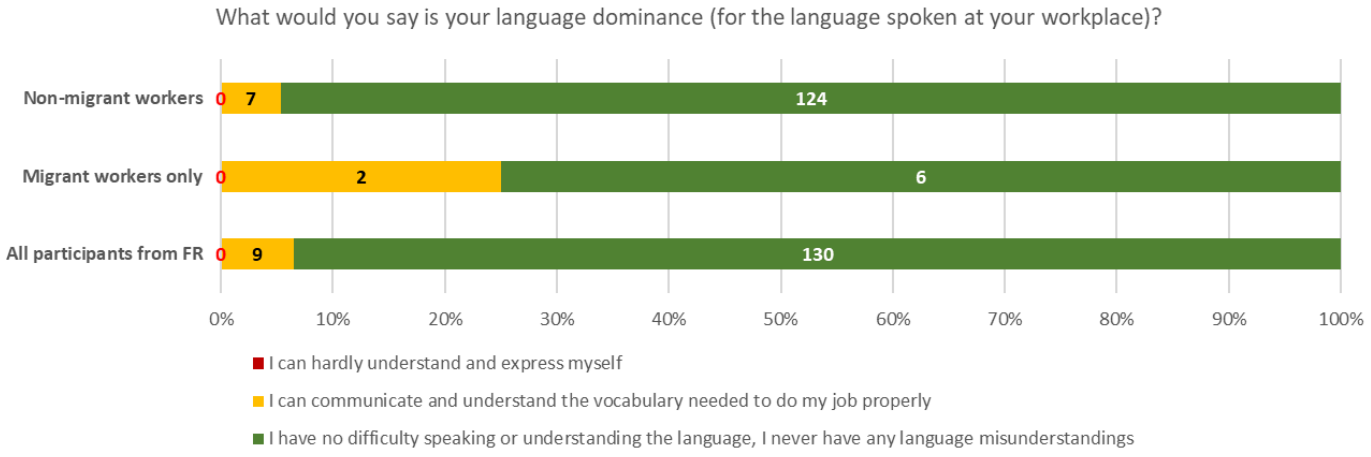


Figure 143. *Language dominance at the workplace*



5.2. Findings on Prevalence: Comparing Well-Being, Risks and Protective Factors Across Targets

5.2.1. Well-Being Results

In this section, the outcomes of work are examined, considering both its positive and negative dimensions. The positive dimension is captured through indicators of psychological well-being or flourishing, while the negative dimension focuses on burnout and perceived strain. In addition, the impact of work on personal life is explored, concluding with a report on employees' expressed desire to leave their job if given the opportunity.

Table 18. *Main results of Wellbeing*

Outcomes	Target	Mean	S.D.	N
Burnout (Disengagement and Exhaustion)	Target A	2.70	0.44	15
	Target B	2.76	0.52	38
	Target C	2.89	0.39	86
	Mean	**2.84**	**0.44**	**139**
Perceived Exertion	Target A	6.60	2.10	15
	Target B	7.18	2.93	38
	Target C	7.41	2.78	86
	Mean	**7.26**	**2.75**	**139**
Turnover intentions	Target A	2.04	1.08	15
	Target B	2.23	1.28	38
	Target C	2.58	1.15	86
	Mean	**2.43**	**1.19**	**139**
Work-Private Life Conflict	Target A	3.13	0.99	15
	Target B	2.56	0.89	38
	Target C	3.18	0.82	86
	Mean	**3.00**	**0.89**	**139**
Work-Private Life Enrichment	Target A	3.28	0.29	15
	Target B	3.36	0.81	38
	Target C	3.13	0.67	86
	Mean	**3.21**	**0.69**	**139**
Happiness	Target A	6.07	1.62	15
	Target B	7.00	1.76	38
	Target C	6.59	1.94	86
	Mean	**6.65**	**1.86**	**139**
Flourishing	Target A	5.13	1.02	15
	Target B	5.57	0.84	38
	Target C	5.35	1.02	86
	Mean	**5.39**	**0.97**	**139**

Note: Target A: Home health aides; Target B: Basic care workers; Target C: Professional care workers.

Negative Indicators: Where Workers Are Struggling

Burnout Results. Burnout is a job-related syndrome that has been defined as a state of physical, emotional and mental exhaustion that results from prolonged exposure to chronic workplace stress that has not been successfully managed. This variable was assessed with the Oldenburg Burnout Inventory OLBI (Demerouti, et al. (2010). Two scales: disengagement (8 items) and psychological exhaustion (8 items). The responses ranged from 1 (strongly disagree) to 4 (strongly agree).

The mean burnout score of the German care workers was 2.84 (SD = 0.44) on a scale of 1 to 4, indicating a moderate to high level of burnout across the sample. This suggests that, on average, care workers reported experiencing both emotional exhaustion and detachment from their work quite frequently. No significant differences were found between the target groups (home health aides, basic care workers and professional care workers), suggesting that levels of burnout were relatively consistent across different care settings and qualification levels.

Physical Exertion Results. This construct refers to the perceived level of physical effort required from care workers during their working hours. In other words, it quantifies the degree of exertion that care workers perceive themselves to be experiencing in relation to the physical demands of their work. This variable was measured using the Borg Rating of Perceived Exertion Scale (RPE) (1970). The scale ranges from 1 (no exertion) to 11 (maximal exertion).

The mean perceived physical strain score was 7.26 (SD = 2.75) on a scale of 1 to 11, indicating that German care workers generally experienced moderate to high levels of physical strain in their work. This reflects the physically demanding nature of care work. No significant differences were found between the target groups, suggesting that perceptions of physical strain were similar for home health aides, basic care workers and professional care workers.

Turnover Intentions Results. This variable examined the intention or desire of care workers to leave or abandon their role within the care profession. It was measured using the Intention to Quit Questionnaire (ITQ), which was developed by Rahnfeld et al. (2016) and adapted from Price (1997). The ITQ comprises three items (example item 'despite the obligations I have made to my employer, I want to quit my job as soon as possible') that assess workers' intentions to quit their care job. Participants were asked to indicate the frequency of their intention to quit on a five-point Likert scale, with responses ranging from 1 (almost never) to 5 (almost always).

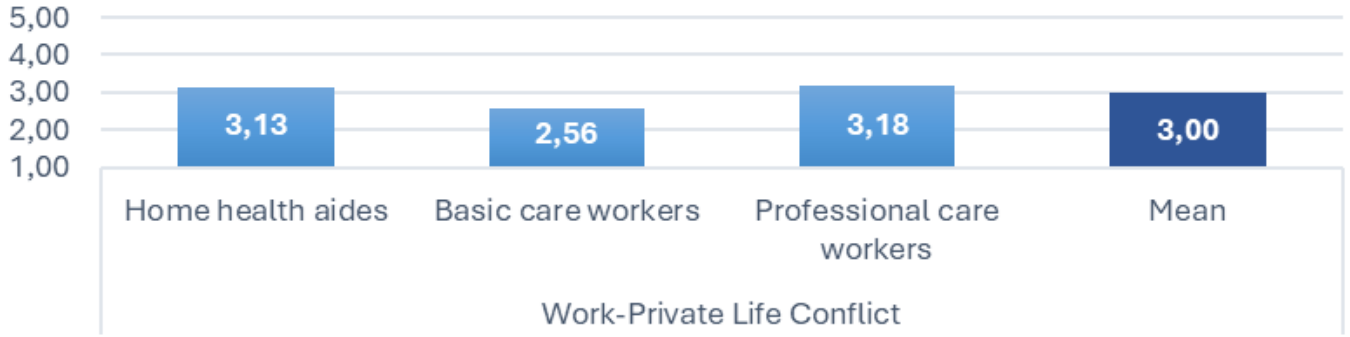
The mean score for turnover intentions was 2.43 (SD = 1.19) on a scale of 1 to 5, indicating a moderate level of desire to leave the current job among German care workers. No significant differences were observed between the target groups, meaning that turnover intentions were

consistently reported by home health aides, basic care workers and professional care workers.

Work-Private Life Conflict Results. This construct represents a form of inter-role conflict, characterised by a clash between the risk factors of one's professional role and those of their personal or familial responsibilities. The scale from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version, comprising five items (e.g., 'Do you feel that your work drains so much of your energy that it has a negative effect on your private life?'), was employed to measure the variable. The responses ranged from 1 (never) to 5 (always).

The mean work-life conflict score was 3.00 (SD = 0.89) on a scale of 1 to 5, indicating a moderate level of conflict between care workers' professional and personal responsibilities. Significant differences were found between the target groups: basic care workers reported lower levels, whereas home health aides and professional care workers reported higher - and statistically similar - levels of work-private life conflict. This suggests that workers in both home-based and highly skilled roles may experience greater challenges in balancing work and personal life than those with intermediate-level qualifications employed in institutional care roles.

Figure 144. *Cross-target work-private life conflict comparative results*



Positive Indicators: Signs of Strength

Work-Private Life Enrichment Results. This variable pertains to a process at the work-private life intersection, in which experience or involvement in one role enhances the quality or performance in the other role. The six-item scale Work-family enrichment, as originally proposed by Carlson et al. (2006) and subsequently abbreviated by Kacmar et al. (2014), was employed to assess the variable in question. Participants were invited to indicate their level of agreement with each item on a five-point Likert scale, with responses ranging from 1 (strongly disagree) to 5 (strongly agree).

The mean score for work-life enrichment was 3.21 (SD = 0.69) on a scale of 1 to 5, indicating that German care workers generally experienced a moderate level of positive interaction between their work and personal lives. This suggests that many participants felt that their

work made a positive contribution to their personal development or quality of life, and vice versa. No significant differences were found between the target groups, meaning that the experience of enrichment was similar for home health aides, basic care workers and professional care workers.

Happiness results. This construct was designed to assess care workers' general levels of happiness and their attitudes towards their own lives. The variable was assessed using a single item: 'taken everything together, how happy are you with your life?'. Participants were instructed to indicate their level of satisfaction on a scale from 0 (totally unhappy) to 10 (extremely happy).

The average happiness score of the German care workers was 6.65 (SD = 1.86) on a scale of 0 to 10, reflecting a moderate to high level of overall happiness across the sample. This suggests that despite the challenges of care work, participants generally felt reasonably satisfied with their lives. No significant differences were observed between the target groups, suggesting that levels of happiness were similar for home health aides, basic care workers and professional care workers.

Flourishing results. The concept of flourishing can be defined as the combination of subjective and psychological well-being, in which the individual is in a positive emotional state, experiencing feelings of engagement, meaning (or purpose), having personal resources and positive interpersonal relationships. It is measured using a scale comprising eight statements (example items are 'I am optimistic about my future' and 'I lead a purposeful and meaningful life') (Diener et al., 2009), with respondents indicating their level of agreement on a scale from 1 (strongly disagree) to 7 (strongly agree).

The mean flourishing score was 5.39 (SD = 0.97) on a scale of 1 to 7, indicating a moderately high level of overall psychological well-being among German care workers. This suggests that participants generally reported feeling positive, engaged and equipped with personal and social resources. No significant differences were found between the target groups, suggesting that flourishing was experienced consistently by home health aides, basic care workers and professional care workers.

5.2.2. Risk Factors among Care Workers

Drawing on the Job Demands–Resources (JD-R) theory (Bakker & Demerouti, 2011), which serves as the theoretical framework for this research, this section examines key findings related to job demands or risk factors as perceived by care workers.

Table 19. *Job, emotional and relational risk factors*

Risk factors	Target	Mean	S.D.	N
Physical Demands	Target A	3.33	1.45	15
	Target B	3.74	1.54	38
	Target C	3.97	1.34	86
	Mean	**3.83**	**1.41**	**139**
Quantitative Demands	Target A	2.83	0.79	15
	Target B	2.91	0.94	38
	Target C	3.47	0.80	86
	Mean	**3.25**	**0.88**	**139**
Work Pace	Target A	3.56	1.01	15
	Target B	3.19	1.09	38
	Target C	3.74	0.91	86
	Mean	**3.57**	**0.99**	**139**
Tasks Beyond Care Workers' duties	Target A	3.27	0.70	15
	Target B	2.79	1.34	38
	Target C	3.15	1.12	86
	Mean	**3.06**	**1.16**	**139**
Emotional Demands	Target A	3.51	0.60	15
	Target B	3.61	0.91	38
	Target C	3.85	0.68	86
	Mean	**3.75**	**0.75**	**139**
Demands for Hiding Emotions	Target A	3.62	1.05	15
	Target B	3.72	0.97	38
	Target C	4.00	0.69	86
	Mean	**3.88**	**0.83**	**139**
Exposure to Workplace Violence	Target A	1.33	0.49	15
	Target B	1.68	0.93	38
	Target C	1.84	0.91	86
	Mean	**1.74**	**0.89**	**139**
Exposure to Discrimination	Target A	0.33	0.90	15
	Target B	0.03	0.16	38
	Target C	0.14	0.58	86
	Mean	**0.13**	**0.55**	**139**
Intragroup Conflict	Target A	2.21	0.51	15
	Target B	2.82	1.15	38
	Target C	2.99	0.76	86
	Mean	**2.86**	**0.89**	**139**

Continuation Table 19.

Risk factors	Target	Mean	S.D.	N
Workplace Incivility	Target A	1.72	0.84	15
	Target B	1.95	0.95	38
	Target C	2.14	0.85	86
	Mean	**2.05**	**0.89**	**139**

Job-related Risk Factors

Physical Demands. This variable pertains to the frequency of physical activity that care workers are required to perform in order to fulfil the duties inherent to their role. These activities may include, but are not limited to, walking, lifting, carrying, reaching, pushing and pulling. Participants were asked to respond on a 5-point Likert scale, from 1 (never) to 5 (everyday).

The mean score for physical demands was 3.83 (SD = 1.41) on a scale of 1 to 5, indicating that German care workers frequently engaged in physically demanding tasks such as lifting, moving or assisting care receivers with mobility. No significant differences were observed between the target groups, suggesting that these physical demands were experienced similarly by home health aides, basic care workers, and professional care workers.

Quantitative Demands. Defined as the psychological demands that arise from the amount of work that must be completed within a given timeframe. These demands are typically high when the volume of work exceeds the capacity to complete it within the specified period. Four items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were employed to assess the job demand in question. An illustrative item is "Is your workload unevenly distributed so it piles up?". The respondents were asked to respond on a 5-point Likert scale, from 1 (never) to 5 (always).

The mean score for quantitative demands was 3.25 (SD = 0.88) on a scale of 1 to 5, reflecting a moderately high level of workload pressure in terms of the amount of work care workers had to complete in a given period of time. Significant differences were observed between the groups: home health aides and basic care workers reported lower levels of quantitative demands, whereas professional care workers reported higher levels. This suggests that workload expectations were higher for professional care workers employed in institutional settings.

Figure 145. *Cross-target quantitative demands comparative results*

Work Pace Demands. The term is defined as the psychological demand associated with the intensity of the work. To assess this job demand, three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were used. An illustrative item is, "Do you work at a high pace throughout the day?" Respondents were asked to indicate their level of agreement with the item on a 5-point Likert scale, from 1 (never) to 5 (always).

The mean score for work pace demands was 3.57 (SD = 0.99) on a scale of 1 to 5, indicating that German care workers generally experienced high work intensity, requiring them to maintain a fast pace to complete their tasks. No significant differences were found between the groups, suggesting that these time pressures were experienced similarly by home health aides, basic care workers and professional care workers.

Tasks Beyond Care Workers' Duties. The variable assessed the frequency of instances over the past year in which care workers were required to perform tasks that were not included in their job description or the care receivers' care plan (question taken from Karlsson et. al. (2020) study, in which 47% of home care aides agreed or strongly agreed with the statement. In our study, the response options were adapted to be coherent with the rest of the survey. They were instructed to indicate their response on a 5-point Likert scale, ranging from 1 (never or almost never) to 5 (a lot of the time).

The mean score for exposure to requests to perform tasks outside of formal care duties was 3.06 (SD = 1.16) on a scale of 1 to 5, indicating that German care workers often experienced requests to take on responsibilities outside of their official job descriptions. No significant differences were found between the groups, suggesting that these requests for additional tasks were common to home health aides, basic care workers and professional care workers.

Emotional Risk Factors

Emotional Demands. The construct pertains to the psychological demands that arise from the interpersonal relationships involved in the work, which require care workers to engage in emotionally charged situations. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were employed to assess the aforementioned job demand. An illustrative item is "Do you have to deal with other people's personal problems as part of your work?" The respondents were requested to respond on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The mean score for emotional demands was 3.75 (SD = 0.75) on a scale of 1 to 5, indicating that German care workers were commonly faced with emotionally challenging situations in their roles, such as managing sensitive interactions with care receivers and families. No significant differences were found between the groups, showing that emotional demands were consistently reported by home health aides, basic care workers and professional care workers.

Demands for Hiding Emotions. The variable in question alludes to the psychological demand associated with the necessity of maintaining a neutral demeanour in the face of unpredictable behaviour exhibited by care receivers, colleagues, superiors, family members, and other individuals within the professional setting. Four items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this job demand. An illustrative item is, "Are you required to be kind and open towards everyone – regardless of how they behave towards you?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The mean score for demands to hide emotions was 3.88 (SD = 0.83) on a scale of 1 to 5, indicating that German care workers regularly felt the need to suppress or manage their emotional responses in work settings. No significant differences were observed between the groups, suggesting that this need for emotional control was a common experience for home health aides, basic care workers and professional care workers.

Relational Risk Factors

Exposure to Workplace Violence. The variable in question was designed to assess the frequency of instances in which care workers were exposed to violent behaviours or attitudes directed towards them in the workplace. Specifically, respondents were asked to respond to one question - In the last year, how often have you been exposed at work to violence from patients and/or their family members?. The respondents were required to indicate their level of agreement with the statement on a five-point Likert scale, with 1 representing "never" and 5 representing "everyday".

The mean score for exposure to workplace violence was 1.74 (SD = 0.89) on a scale of 1 to 5, indicating that German care workers reported experiencing violence from patients or their families very occasionally, although such experiences were not widespread. No significant differences were found between the groups, suggesting that exposure to violence in the workplace was reported at similar levels by home health aides, basic care workers and professional care workers.

Exposure to Discrimination. This variable assessed the frequency with which care workers had experienced discriminatory behaviour or attitudes that made them feel vulnerable because of their gender, ethnicity or colour in the past year. This was measured on a 4-point scale (0 - never; 1 - once; 2 - two or three times; and 3 - four or more times). The question was adapted from the Experiences of Discrimination Scale (EOD) developed by Williams et al. (1997).

A total of 8 out of 139 German care workers (around 5.8%) reported experiencing discrimination at work in the past year. The most common reason given was gender, followed by weight or height, age, nationality, ethnicity, skin colour and education or income level.

Figure 146. *Exposure to discrimination variable results*

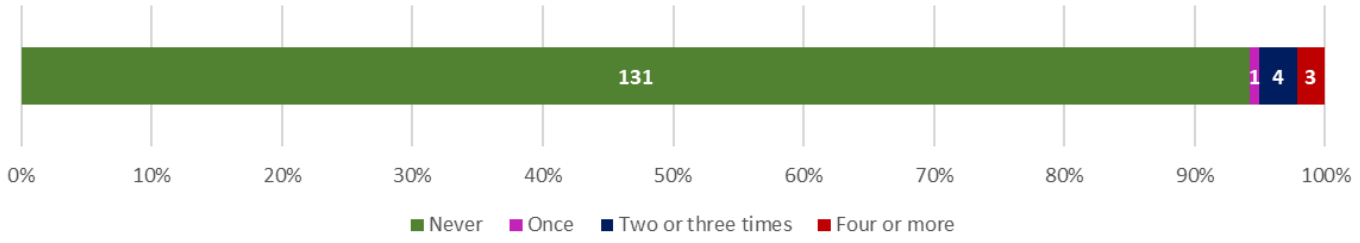
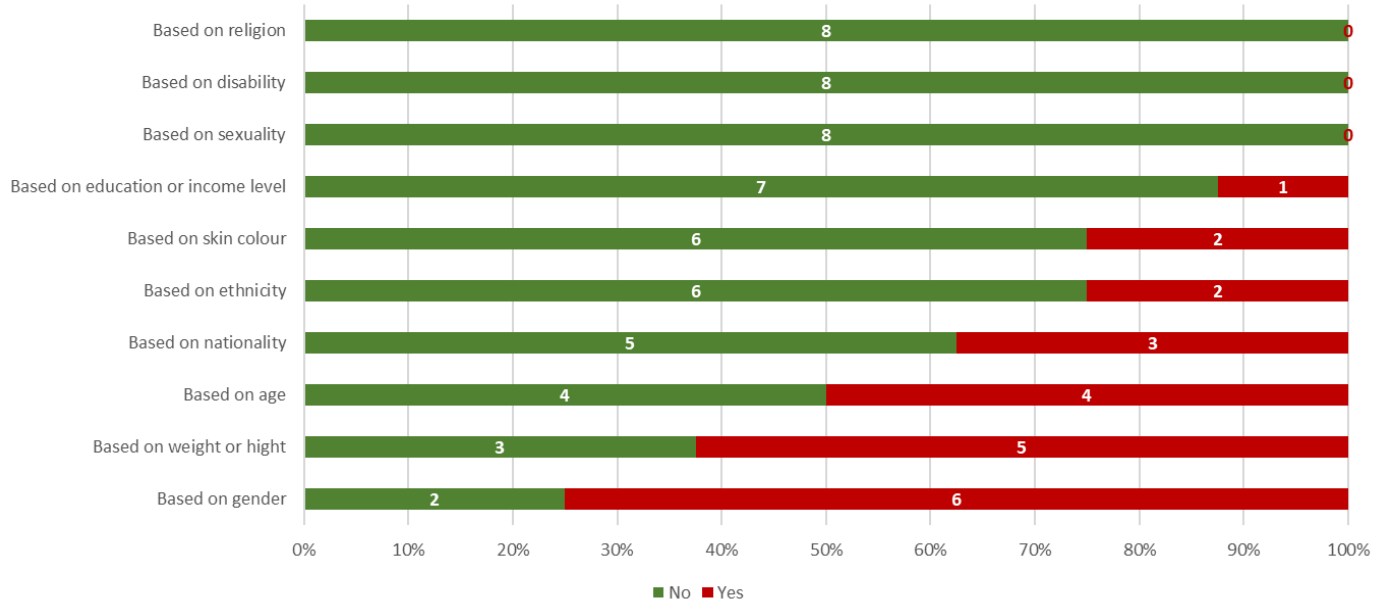


Figure 147. *Perceived motive of discrimination of those who experienced it*



The mean score for exposure to discrimination was 0.13 (SD = 0.55) on a scale of 0 to 3, indicating that reported incidents of discrimination were generally rare. No significant differences were observed between the groups, suggesting that discrimination was reported at similarly low levels by home health aides, basic care workers and professional care workers. However, it is important to note that these low levels of reporting may be influenced not only by actual incidence, but also by the low representation of migrant workers in the sample, as well as possible under-reporting or reluctance to disclose such experiences.

Intragroup Conflict. The construct refers to the frequency with which carers experience conflict within a team, with the care receiver, their family members or other people at work, where members clash over work procedures or due to personality clashes. The 8-item scale was adapted from Jehn (1995). Participants were asked to respond on a 5-point Likert scale from 1 (none) to 5 (a lot).

The mean score for intragroup conflict was 2.86 (SD = 0.89) on a scale of 1 to 5, indicating that German care workers experienced moderate levels of conflict with colleagues or others in their work environment. Significant differences were found between the groups: home health aides reported lower levels of intragroup conflict, while basic care workers and professional care workers reported higher - and statistically similar - levels. This suggests that interpersonal conflict may be more common in institutional settings, where basic and professional care workers typically work.

Figure 148. *Cross-target intragroup conflict comparative results*

Workplace Incivility. The variable is defined as low-intensity deviant behaviour (by care receivers, family members, colleagues, etc.) with ambiguous intent to harm the target (the care worker), in violation of workplace norms of mutual respect. The 4-item scale shortened by Matthews & Ritter (2016) from Cortina et al. (2013) was used to assess this construct. An example item is "In the past year, have you been in a situation where people you interact with at work made jokes at your expense?" Participants were asked to respond on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The mean score for workplace incivility was 2.05 (SD = 0.89) on a scale of 1 to 5, indicating that German care workers occasionally experienced disrespectful or inappropriate behaviour in their work environment. No significant differences were found between the groups, suggesting that experiences of incivility were reported at similar levels by home health aides, basic care workers and professional care workers.

5.2.3. Protective Factors in the Care Sector

This section focuses on the resources available to care workers to help them cope with the demands of their work. As in the previous section, both overall results and comparisons between different target groups are presented.

Table 20. *Job, emotional and relational protective factors*

Protective factors	Target	Mean	S.D.	N
Possibilities for Development	Target A	3.96	0.84	15
	Target B	3.70	0.95	38
	Target C	3.63	0.78	86
	Mean	**3.69**	**0.84**	**139**
Variation of Work	Target A	2.87	0.64	15
	Target B	3.01	0.88	38
	Target C	3.10	0.91	86
	Mean	**3.05**	**0.88**	**139**
Control over Working Time	Target A	3.03	0.71	15
	Target B	2.82	0.66	38
	Target C	2.97	0.64	86
	Mean	**2.94**	**0.65**	**139**
Predictability	Target A	3.57	0.80	15
	Target B	3.55	1.04	38
	Target C	3.49	0.91	86
	Mean	**3.51**	**0.93**	**139**
Autonomy	Target A	2.56	0.84	15
	Target B	2.82	0.87	38
	Target C	2.91	0.66	86
	Mean	**2.85**	**0.74**	**139**
Meaning of Work	Target A	4.63	0.58	15
	Target B	4.70	0.50	38
	Target C	4.65	0.54	86
	Mean	**4.66**	**0.53**	**139**
Recognition	Target A	3.87	0.74	15
	Target B	3.72	1.09	38
	Target C	3.50	0.97	86
	Mean	**3.60**	**0.99**	**139**
Emotional Social Support	Target A	3.40	0.99	15
	Target B	3.48	1.03	38
	Target C	3.25	0.83	86
	Mean	**3.33**	**0.90**	**139**
Instrumental Social Support	Target A	2.23	0.70	15
	Target B	2.96	0.81	38
	Target C	2.71	0.76	86
	Mean	**2.73**	**0.79**	**139**

Job-related Protective Factors

Possibilities for Development. The variable in question refers to the extent to which job performance provides opportunities for care workers to put their knowledge, skills and experience into practice and to acquire new knowledge, skills and experience. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. An illustrative item is "Do you have the possibility of learning new things through your work?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The mean score for development opportunities was 3.69 (SD = 0.84) on a scale of 1 to 5, indicating that German care workers generally felt they had good opportunities to use and develop their skills and knowledge in the workplace. There were no significant differences between the groups, suggesting that perceptions of development opportunities were similar for home health aides, basic care workers and professional care workers.

Variation of Work. The construct refers to whether care work tasks are repetitive or, on the contrary, diverse or varied. Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. An illustrative item is "Do you have to do the same thing over and over again?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The mean score for job variety was 3.05 (SD = 0.88) on a scale of 1 to 5, indicating that German care workers experienced a moderate level of job variety, with some diversity in their daily tasks, but also some repetition. No significant differences were found between the groups, meaning that perceptions of task variety were similar for home health aides, basic care workers and professional care workers.

Control over Working Time. The construct refers to care workers'' control over their working time in aspects such as starting and ending the working day, when to take breaks, days off, holidays, and control over whether, when and how much overtime to work. 5 items from the long version of the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) were selected to assess this resource. An illustrative item is "Can you decide when to take a break?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The mean score for control over working time was 2.94 (SD = 0.65) on a scale of 1 to 5, suggesting that German care workers had a moderate degree of agency in managing aspects of their schedules, such as start and end times, breaks, and days off. No significant differences were found between the groups, suggesting that control over working time was similarly reported by home health aides, basic care workers and professional care workers.

Predictability. Work is predictable if the worker has adequate, sufficient and timely information to be able to perform the job correctly and to adapt to changes (future restructuring, new technologies, new tasks, new methods and the like). Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected for the assessment of this resource. One illustrative item is, "Do you receive all the information you need in order to do your work well?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The mean score for predictability was 3.51 (SD = 0.93) on a scale of 1 to 5, indicating that German care workers generally felt they had a moderate to high level of timely and sufficient information to carry out their tasks and adapt to changes in their work environment. No significant differences were found between the groups, suggesting that predictability was experienced consistently by home health aides, basic care workers and professional care workers.

Autonomy. The construct refers to the degree of influence or decision latitude that the care worker has in the day-to-day activities, particularly in relation to the tasks to be carried out and the manner in which they are to be carried out. The three-item scale from Bakker and Bal (2010), adapted from Karasek et al. (1985), was used to quantify this resource. An illustrative item is "I have a lot of freedom in the execution of my work". The responses ranged from 1 (strongly disagree) to 4 (strongly agree).

The mean score for autonomy was 2.85 (SD = 0.74) on a scale of 1 to 5, indicating that German care workers experienced a moderate degree of independence and freedom of decision-making in the performance of their daily tasks. No significant differences were found between the groups, suggesting that levels of autonomy were consistent between home health aides, basic care workers and professional care workers.

Emotional Protective Factors

Meaning of Work. The variable is defined as the relationship that work has to values other than those associated with having a job and earning an income. These include the utility, importance or social value, or learning involved. Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected for the assessment of this resource. One illustrative item is, "Are you required to be kind and open towards everyone – regardless of how they behave towards you?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The mean score for meaning of work was 4.66 (SD = 0.53) on a scale of 1 to 5, indicating that German care workers strongly perceived their work as meaningful and valuable beyond its financial or practical aspects. No significant differences were found between the groups,

suggesting that this strong sense of purpose was consistently reported by home health aides, basic care workers and professional care workers.

Relational Protective Factors

Recognition. The term denotes the appreciation, respect and fair treatment afforded to care workers by their supervisors in the workplace. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. One illustrative item is, "Is your work recognised and appreciated by the management/supervisor?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The mean score for recognition was 3.60 (SD = 0.99) on a scale of 1 to 5, suggesting that German care workers typically felt valued, respected, and treated fairly by their supervisors. No significant differences were found between the groups, indicating that the experience of recognition was similar for home health aides, basic care workers and professional care workers.

Social Support. The variable can be defined as the degree to which care workers receive emotional and instrumental (help with job tasks) support from the individuals with whom they interact at their place of work. The 8-item scale was adapted from that used by Peeters et al. (1995) for the purpose of measuring this resource. An example item is, "The people you interact with at work showed that they appreciated the way you do your work". The responses were measured on a scale ranging from 1 (not at all) to 5 (a lot).

The results show that German care workers perceived moderate levels of social support overall, measured across two key dimensions: emotional and instrumental support. Emotional support - reflecting the extent to which care workers felt cared for and listened to - had a mean score of 3.33 (SD = 0.90), with no significant differences between the target groups. This suggests that emotional support was fairly consistent across roles and settings.

Instrumental support, which refers to practical assistance with work tasks, was rated lower, with a mean score of 2.73 (SD = 0.79). There were significant differences here: home health aides reported the lowest levels of instrumental support, while basic care workers reported the highest, with professional care workers falling in between.

Figure 149. *Cross-target instrumental support comparative results*

5.2.4. Summary: Main Differences Across Targets in Germany

Table 21. *Summary of prevalence results in Germany*

Dimension		Variable	Overall level	Cross-target differences
Well-being indicators	***Negative well-being indicators***	Burnout (Disengagement and Exhaustion)	Moderate-High	No differences
		Physical Exertion	Moderate-High	No differences
		Turnover Intentions	Low-Moderate	No differences
		Work–Private Life Conflict	Moderate	C, A > B
	Positive well-being indicators	Work–Private Life Enrichment	Moderate-High	No differences
		Happiness	Moderate-High	No differences
		Flourishing	Moderate-High	No differences
Risk factors	***Job-related risk factors***	Physical Demands	Moderate-High	No differences
		Quantitative Demands	Moderate-High	C > B, A
		Work Pace Demands	Moderate-High	No differences
		Tasks Beyond Job Duties	Moderate	No differences
	Emotional risk factors	Emotional Demands	Moderate-High	No differences
		Demands for Hiding Emotions	High	No differences
	Relational risk factors	Exposure to Workplace Violence	Low	No differences
		Exposure to Discrimination	Low	No differences
		Intragroup Conflict	Moderate	C, B > A
		Workplace Incivility	Low	No differences
Protective factors	***Job-related protective factors***	Possibilities for Development	Moderate-High	No differences
		Variation of Work	Moderate	No differences
		Control Over Time	Moderate	No differences
		Predictability	Moderate-High	No differences
		Autonomy	Moderate	No differences
	Emotional protective factors	Meaning of Work	High	No differences
	Relational protective factors	Recognition	Moderate-High	No differences
		Emotional Support	Moderate	No differences
		Instrumental Support	Moderate	B > C > A

Note: Consider the sample sizes for each group (15 home health aides - A; 38 basic care workers - B; and 86 professional care workers - C)

The findings from the German sample paint a picture of care workers who experience meaningful and rewarding aspects of their work, while at the same time managing a number of significant job-related risk factors. Care workers reported moderate to high levels of psychological well-being, with a deep sense of meaning in their role and generally good levels of happiness and flourishing. Levels of burnout were moderate to high, reflecting the intensity of care work, and turnover intentions were at moderate levels, suggesting that while many workers remain engaged, there is also a noticeable segment who are considering leaving their roles.

In terms of risk factors, both physical and emotional pressures were central aspects of the job for all groups. Care workers were often faced with physically demanding tasks and emotionally challenging situations, often having to hide their emotional reactions in professional contexts. Workload-related pressures, such as quantitative and pace demands, were evident and tended to be higher for professional care workers. Requests to take on tasks beyond their formal job duties were also common, further illustrating the wide range of responsibilities in care work.

Risk factors related to interpersonal dynamics - such as workplace violence, conflict and discrimination - were reported at low to moderate levels. However, it's important to note that the relatively low reporting of discrimination may be partly explained by the low proportion of migrant workers in this sample, as well as possible under-reporting.

In terms of protective factors, care workers expressed a strong sense of meaning and purpose in their work. They also generally reported good access to development opportunities, recognition and predictability. Emotional support was felt across the board, although instrumental (task-related) support varied, with home health aides experiencing less practical support than those in institutional settings. Autonomy and control over working time were moderate, suggesting potential areas for growth in enabling care workers to have greater influence over their daily routines.

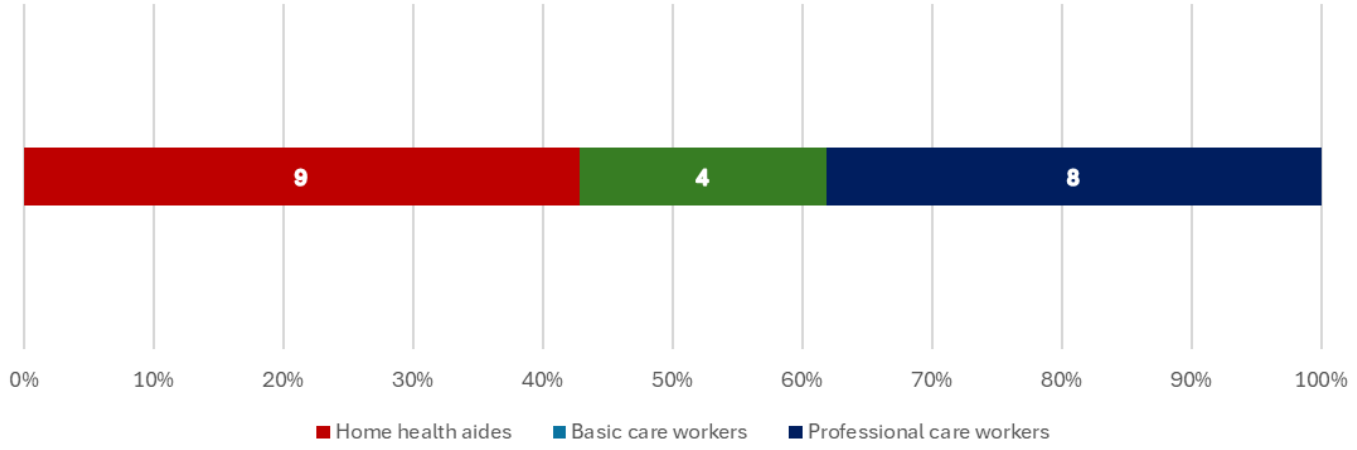
In summary, German care workers find meaning and fulfilment in their roles, but face a number of persistent risk factors, particularly physical and emotional pressures, and some gaps in practical, task-related support. While overall well-being indicators are positive, moderate levels of burnout and turnover intentions suggest areas of strain. The findings point to the importance of continuing to monitor working conditions closely, with particular attention to improving practical support where it is lacking, and ensuring that care workers - in all settings - can maintain both their health and their sense of purpose in the long term.

Chapter 6. Qualitative Data Set: Making Sense of the Findings Through Workers' Voices

6.1. Profile of the Care Workforce: Focus Group Sample

A total of 21 care workers from Germany participated in the study, 9 from Target A (in red, home health aides), 4 from Target B (in green, basic care workers) and 8 participants from Target C. Among home health aides who answered their work modality the whole sample were live-in home care workers.

Figure 150. *Participants per target group*



The average age of the German participants was 44.71 years and the majority were women (90.4%). Among age groups 19% were younger adults, 38% were adults and 43% were middle-aged adults.

Figure 151. *Age groups*

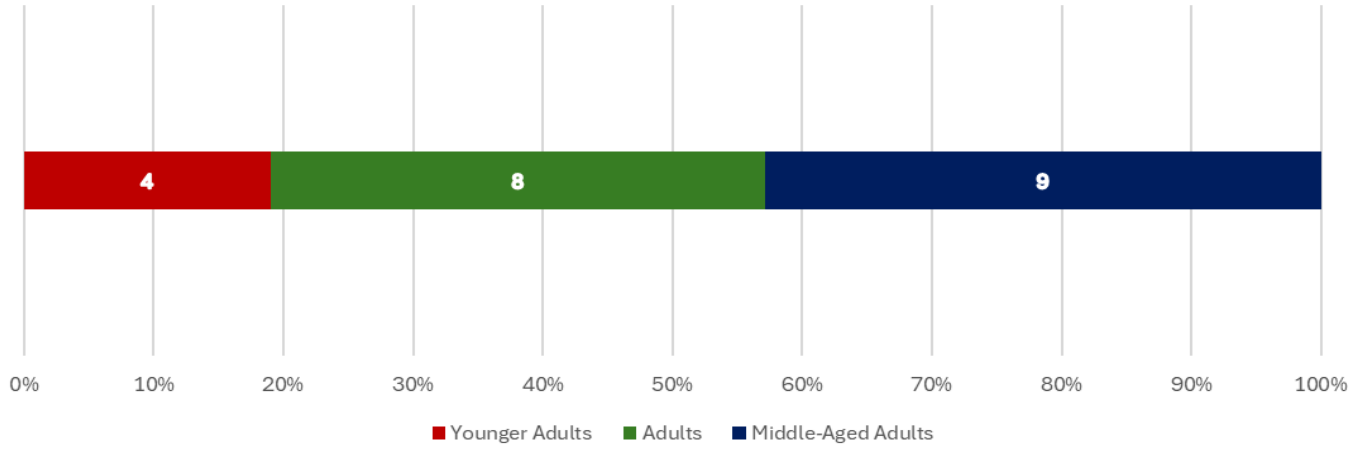
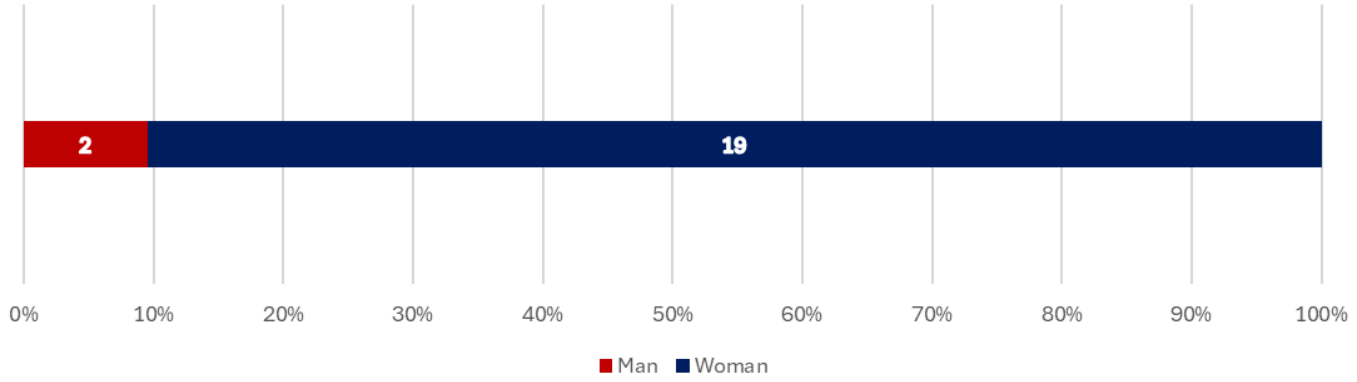


Figure 152. *Gender*

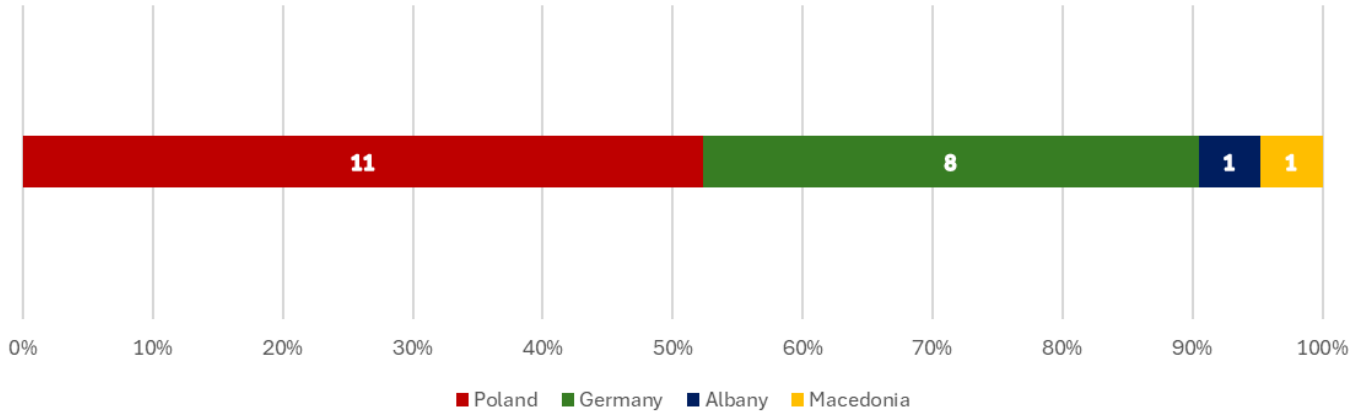


Most participants were Polish (52.4%) followed by German (38%). A few were from Albany and Macedonia.

Table 22. *Country of origin*

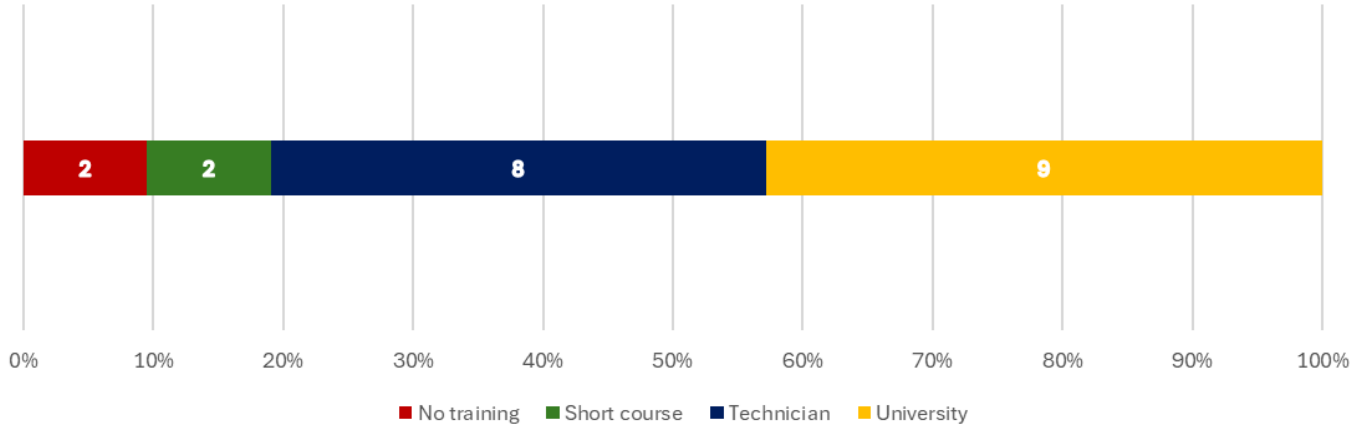
Country	Participants	Percentage
Poland	11	52.4
Germany	8	38
Albany	1	4.8
Macedonia	1	4.8
Total	21	100

Figure 153. *Country of origin*



Educational levels were diverse: 9.5% had no training in care sector activities, 9.5% had a short course in care activities, 38% were technicians and 43% had completed a university degree.

Figure 154. *Educational status*



6.2 Focus Group Findings: Understanding Pressures and Supports Across Worker Groups

The qualitative results are presented by the target group. Within each group, risk factors (demands) and protective factors (resources) have been identified. Three domains have been differentiated for both: job, relational (where applicable) and personal. The most salient codes are highlighted to ensure consistency with the quantitative results and clarify subjective experiences. Each domain is depicted using a Sankey diagram indicating code frequencies.

Table 23. *German focus group index*

Name of FG	Target	N	Gender		Age average	Country of origin	Modality
			F	M			
FG 1 DE A	A	4	3	1	51.25	Poland	Online
FG 2 DE A	A	5	4	1	49.8	Poland	Online
FG 3 DE B	B	4	4	0	37.25	Germany, Macedonia, Poland	Face-to-face
FG 4 DE C	C	2	2	0	30	Albania and Germany	Face-to-face
FG 5 DE C	C	6	6	0	46	Germany	Face-to-face

6.2.1. Home Care: Risk and Protective Factors

The information in the following section is based on the testimonies of home care workers. They are nursing and care professionals working in domestic and outpatient settings, lacking specific training, who provide care for elderly, sick or other individuals requiring home care.

Risk Factors

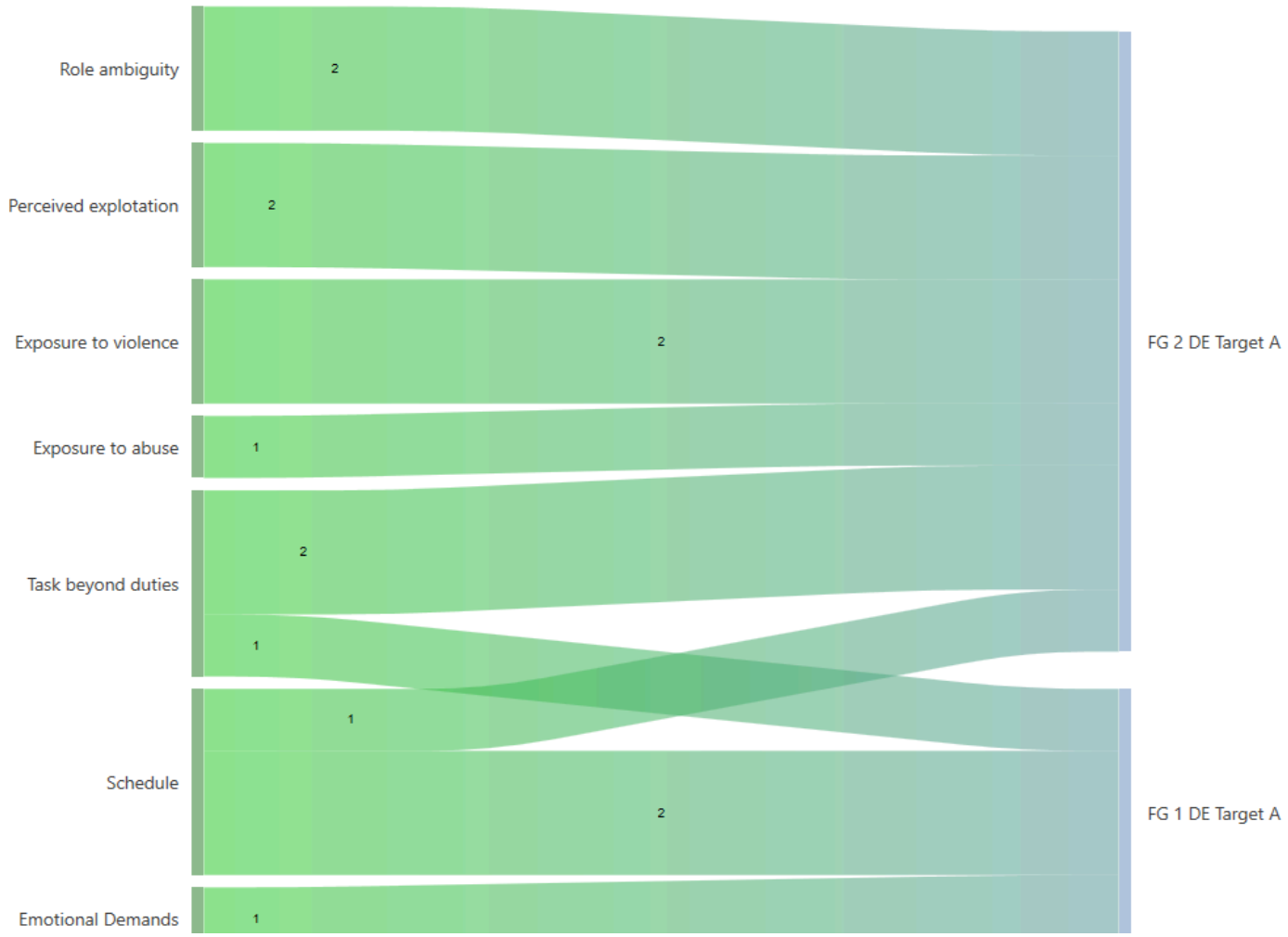
Job-related Risk Factors

This diagram reveals that the most frequent job-related risks are physical demands, quantitative demands, and work demands, reflecting the high physical and temporal workload experienced by home care workers. Task beyond duties also appears prominently, showing that workers often perform responsibilities outside their contractual scope. Medium-width flows for role ambiguity, perceived exploitation, and exposure to violence indicate additional sources of stress related to unclear job expectations, unfair treatment, and exposure to aggression. Thinner flows, such as exposure to abuse, schedule, and emotional demands, point to situational challenges that reinforce instability and emotional

strain.

Overall, the diagram portrays a scenario where overwork, ambiguous roles, and exposure to physical or psychological risks converge to create a demanding and potentially unsafe work environment.

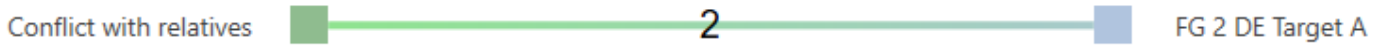
Figure 155. *Job-related risk factors among home care workers group in Germany*



Relational Risk Factors

This diagram shows that conflict with relatives is the main relational risk factor, appearing as a single thick flow in *FG2 DE Target A*. The code reflects situations in which unrealistic expectations or disagreements with family members of care receivers generate stress and tension for care workers. No additional relational codes appear in this diagram, suggesting that the primary relational pressure arises from the family–worker interface, where communication breakdowns or emotional misalignments tend to occur.

Figure 156. *Relational risk factors among home care workers group in Germany*



Personal Risk Factors

The personal risk factors diagram displays foreign language as the only coded element, with two medium-width flows connected to *FG1 DE Target A* and *FG2 DE Target A*. This highlights language barriers as a central difficulty, particularly among migrant care workers. The inability to fully communicate with care receivers or their families can limit trust, complicate daily tasks, and reduce perceived care quality. The diagram thus points to communication challenges as a structural personal vulnerability that impacts both performance and emotional well-being.

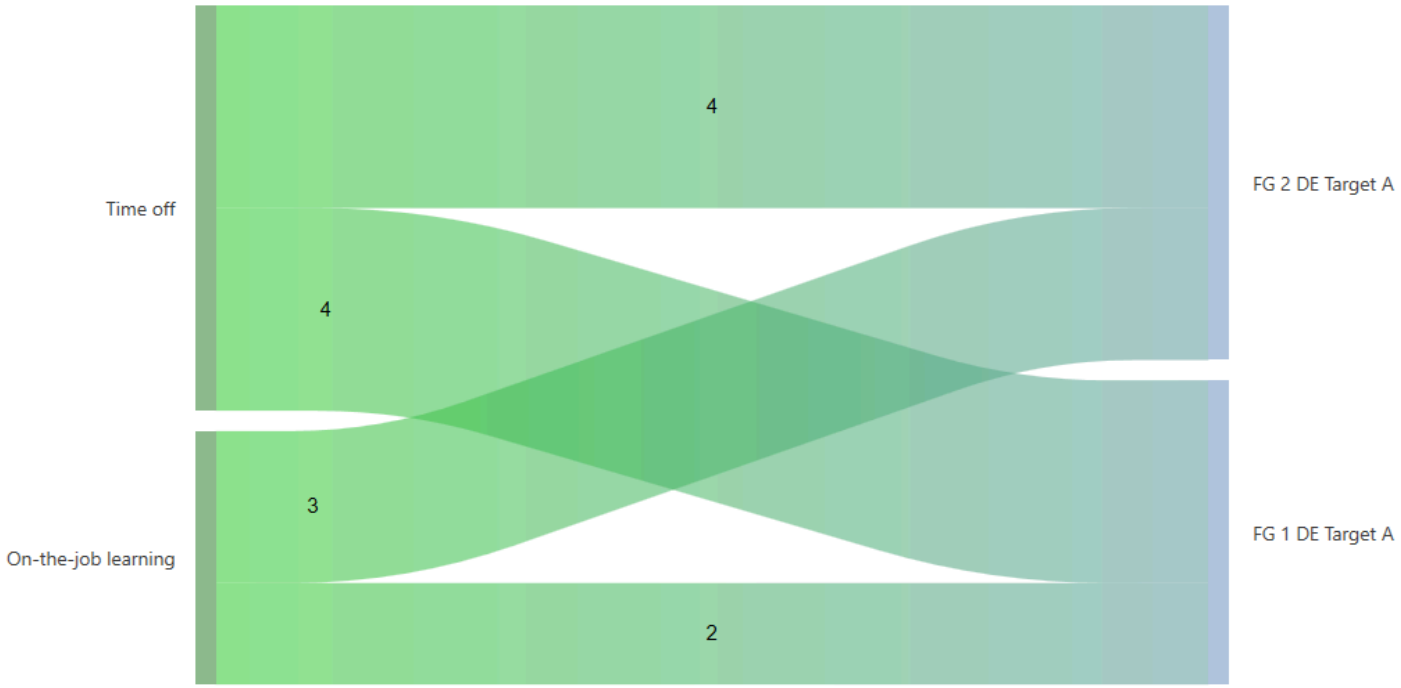
Figure 157. *Personal risk factors among home care workers group in Germany*

Protective Factors

Job-related Protective Factors

This diagram identifies time off as the most valued job-related protective factor. The thickest flows, appearing across multiple focus groups (*FG1 DE Target A* and *FG2 DE Target A*), show that rest and personal recovery are essential for maintaining well-being amid high workload. On-the-job learning also emerges with visible flows, suggesting that opportunities for training and knowledge acquisition provide a sense of development and professional security. Overall, the figure reveals that adequate rest and continuous learning are viewed as the most effective organisational resources for coping with workload and preventing burnout.

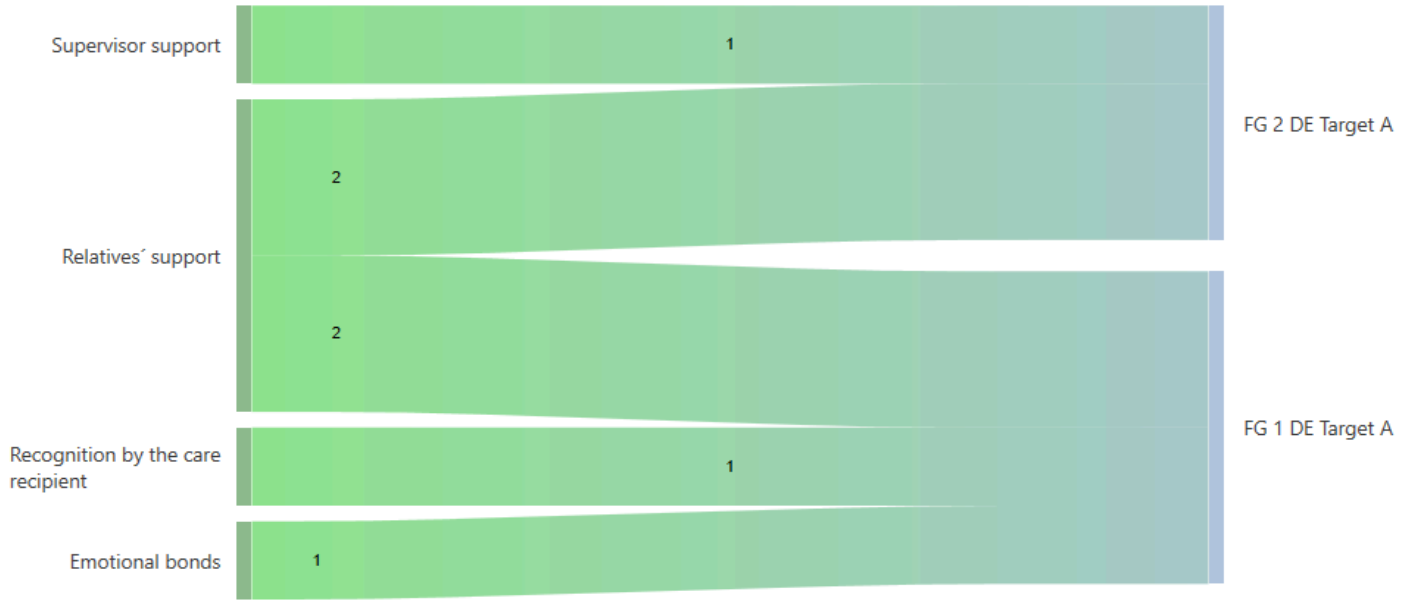
Figure 158. *Job-related protective factors among home care workers group in Germany*



Relational Protective Factors

This diagram visualises interpersonal sources of support. The thickest flows correspond to supervisor support and relatives' support, followed by recognition by the care receiver and emotional bonds. These codes indicate that care workers rely heavily on emotional and instrumental help from their supervisors, families, and the people they care for. Recognition and appreciation from recipients are especially valued as moral reinforcement. The overall pattern demonstrates that social relationships—both professional and personal—function as the key protective layer mitigating isolation and emotional fatigue in German home care work.

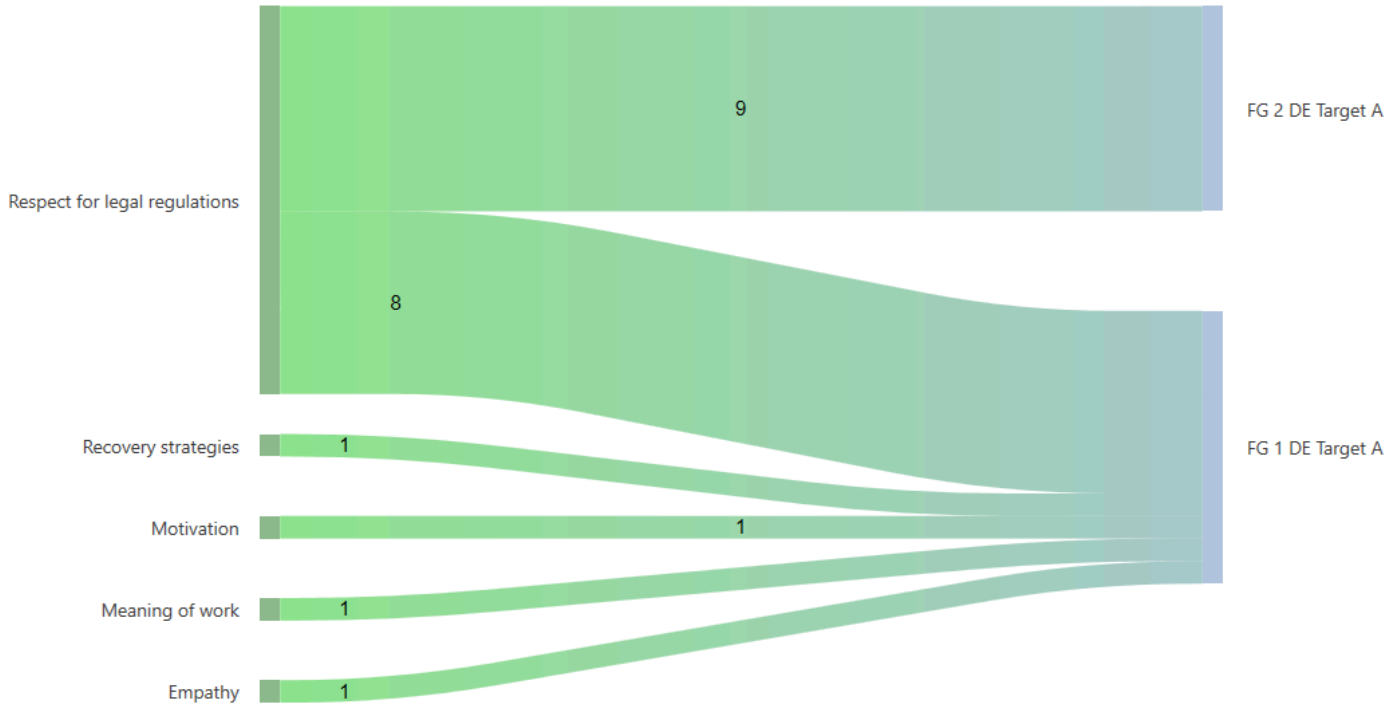
Figure 159. *Relational protective factors among home care workers group in Germany*



Personal Protective Factors

This diagram displays a combination of moral, motivational, and emotional resources. The thickest flows correspond to respect for legal regulations, which dominates the figure and appears prominently in *FG2 DE Target A*. This indicates that awareness of rights and fair labour conditions are crucial sources of psychological security for German care workers. Medium-width flows for recovery strategies, motivation, and meaning of work show that self-care, personal engagement, and the sense of purpose derived from caregiving reinforce resilience. Thinner flows, such as empathy, complement the emotional dimension of these coping strategies. Overall, the diagram highlights that German home care workers rely on knowledge of their rights, motivation, and personal meaning as central protective factors, grounded in both legal awareness and intrinsic commitment.

Figure 160. *Personal protective factors among home care workers group in Germany*



German home care workers face intense physical and emotional workloads but display a structured sense of responsibility and legal consciousness that reinforces their endurance. The presence of supervisory and family support adds relational stability, while individual motivation and self-care practices sustain personal engagement. The visual analysis thus portrays a workforce that, despite systemic constraints, maintains resilience through a combination of institutional awareness, moral purpose, and social connection.

6.2.2. Institutional Care: Risk and Protective Factors

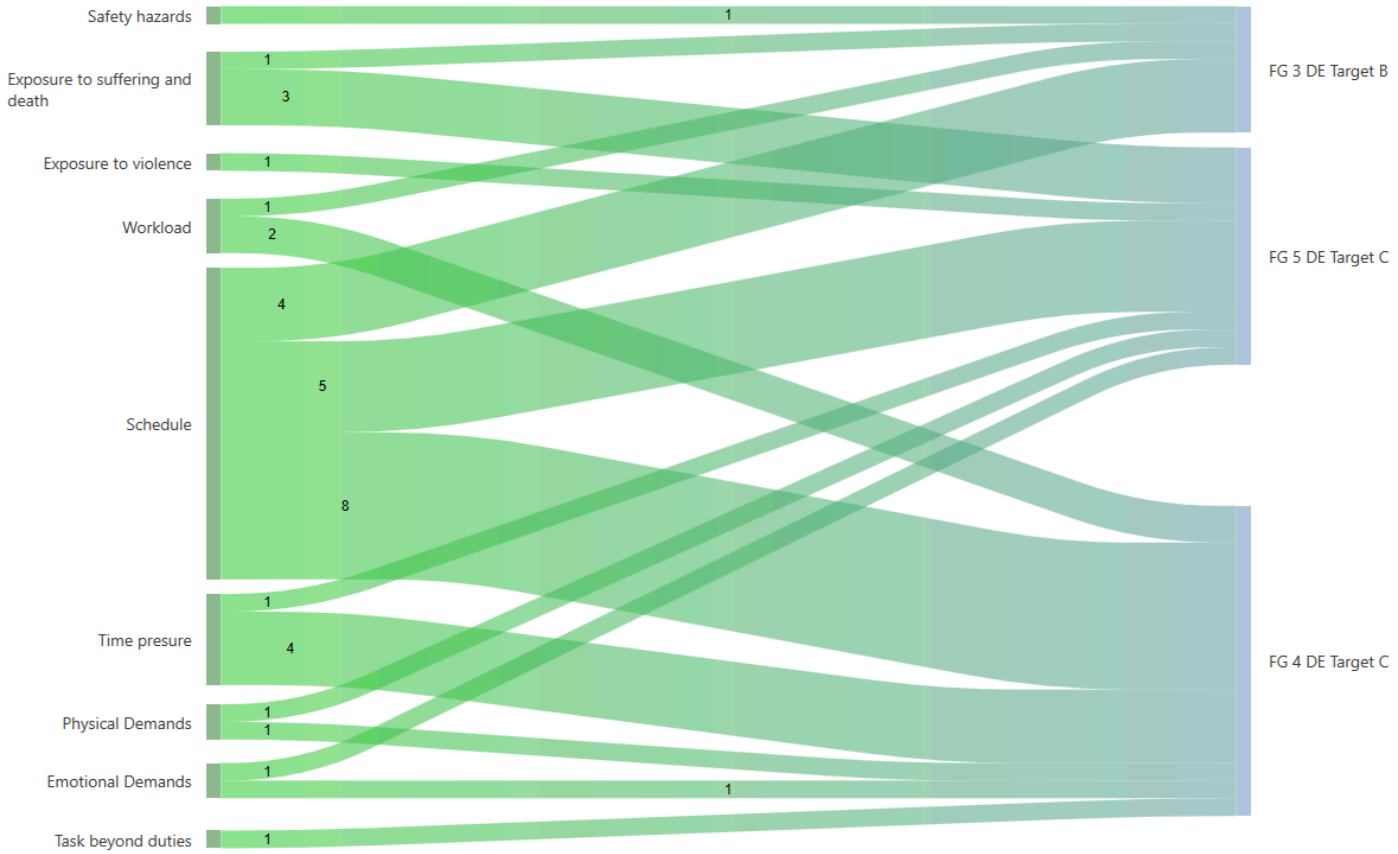
This part encompasses a mixed target: Basic care workers (target B: nursing and care staff who work in hospitals, retirement homes, nursing homes or day care centres and who have been trained in at least one short course) and Professional care workers (target C: specialists in the nursing or healthcare sector with vocational training or a Bachelor's degree).

Risk Factors

Job-related Risk Factors

This diagram reveals that the most salient job-related risks include workload, time pressure, and schedule, all of which exhibit thick flows and appear across several focus groups (*FG4 DE Target B*, *FG6 DE Target C*). These codes represent the central organisational pressures experienced in institutional care — long shifts, unpredictable schedules, and chronic understaffing. Tasks beyond duties also shows visible flows, highlighting that staff are often required to perform additional, non-assigned responsibilities, further exacerbating time-related stress. Emotional demands, physical demands, and exposure to suffering and death appear as medium-width flows, reflecting the emotional and bodily toll of working with dependent or terminally ill patients. Thinner flows for safety hazards and exposure to discrimination indicate less frequent, yet notable mentions of occupational safety concerns and instances of unfair treatment.
Overall, the diagram portrays a sector characterised by intense workloads, irregular scheduling, emotional fatigue, and task overload, pointing to structural deficiencies that heighten both psychological and physical risks.

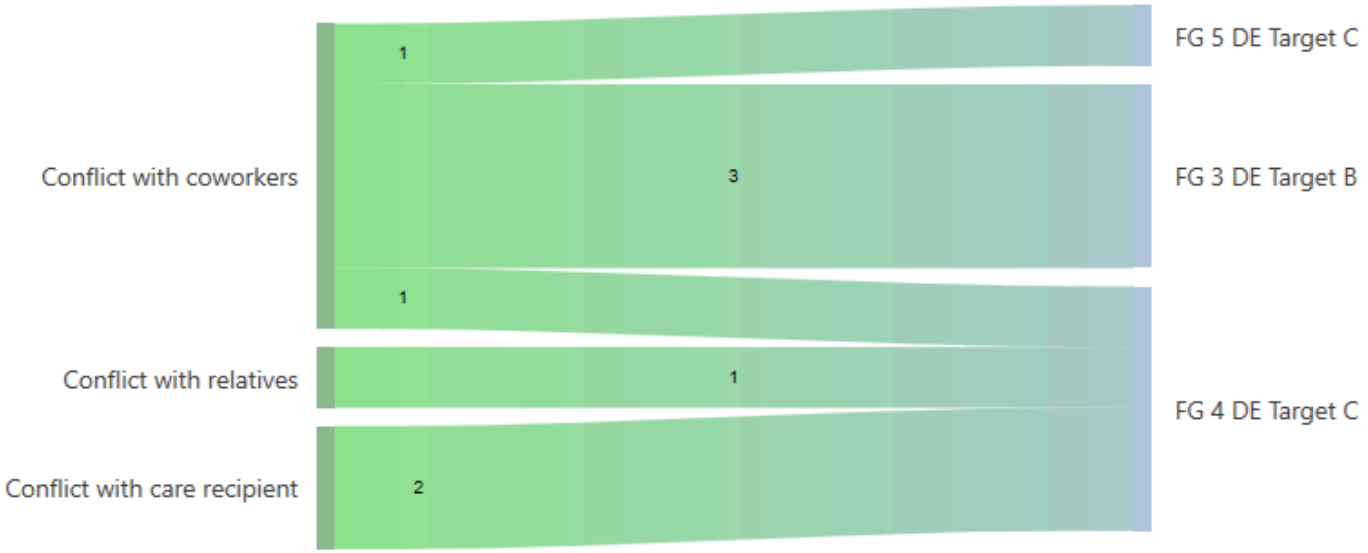
Figure 161. *Job-related risk factors among basic and professional care workers group in Germany*



Relational Risk Factors

This diagram centres on interpersonal strain in institutional settings. The thickest flow corresponds to conflict with coworkers, visible across *FG3 DE Target B* and *FG5 DE Target C*, making it the most prominent relational risk. This reflects the presence of intra-team tensions that disrupt collaboration and workplace harmony. Thinner flows for conflict with relatives and conflict with care receivers indicate that, while less frequent, these external relationships can also be sources of emotional tension and frustration. Overall, the figure reveals that team conflict is the primary relational stressor in German institutional care, surpassing conflicts with families or patients in frequency and impact.

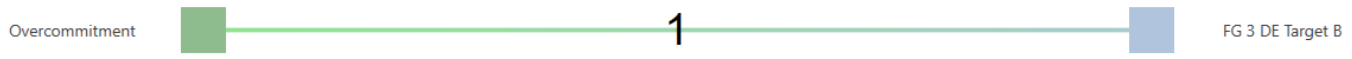
Figure 162. *Relational risk factors among basic and professional care workers group in Germany*



Personal Risk Factors

The personal risk factors diagram displays overcommitment as the only significant self-related risk, with a single flow connected to *FG3 DE Target B*. This pattern suggests that workers often invest excessive emotional and physical energy in their duties, struggling to set personal limits. The prominence of this code, despite its solitary representation, underscores that overcommitment functions as a pervasive, internalised form of stress, reflecting the moral pressure many workers feel to provide continuous, high-quality care even at personal cost.

Figure 163. *Personal risk factors among basic and professional care workers group in Germany*

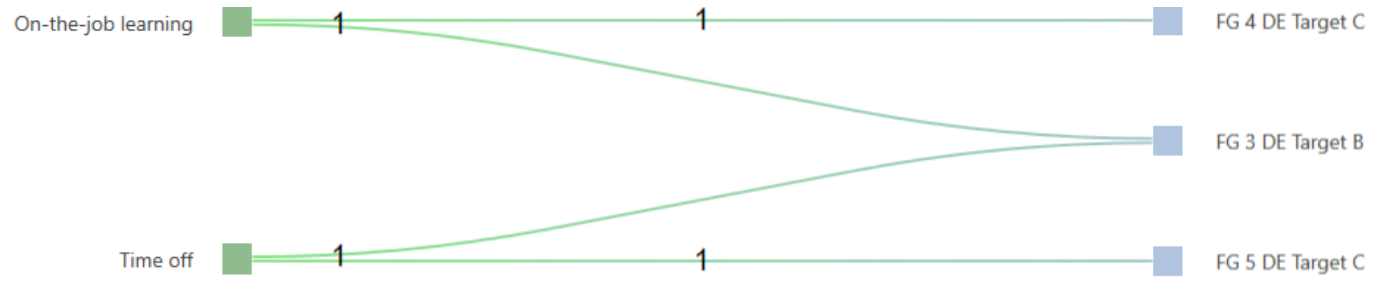


Protective Factors

Job-related Protective Factors

This diagram identifies organisational supports that mitigate stress. The thickest flows correspond to time off, on-the-job learning, and workplace ergonomics and assistive devices in homes, distributed across *FG3 DE Target B*, *FG4 DE Target C*, and *FG5 DE Target C*. The combination of these elements reflects a positive perception of institutional measures that allow rest, promote skills development, and ensure safer work conditions. Overall, the figure highlights that structured rest periods, ergonomic resources, and continuous training are key organisational buffers against the demands of institutional care.

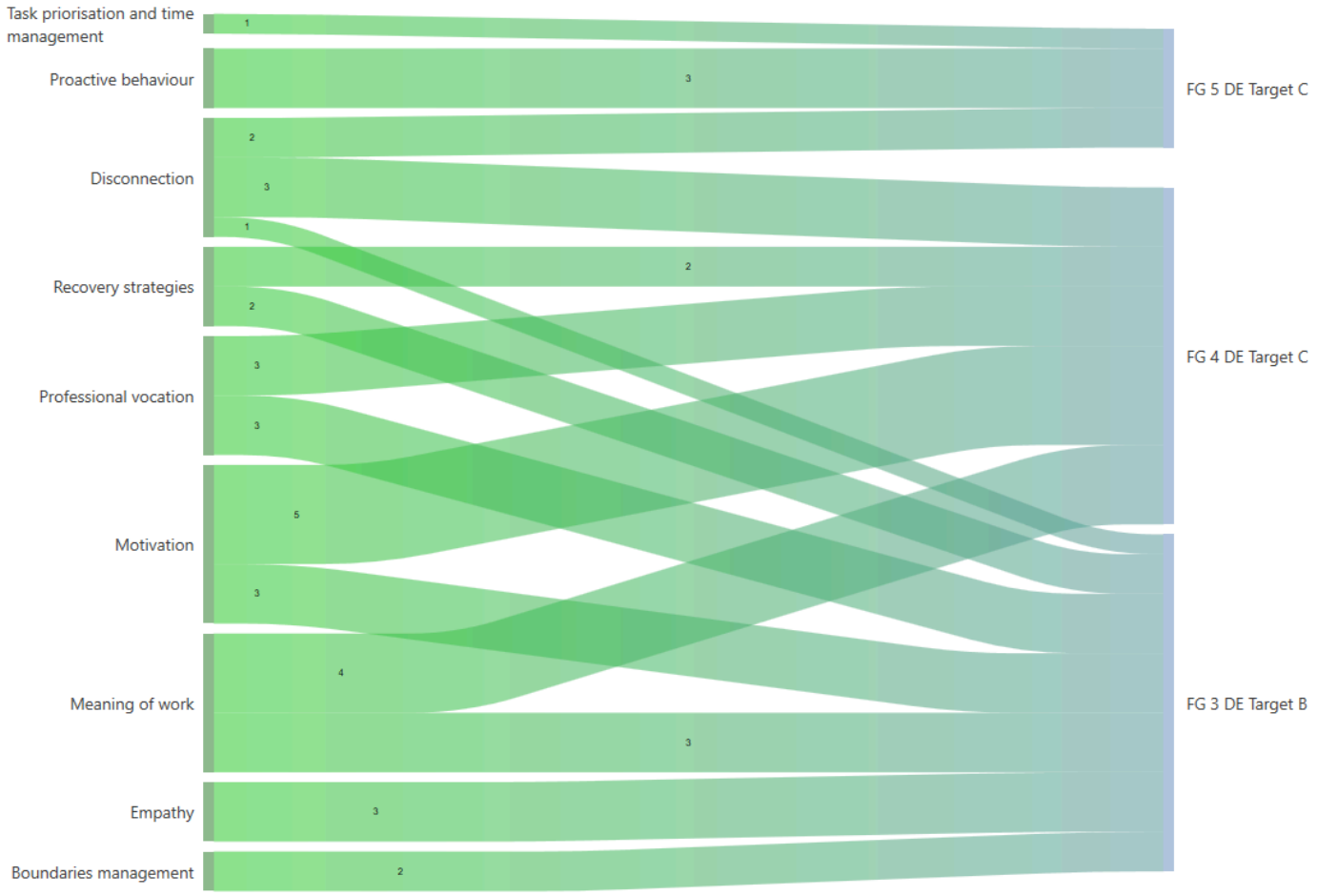
Figure 164. *Job related protective factors among basic and professional care workers group in Germany*

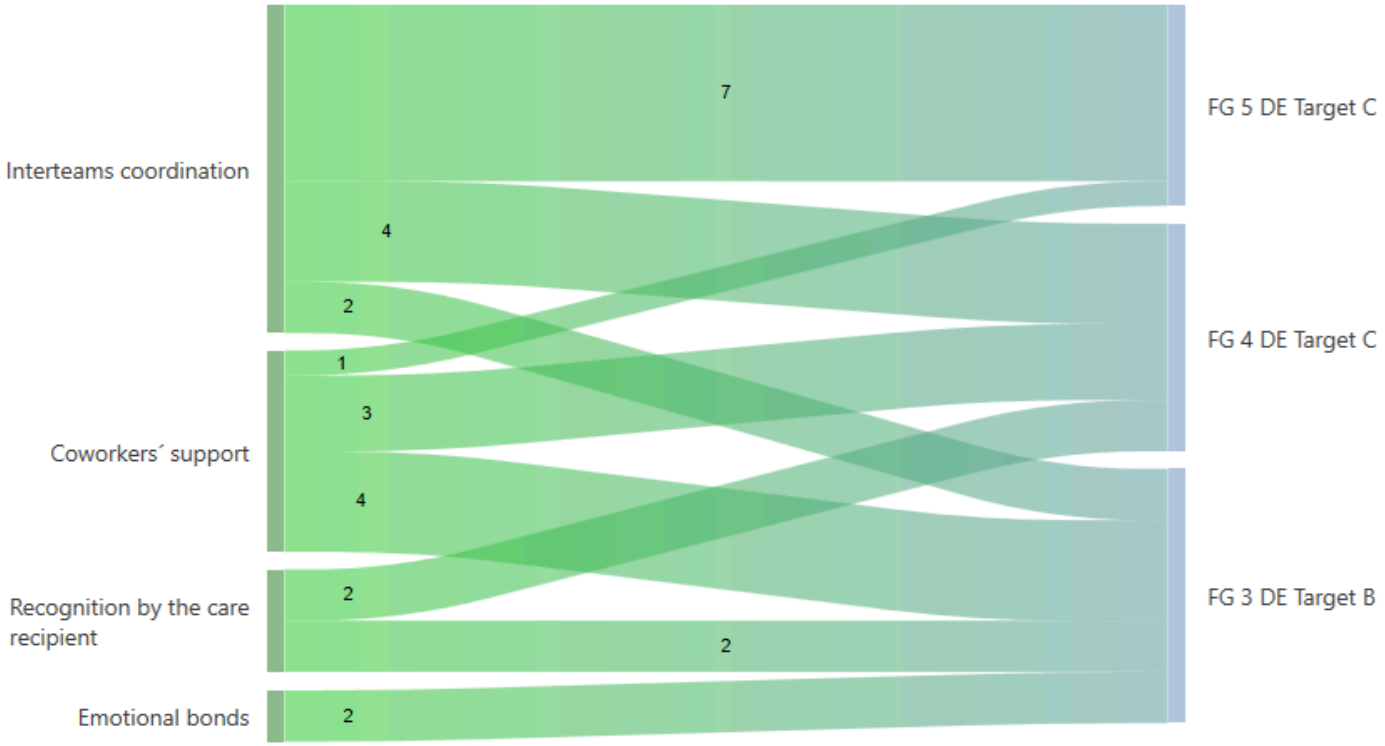


Relational Protective Factors

This diagram shows the strong presence of interpersonal resources in institutional care. The thickest flows correspond to coworkers' support and interteams coordination, indicating that cooperation, empathy, and shared responsibility among colleagues are the main sources of emotional and practical assistance. Medium-width flows for recognition by the care receiver and emotional bonds show that gratitude and relational closeness with patients also function as meaningful reinforcements. The overall pattern reveals that peer solidarity and coordinated teamwork are the most influential protective factors at the relational level, supported by emotional reciprocity from care receivers.

Figure 165. *Relational protective factors among basic and professional care workers group in Germany*

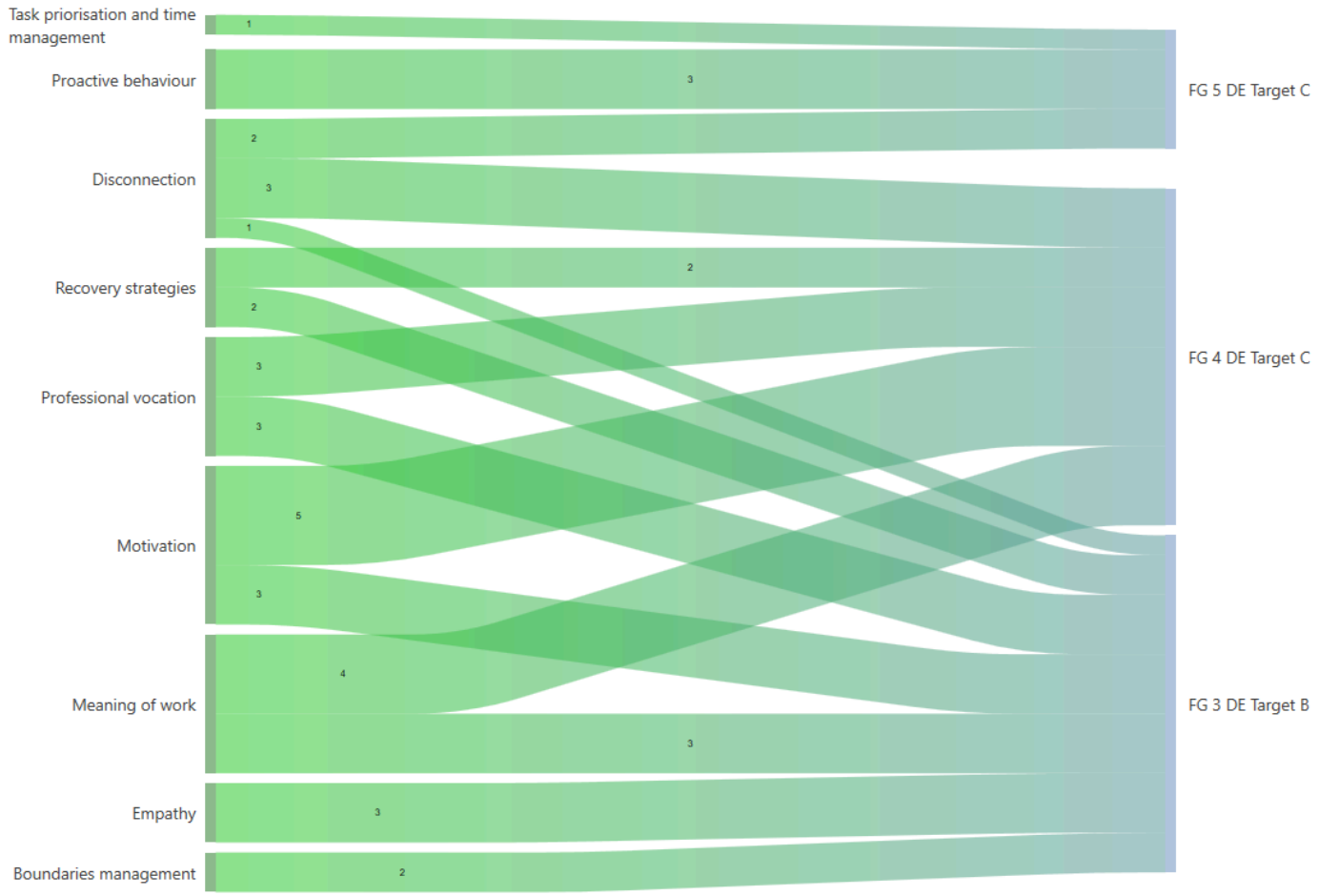




Personal Protective Factors

This diagram visualises individual psychological and emotional strengths. The thickest flows correspond to meaning of work, motivation, and professional vocation, indicating that workers find deep purpose and moral fulfilment in their caregiving role. These themes appear consistently across *FG3 DE Target B*, *FG4 DE Target C*, and *FG5 DE Target C*. Medium-width flows for recovery strategies, disconnection, and boundaries management show that workers actively try to regulate stress by detaching from work during off-hours and preserving personal balance. Thinner flows for proactive behaviour, task prioritisation and time management, and empathy highlight adaptive efforts to maintain control over their workload and emotions. Overall, this figure portrays a workforce sustained by intrinsic motivation, ethical commitment, and deliberate self-care practices, reflecting strong personal resilience despite persistent job strain.

Figure 166. *Personal protective factors among home care workers group in Germany*



The institutional care sector in Germany exhibits high structural and interpersonal demands combined with a notable capacity for collective and individual resilience. The German institutional care context combines heavy workloads and emotional strain with robust professional ethics and team cohesion. Workers rely on intrinsic motivation and peer collaboration to compensate for organisational shortcomings, demonstrating a professional identity rooted in moral responsibility, resilience, and commitment to quality care.

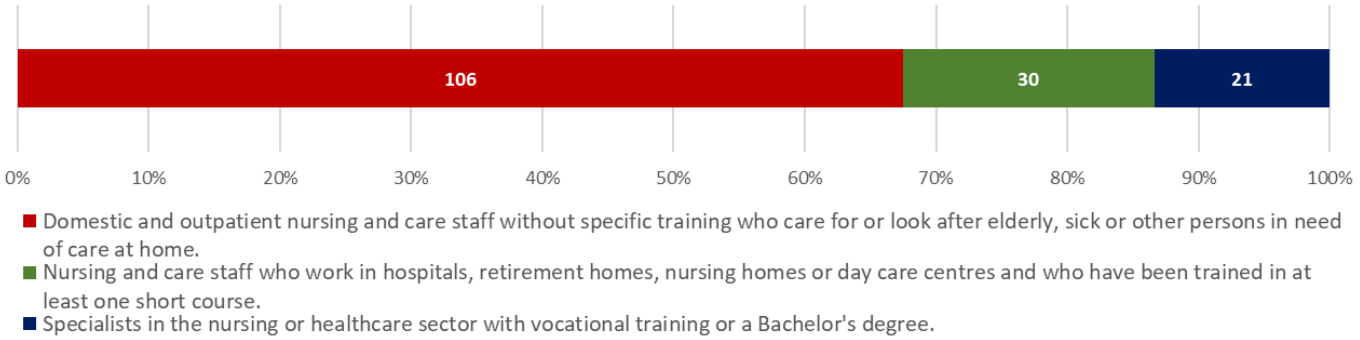
PART 4. CARE WORKERS IN SPAIN

Chapter 7. Quantitative Data Set: What the Surveys Revealed About Care Work in Spain

7.1. Profile of the Care Workforce Sample

A total of 157 care workers from Spain took part in the study (106 from target A - in red, home health aides; 30 from target B - in green, basic care workers; and 21 from target C - in dark blue, professional care workers). The mean age of participants was 42.57 years (SD = 11.18; see Figure X for details on age distribution). The overwhelming majority were women (96.2%), with 40.9% being married or in a civil partnership. Most worked in urban areas (80.5%).

Figure 167. *Participants per target group*



The sample included a majority of Spanish nationals (66.2%), alongside participants born in other countries, including several South American nations (e.g. Peru, Colombia, Nicaragua, Venezuela, Honduras, El Salvador, Guatemala, and Paraguay), as well as Ukraine, Belarus, and Congo.

Figure 168. *Age groups*

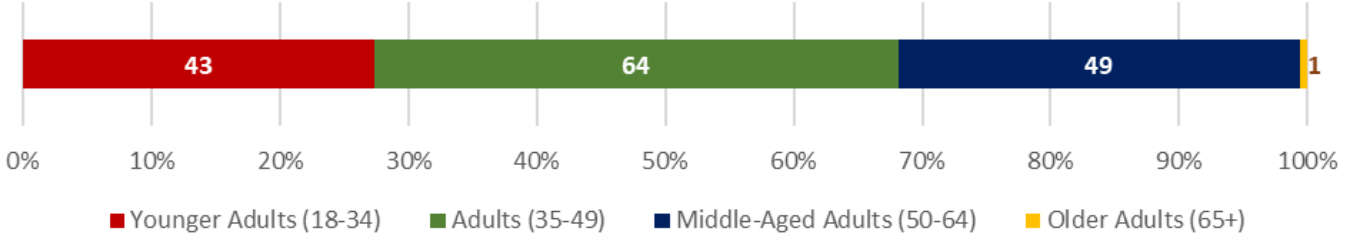


Figure 169. *Gender*

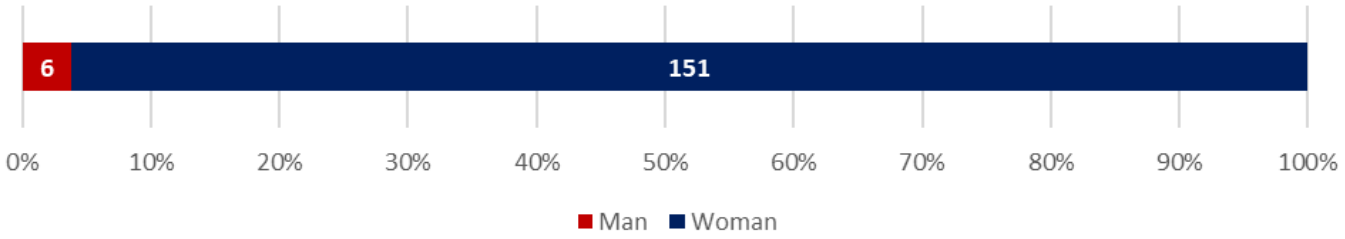


Figure 170. *Marital status*

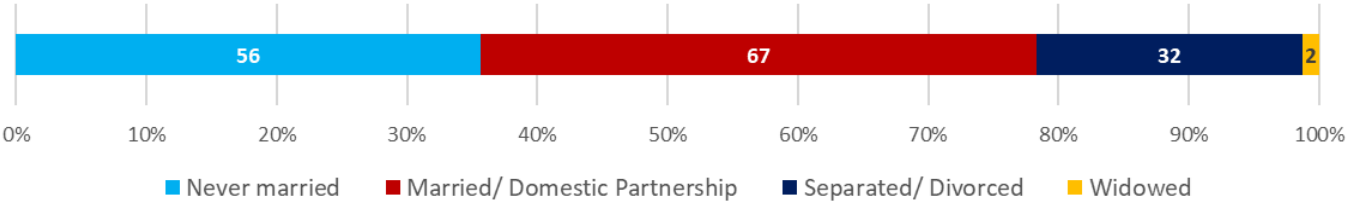


Table 24. *Descriptive statistics of the quantitative variables*

	N	Min	Max	Mean	SD
Age	157	19	67	42.57	11.18
Tenure in months	140	0	324	96.34	81.22
Monthly wages all participants	123	150	1956.32	960.74	339.73
Monthly wages in Institutionalised care	32	500	1956.32	1257.42	343.47
Monthly wages in home based care	91	150	1363	856.42	271.14
Hours worked in a week	157	3	144	33.99	22.20
Number of home care receivers in a week (HCWs)	100	1	45	4,66	6.76
Duration of stay (days in a week for live-in HCWs)	25	2	7	5.68	1.46
Months of residence (migrant workers)	52	0	288	60.27	63.51
Knowledge of benefits (out of 9)	157	0	9	2.64	2.87
Use of benefits (out of 9)	157	0	9	0.80	1.52

Figure 171. *Area of work*

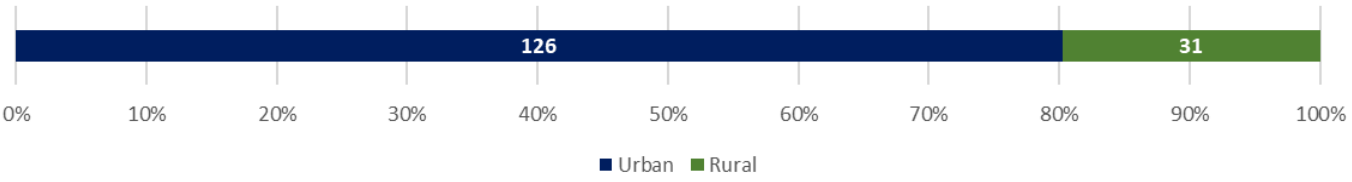


Figure 172. *Nationality*

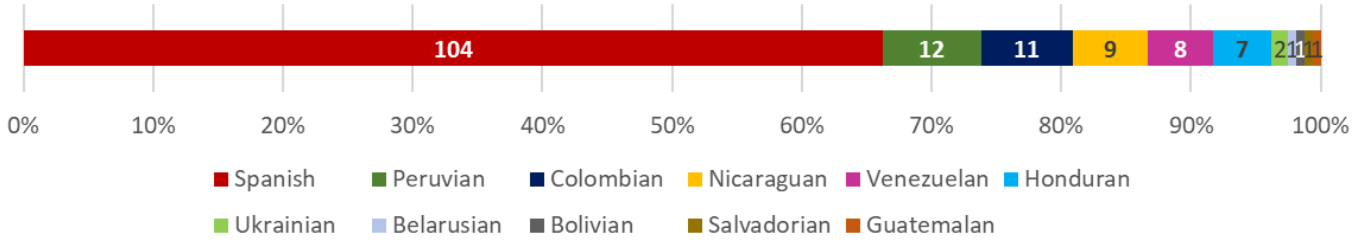
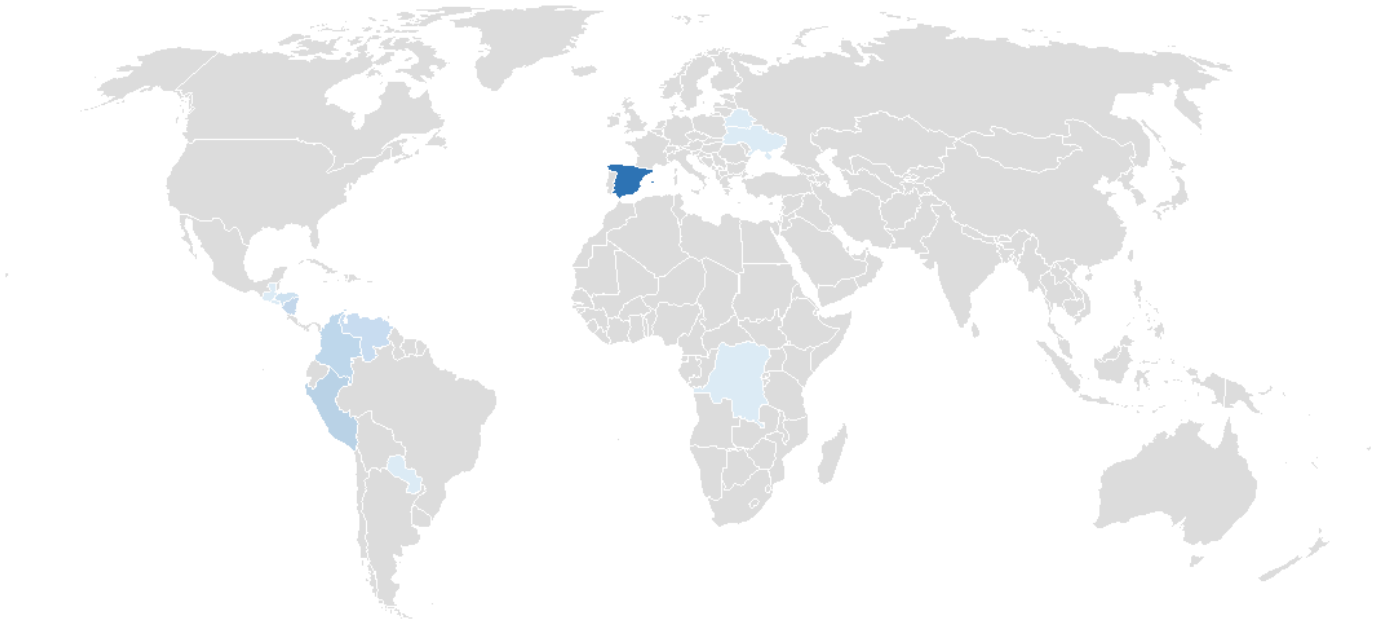


Table 173. *Country of origin*



In terms of education, 36.3% had completed three or more years of post-compulsory education, 19.7% had completed up to two years, 36.3% had finished secondary education, 6.4% had completed only primary education, and 1.3% reported no formal education. Most participants (81.5%) had received formal education or training specifically related to care services.

Workplace safety training was reportedly provided by the current employer for 58.6% of participants; 21% had received such training in a previous role or on their own initiative, while 20.4% had never received this training. Participants had an average tenure of approximately 8 years in the care sector (Mean = 96.34 months; SD = 81.22).

Figure 174. *Educational status*

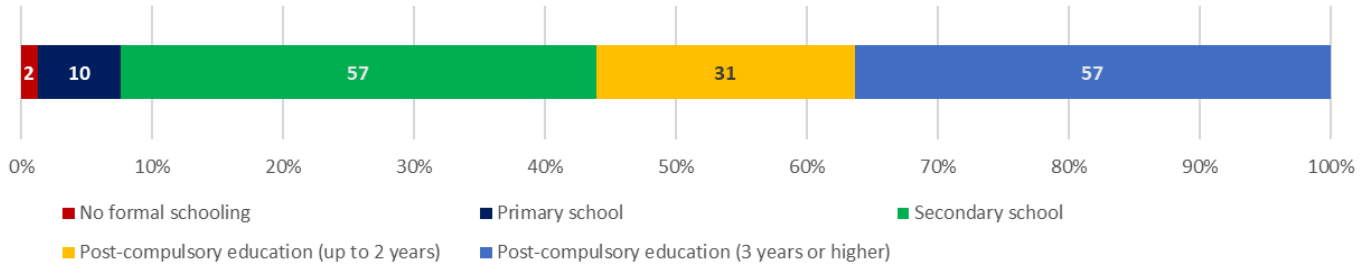


Figure 175. *Formal education in care services*

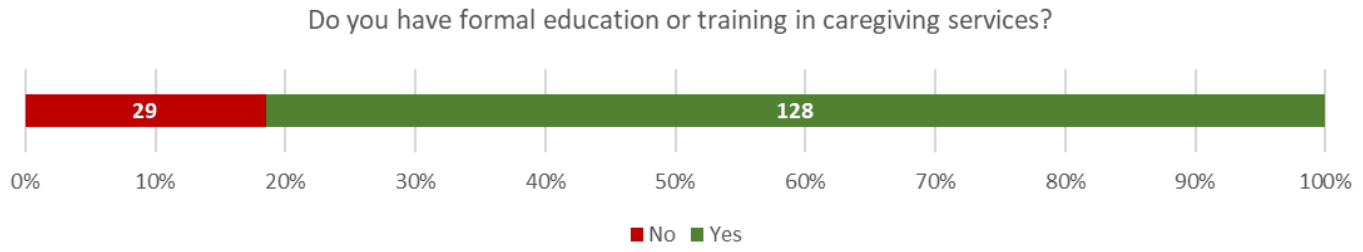
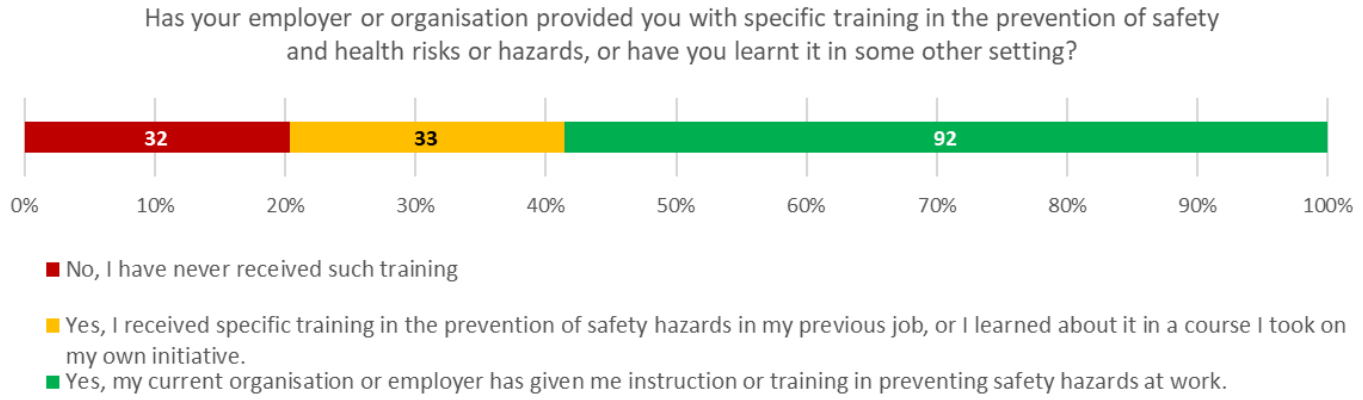
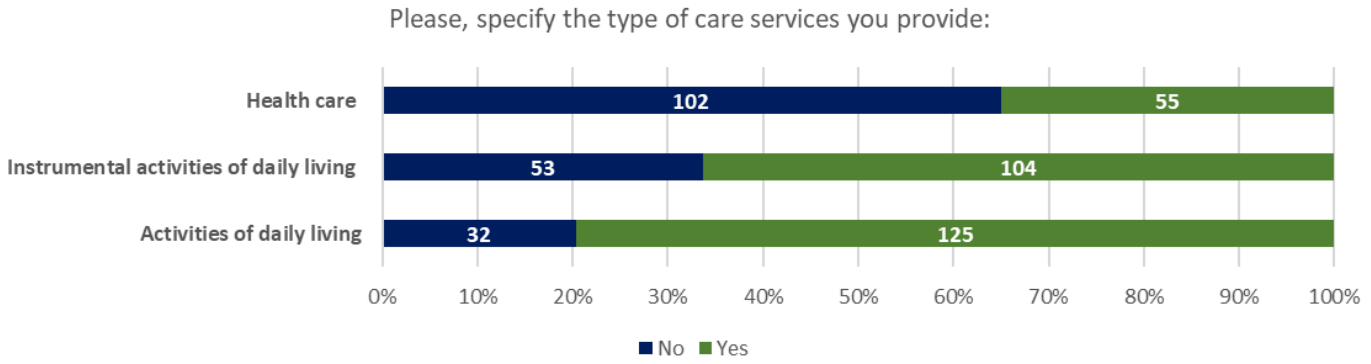


Figure 176. *Safety hazards training*



Most participants reported performing both activities of daily living (ADLs) (79.6%) and instrumental activities of daily living (IADLs) (66.2), with a portion providing healthcare tasks (35%). However, significant proportions lacked training in key care areas: 51.6% had not received training in healthcare tasks, 51.6% in IADLs, and 36.9% in ADLs. Additionally, 63.1% had not received training tailored to the specific health conditions or diagnoses of their care receivers. This is concerning given that most care workers provided support to care receivers with specific conditions (68.81%), including mobility problems (78.3%), physical health conditions (71.3%), behavioural or psychiatric disorders (68.2%), obesity (53.5%), and infectious diseases (15.9%).

Figure 177. *Type of care tasks they perform*



Note: **Activities of daily living or ADL** (dressing, toileting, mobility, bowel and bladder management, sleep time regulation, feeding, transferring from one position to another, personal hygiene, walking, caring for pets, personal care bathing, eating, toilet hygiene, grooming, ambulating, companionship and socialisation).
Instrumental activities of daily living or IADL (using the phone, shopping for groceries, managing medication, preparing meals, doing laundry, housekeeping, managing finances, assistance with using transportation).
Health services (nursing, auxiliary services, wound care, infusion therapy, physical or cognitive rehabilitation, injections, diagnostic services, prescriptions, treatment of injuries or illnesses, occupational therapy, hospice care, therapists and social workers.

Figure 178. *Type of formal education in care services*

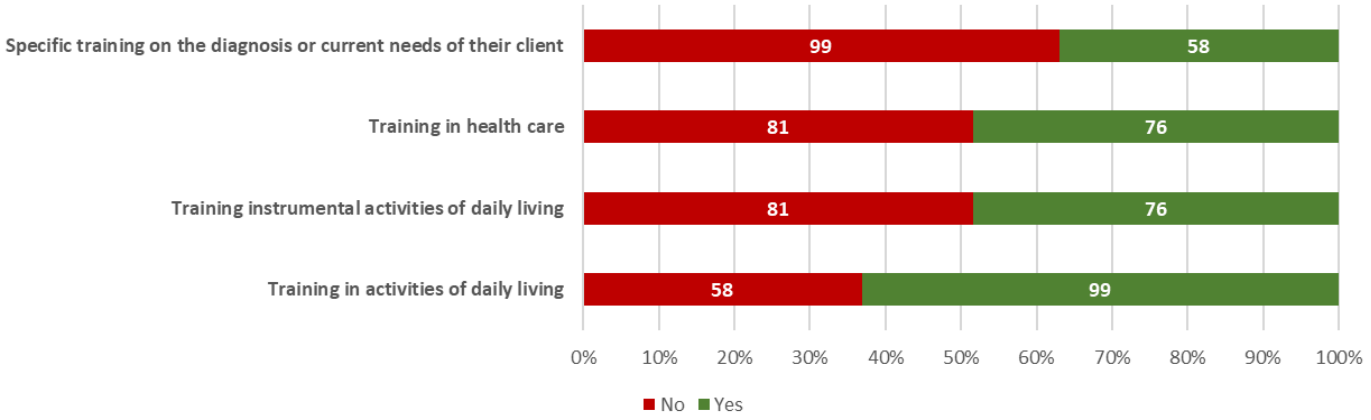
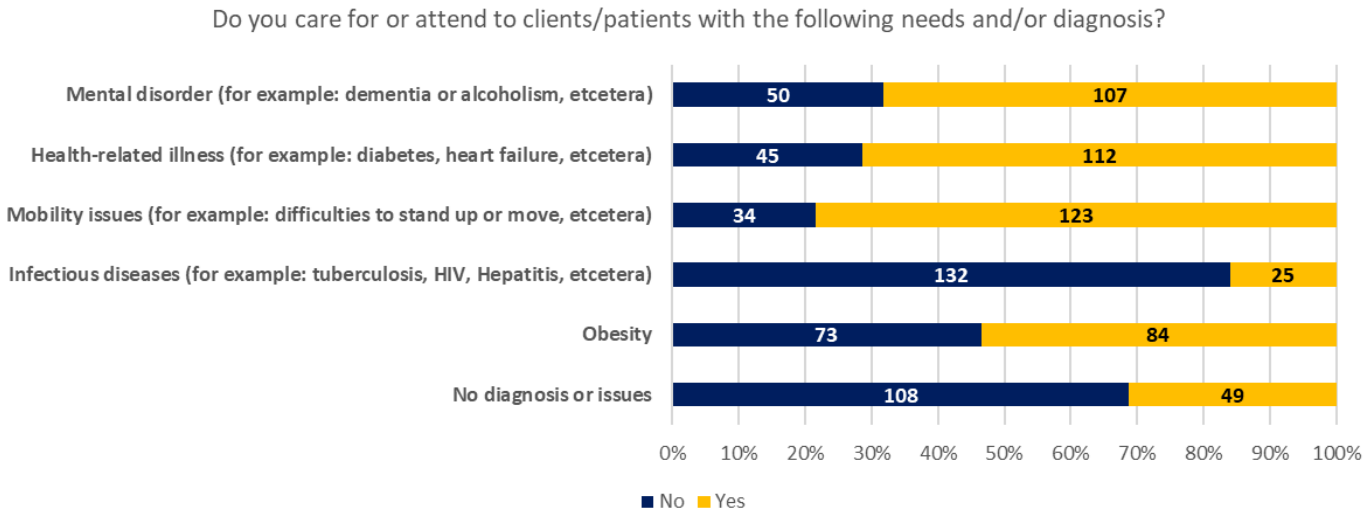


Figure 179. *Type of medical condition of the person receiving care*



Supervision was common, with 70.1% reporting that they received some form of oversight during their shifts. Despite this, 68.8% worked alone, while 31.2% worked in teams. Most participants were employed in the private or for-profit sector (59.9%), 29.3% were self-employed, and 12.7% worked in the public or non-profit sector. Only 1915% reported being members of a trade union or similar association.

Regarding employment conditions, 40.8% had a full-time contract, 32.5% worked part-time, and 26.8% were hourly workers. Most held permanent contracts (63.7%), followed by temporary contracts (21%) and informal or no contracts (15.3%). Work schedules were primarily fixed (55.4%), with 23.6% working shifts and 21% reporting flexible hours.

Figure 180. *Supervision*

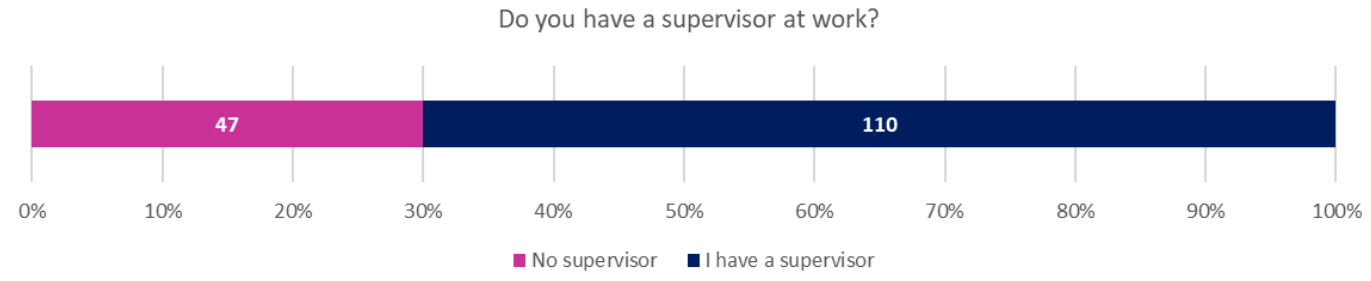


Figure 181. *Teamwork*

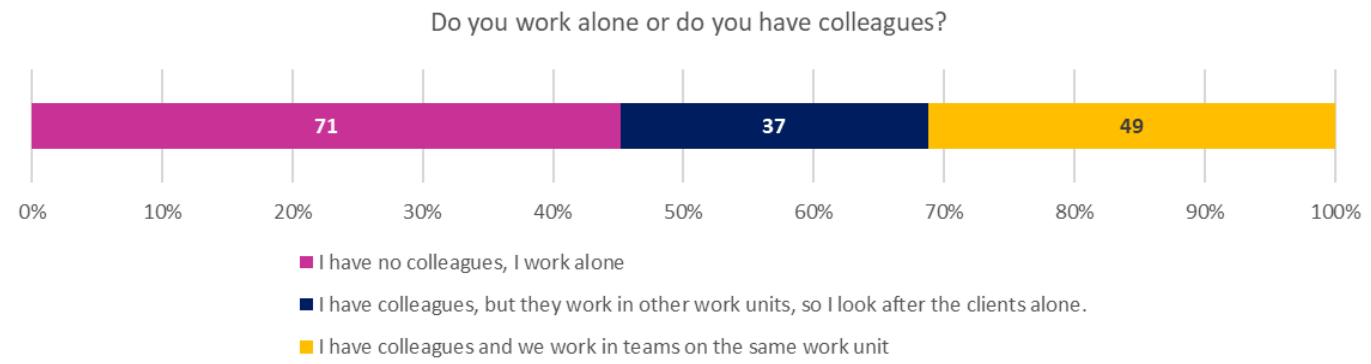


Figure 182. *Employment status*

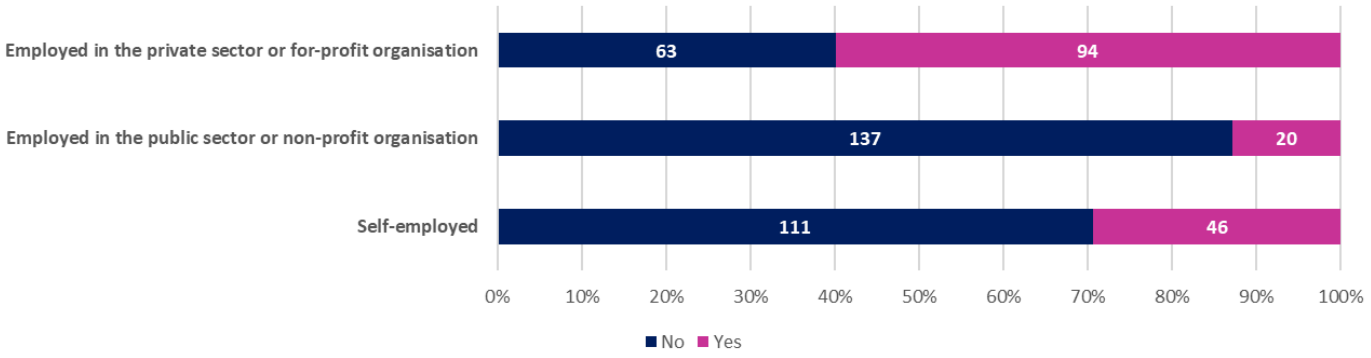


Figure 183. *Belonging to a union or association*

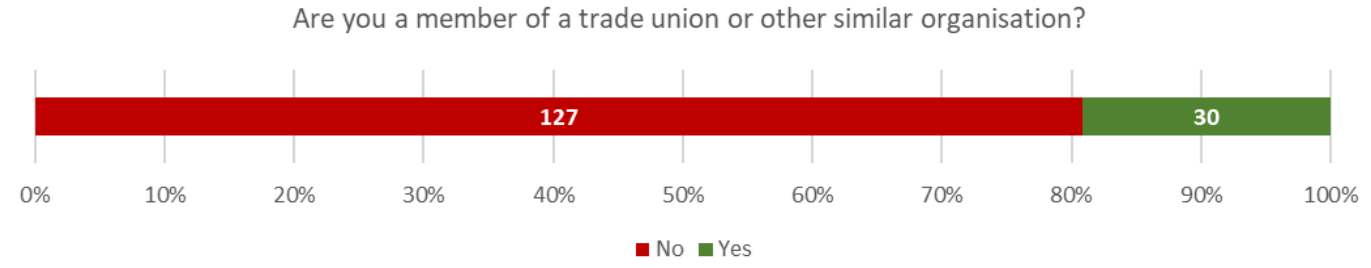


Figure 184. *Type and duration of contract*

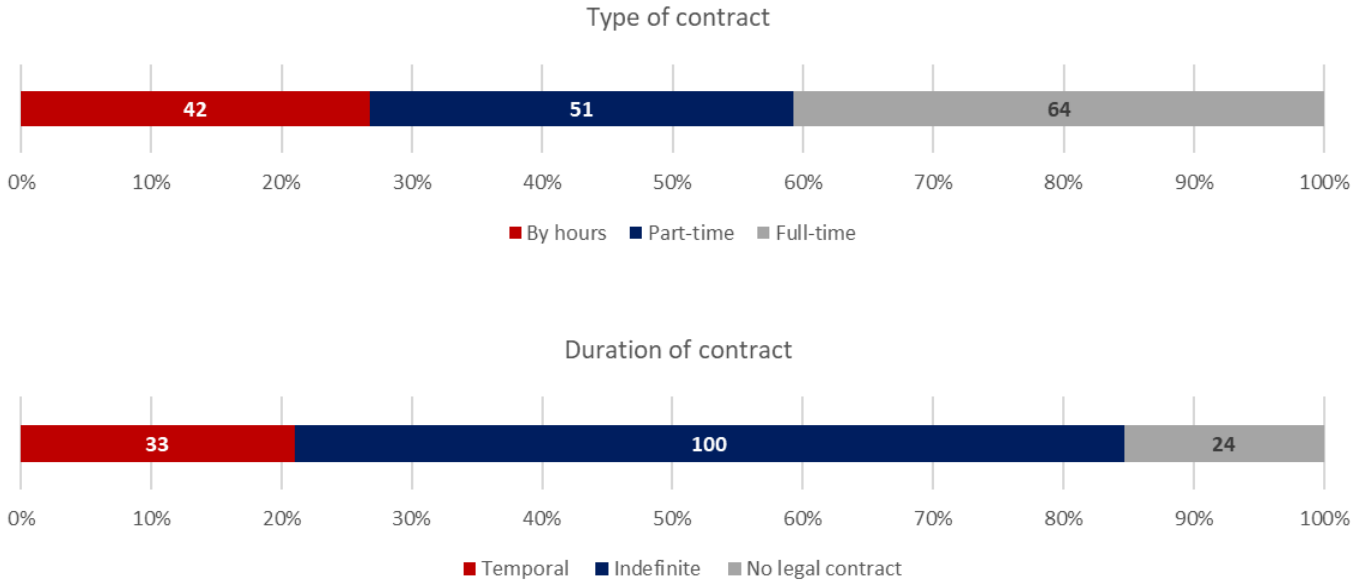
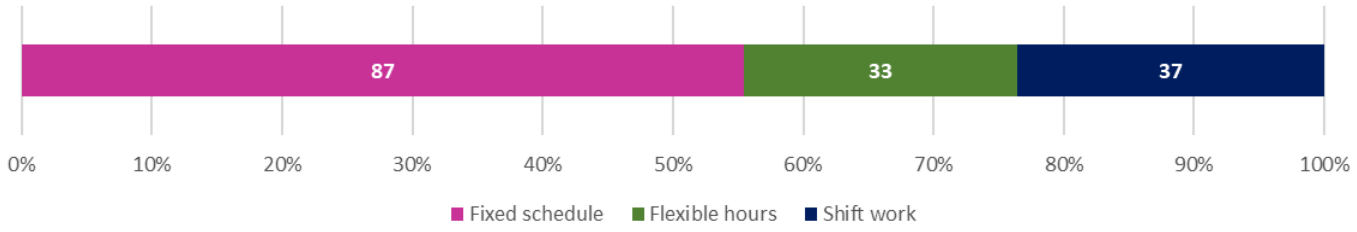


Figure 185. *Type of schedule or work shift*



Participants reported low awareness of and access to employer-provided benefits (Mean = 2.64 out of 9; SD = 2.87). The most commonly known benefits were paid vacation (61.1%), sick leave (48.4%), and extra time off (28.7%). Use of benefits was even lower (Mean = 0.80 out of 9; SD = 1.52), with paid vacation being the most used (21%). Only 21.7% reported being aware of fuel reimbursement schemes, and a mere 8.3% had used them — a noteworthy finding given that 45.2% used their own vehicle for commuting. This likely contributes to the financial strain faced by home care workers, who have to travel more frequently, and whose wages were lower (Mean = €856.42; SD = €271.14) than those working in institutional care settings (Mean = €1,257.42; SD = €343.47).

Access to lifting aids or mobility equipment was reported by 49.7%, indicating that half of the participants worked without such tools — a potential risk for musculoskeletal injuries. On average, care workers reported working 33.99 hours per week (SD = 22.20).

Figure 186. *Knowledge and use of workplace benefits and/or rewards*

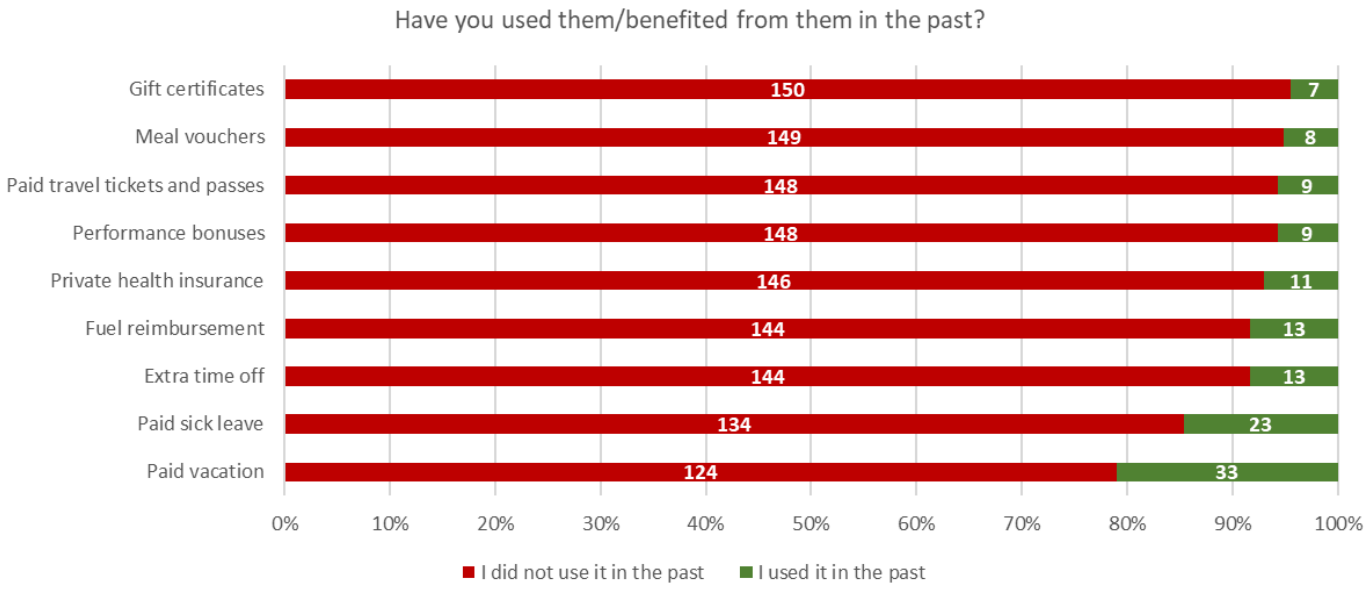


Figure 187. *Access to lifting aids or equipment*

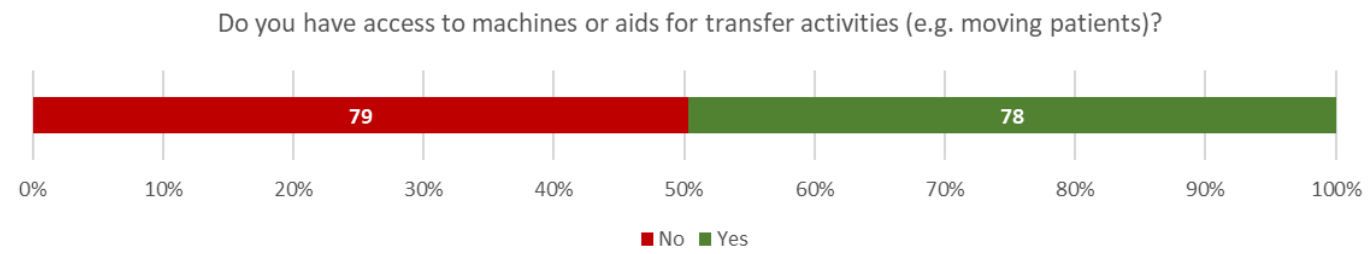
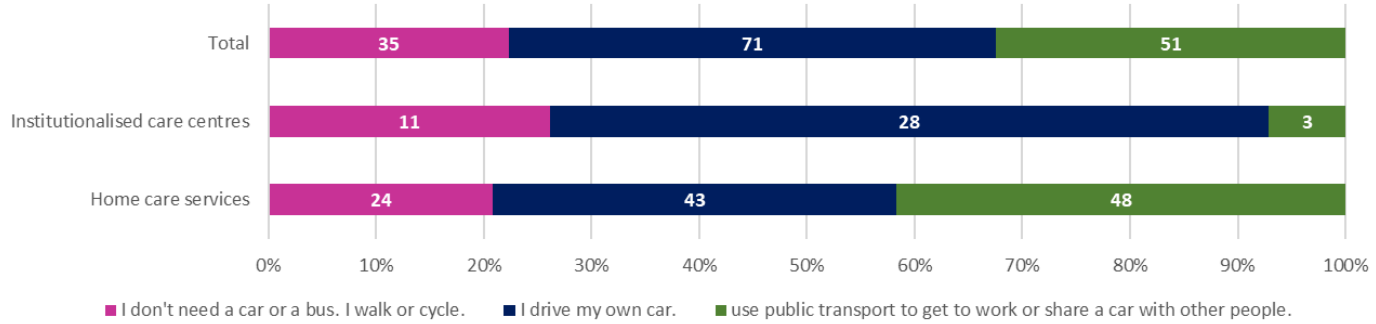


Figure 188. *Transport or commuting to work*



Of all participants, 73.2% worked in home care and 26.8% in institutional settings. Among home care workers, 72.6% were "live-out" carers (making visits to care receivers' homes), while 27.4% were "live-in" carers. Long-term care relationships (continuity of care) were common, with 30.5% supporting the same care receivers for 6–12 months, and 44.2% for more than one year. Home care workers cared for an average of 4.66 care receivers per week (SD = 6.76). Live-in workers spent an average of 5.68 days per week in care receivers' homes (SD = 1.46), with several reporting suboptimal living conditions: 4 lacked a private room, 5 did not have a personal wardrobe, and some experienced extreme indoor temperatures (too hot: n = 10; too cold: n = 4).

Figure 189. *Place of work*

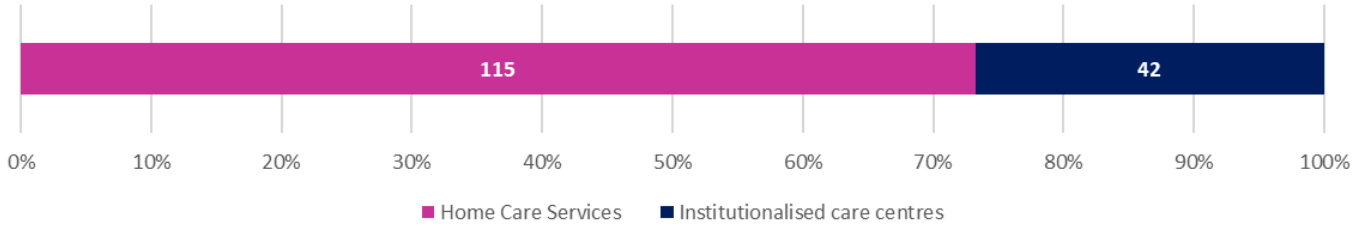


Figure 190. *Modality of home care work (HCWs)*

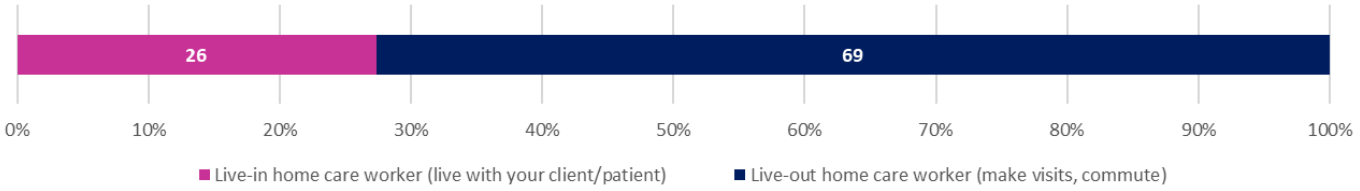


Figure 191. *Continuity of home care work (HCWs)*

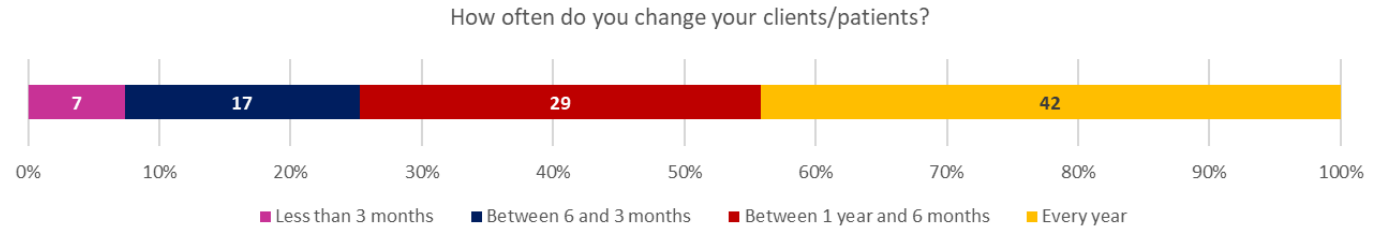
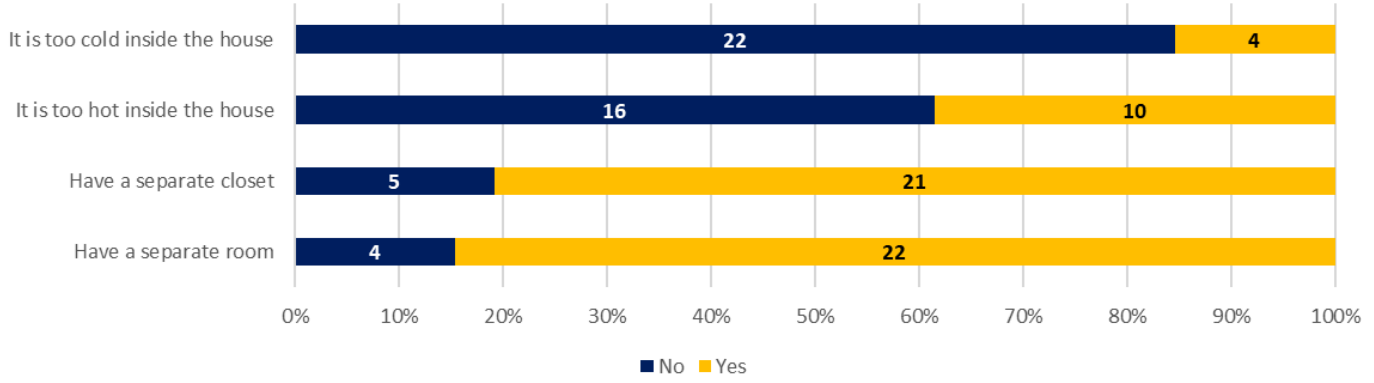


Figure 192. *Living conditions of live-in HCWs*



A total of 57 participants (36.3%) were migrants, with a mean duration of residence in Spain of 60.27 months (SD = 63.51). Of these, 40.4% did not hold a legal work permit. Nonetheless, language was not generally reported as a barrier, likely due to the predominance of Spanish-speaking migrants in the sample.

Figure 193. *Immigration status*

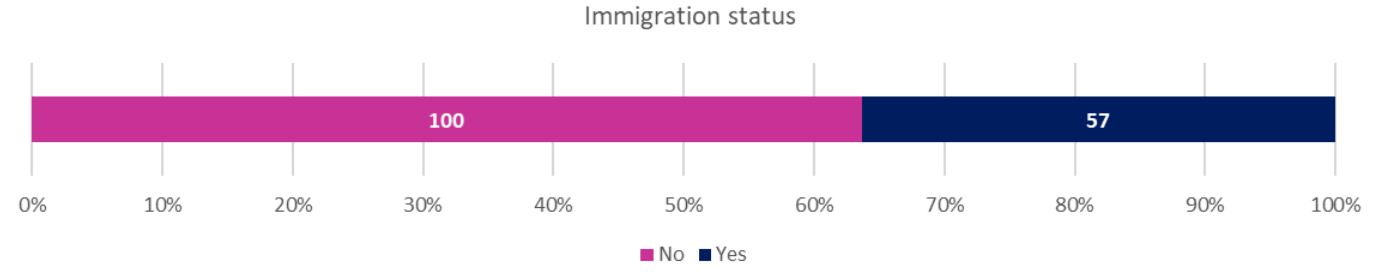


Figure 194. *Possession of work permit (migrant care workers)*

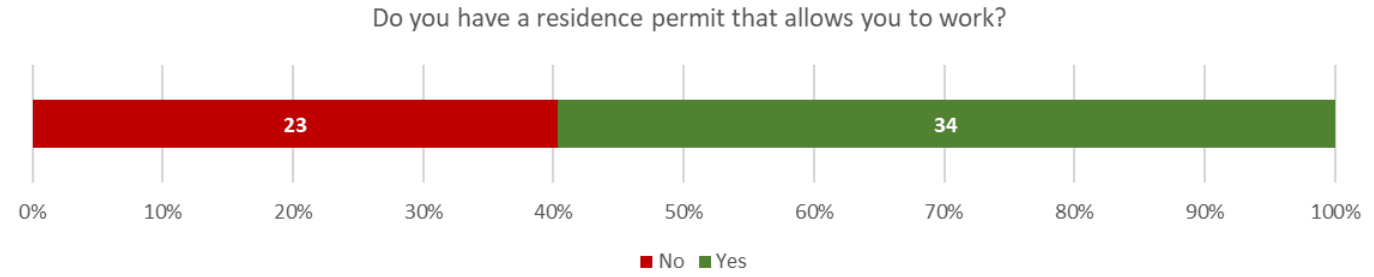
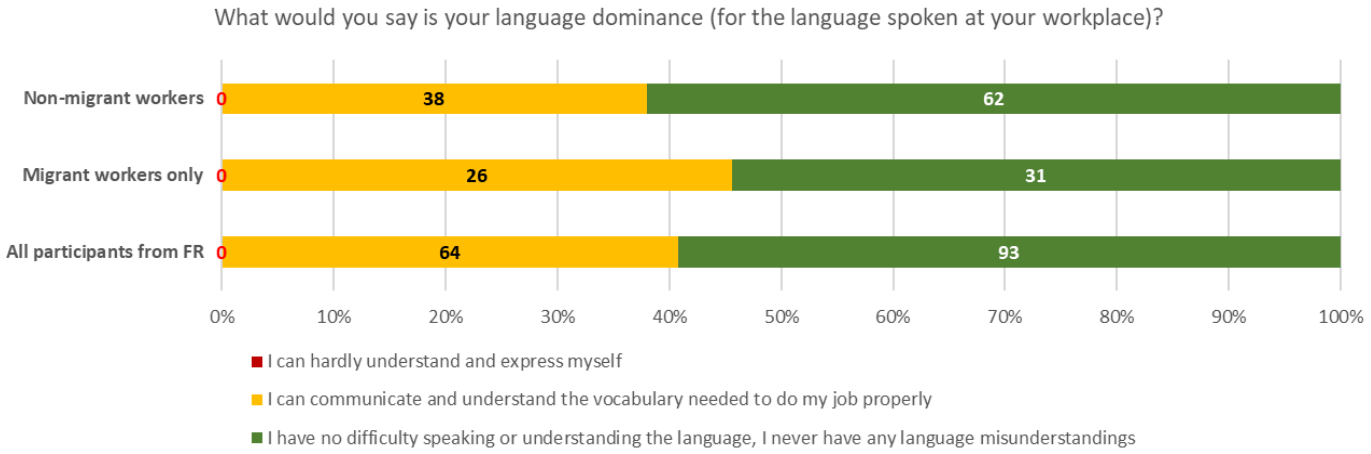


Figure 195. *Language dominance at the workplace*



In summary, these findings reveal several areas of concern and opportunity. First, a substantial proportion of participants reported performing healthcare tasks and supporting care receivers with complex conditions, yet many lacked specific training for these responsibilities. Second, while the majority of care workers were formally employed — most with full-time or permanent contracts — a smaller proportion reported working under temporary arrangements or without a legal contract. However, across the full sample, participants described limited access to, and minimal use of, employer-provided benefits or rewards. This points to broader gaps in workplace support, even among those with formal employment status. Additionally, only half of the participants reported having access to lifting aids or mobility equipment, exposing many to potential health and safety risks. Third, the lower wages and longer hours associated with home-based care, combined with frequent use of personal vehicles for work-related travel, point to a potential economic vulnerability for this group. Finally, although most workers received supervision and were based in urban areas, many reported working alone. While this may reflect the nature of the work, it also underlines the degree of individual responsibility placed on care workers and may have implications for their sense of support and professional wellbeing.

7.2. Findings on Prevalence: Comparing Well-Being, Risks and Protective Factors Across Targets

7.2.1. Well-Being Results

In this section, the outcomes of work are examined, considering both its positive and negative dimensions. The positive dimension is captured through indicators of psychological well-being or flourishing, while the negative dimension focuses on burnout and perceived strain. In addition, the impact of work on personal life is explored, concluding with a report on employees' expressed desire to leave their job if given the opportunity.

Table 25. *Main results of Wellbeing*

Outcomes	Target	Mean	S.D.	N
Burnout (Disengagement and Exhaustion)	Target A	2.80	0.40	106
	Target B	2.74	0.34	30
	Target C	2.77	0.37	21
	Mean	**2.78**	**0.39**	**157**
Perceived Exertion	Target A	6.71	1.52	106
	Target B	7.43	2.01	30
	Target C	5.90	2.63	21
	Mean	**6.74**	**1.84**	**157**
Turnover intentions	Target A	2.17	1.03	106
	Target B	1.88	1.03	30
	Target C	2.00	1.05	21
	Mean	**2.09**	**1.03**	**157**
Work-Private Life Conflict	Target A	2.79	0.97	106
	Target B	2.59	0.95	30
	Target C	2.33	0.77	21
	Mean	**2.69**	**0.95**	**157**
Work-Private Life Enrichment	Target A	3.57	0.69	106
	Target B	3.69	0.48	30
	Target C	3.87	0.82	21
	Mean	**3.63**	**0.68**	**157**
Happiness	Target A	6.91	1.74	106
	Target B	7.13	1.66	30
	Target C	7.00	1.45	21
	Mean	**6.96**	**1.68**	**157**
Flourishing	Target A	5.55	0.94	106
	Target B	5.84	0.82	30
	Target C	5.98	0.65	21
	Mean	**5.67**	**0.90**	**157**

Note: Target A: Home health aides; Target B: Basic care workers; Target C: Professional care workers.

Negative Indicators: Where Workers Are Struggling

Burnout Results. Burnout is a job-related syndrome that has been defined as a state of physical, emotional and mental exhaustion that results from prolonged exposure to chronic workplace stress that has not been successfully managed. This variable was assessed with the Oldenburg Burnout Inventory OLBI (Demerouti, et al. (2010). Two scales: disengagement (8 items) and psychological exhaustion (8 items). The responses ranged from 1 (strongly disagree) to 4 (strongly agree).

The average burnout score was moderately high (M = 2.78, SD = 0.39) on a scale from 1 to 4, with higher scores indicating greater burnout. This suggests that, on average, care workers reported frequent experiences of exhaustion and disengagement from their work — the two core dimensions of burnout. There are no significant differences between targets.

Physical Exertion Results. This construct refers to the perceived level of physical effort required from care workers during their working hours. In other words, it quantifies the degree of exertion that care workers perceive themselves to be experiencing in relation to the physical demands of their work. This variable was measured using the Borg Rating of Perceived Exertion Scale (RPE) (1970). The scale ranges from 1 (no exertion) to 11 (maximal exertion).

The average level of perceived physical exertion among participants was 6.74 (SD = 1.84) on a scale from 1 to 11, indicating a moderate to high sense of physical effort associated with their work. Significant differences were found between the groups: basic care workers reported the highest levels of exertion, while professional care workers reported the lowest.

Figure 196. *Cross-target physical exertion comparative results*

Turnover Intentions Results. This variable examined the intention or desire of care workers to leave or abandon their role within the care profession. It was measured using the Intention to Quit Questionnaire (ITQ), which was developed by Rahnfeld et al. (2016) and adapted from Price (1997). The ITQ comprises three items (example item 'despite the obligations I have made to my employer, I want to quit my job as soon as possible') that assess workers' intentions to quit their care job. Participants were asked to indicate the frequency of their intention to quit on a five-point Likert scale, with responses ranging from 1 (almost never) to 5 (almost always).

The average score for turnover intentions was 2.09 (SD = 1.03) on a scale from 1 to 5, indicating relatively low overall desire to leave one's job among care workers. No significant differences were found between the groups, suggesting that intentions to leave were consistent across different care settings or employment groups.

Work-Private Life Conflict Results. This construct represents a form of inter-role conflict, characterised by a clash between the risk factors of one's professional role and those of their personal or familial responsibilities. The scale from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version, comprising five items (e.g., 'Do you feel that your work drains so much of your energy that it has a negative effect on your private life?'), was employed to measure the variable. The responses ranged from 1 (never) to 5 (always).

The average score for work–private life conflict was 2.69 (SD = 0.95) on a scale from 1 to 5, indicating a moderate level of conflict between professional and personal responsibilities among care workers. No significant differences were found between the study groups, suggesting that this experience was consistent across employment groups.

Positive Indicators: Signs of Strength

Work-Private Life Enrichment Results. This variable pertains to a process at the work-private life intersection, in which experience or involvement in one role enhances the quality or performance in the other role. The six-item scale Work-family enrichment, as originally proposed by Carlson et al. (2006) and subsequently abbreviated by Kacmar et al. (2014), was employed to assess the variable in question. Participants were invited to indicate their level of agreement with each item on a five-point Likert scale, with responses ranging from 1 (strongly disagree) to 5 (strongly agree).

The average score for work–private life enrichment was 3.63 (SD = 0.68) on a scale from 1 to 5, indicating that care workers generally experienced a positive interplay between their professional and personal lives (work-life spillover). This suggests that involvement in one domain was perceived to enhance experiences or functioning in the other. No significant differences were found between the study targets, indicating similar levels of enrichment across employment contexts.

Happiness results. This construct was designed to assess care workers' general levels of happiness and their attitudes towards their own lives. The variable was assessed using a single item: 'taken everything together, how happy are you with your life?'. Participants were instructed to indicate their level of satisfaction on a scale from 0 (totally unhappy) to 10 (extremely happy).

Participants reported an average happiness score of 6.96 (SD = 1.68) on a scale from 0 to 10, where higher values indicate greater overall satisfaction with life. This suggests a moderately high level of happiness among care workers. There are no significant differences between targets.

Flourishing results. The concept of flourishing can be defined as the combination of subjective and psychological well-being, in which the individual is in a positive emotional state, experiencing feelings of engagement, meaning (or purpose), having personal resources and positive interpersonal relationships. It is measured using a scale comprising eight statements (example items are 'I am optimistic about my future' and 'I lead a purposeful and meaningful life') (Diener et al., 2009), with respondents indicating their level of agreement on a scale from 1 (strongly disagree) to 7 (strongly agree).

The average flourishing score was 5.67 (SD = 0.90) on a scale from 1 to 7, suggesting that care workers generally reported a high level of overall mental well-being, engagement, and positive functioning in their lives. No significant differences were observed between the groups, indicating that this sense of flourishing was consistent across different care settings and employment groups.

7.2.2. Risk Factors among Care Workers

Drawing on the Job Demands–Resources (JD-R) theory (Bakker & Demerouti, 2011), which serves as the theoretical framework for this research, this section examines key findings related to job demands or risk factors as perceived by care workers.

Table 26. *Job, emotional and relational risk factors*

Risk factors	Target	Mean	S.D.	N
Physical Demands	Target A	4.21	1.16	106
	Target B	4.80	0.41	30
	Target C	3.67	1.49	21
	Mean	**4.25**	**1.15**	**157**
Quantitative Demands	Target A	2.02	0.69	106
	Target B	2.37	0.71	30
	Target C	2.62	0.80	21
	Mean	**2.17**	**0.74**	**157**
Work Pace	Target A	3.31	1.00	106
	Target B	3.91	0.84	30
	Target C	3.54	0.85	21
	Mean	**3.46**	**0.98**	**157**
Tasks Beyond Care Workers' duties	Target A	2.70	1.48	106
	Target B	2.67	1.42	30
	Target C	3.71	1.38	21
	Mean	**2.83**	**1.49**	**157**
Emotional Demands	Target A	3.28	1.07	106
	Target B	3.28	0.66	30
	Target C	3.59	0.89	21
	Mean	**3.32**	**0.98**	**157**
Demands for Hiding Emotions	Target A	3.59	1.11	106
	Target B	3.81	0.76	30
	Target C	3.55	1.10	21
	Mean	**3.62**	**1.05**	**157**
Exposure to Workplace Violence	Target A	1.98	1.12	106
	Target B	2.73	1.14	30
	Target C	2.67	1.16	21
	Mean	**2.22**	**1.17**	**157**
Exposure to Discrimination	Target A	0.60	1.01	106
	Target B	0.23	0.73	30
	Target C	0.00	0.00	21
	Mean	**0.45**	**0.92**	**157**
Intragroup Conflict	Target A	2.17	0.86	106
	Target B	2.56	0.80	30
	Target C	2.78	0.83	21
	Mean	**2.33**	**0.87**	**157**

Continuation Table 26.

Demand	Target	Mean	S.D.	N
Workplace Incivility	Target A	2.07	0.82	106
	Target B	2.12	0.64	30
	Target C	1.95	0.73	21
	Mean	**2.07**	**0.77**	**157**

Job-related Risk Factors

Physical Demands. This variable pertains to the frequency of physical activity that care workers are required to perform in order to fulfil the duties inherent to their role. These activities may include, but are not limited to, walking, lifting, carrying, reaching, pushing and pulling. Participants were asked to respond on a 5-point Likert scale, from 1 (never) to 5 (everyday).

The average score for physical demands was 4.25 (SD = 1.15) on a scale from 1 to 5, indicating that care workers frequently engaged in physically demanding tasks such as walking, lifting, carrying, and other forms of physical exertion. Significant differences were found between the groups: basic care workers reported the highest levels of physical demands, while professional care workers reported the lowest.

Figure 197. *Cross-target physical demands comparative results*

Quantitative Demands. Defined as the psychological demands that arise from the amount of work that must be completed within a given timeframe. These demands are typically high when the volume of work exceeds the capacity to complete it within the specified period. Four items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were employed to assess the job demand in question. An illustrative item is "Is your workload unevenly distributed so it piles up?". The respondents were asked to respond on a 5-point Likert scale, from 1 (never) to 5 (always).

The average score for quantitative demands was 2.17 (SD = 0.74) on a scale from 1 to 5, suggesting a moderate level of workload pressure among care workers. Significant differences were found between the groups: home health aides reported the lowest levels, while professional care workers reported the highest. This indicates that perceptions of workload varied across different care groups.

Figure 198. *Quantitative demands results*

Work Pace Demands. The term is defined as the psychological demand associated with the intensity of the work. To assess this job demand, three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were used. An illustrative item is, "Do you work at a high pace throughout the day?" Respondents were asked to indicate their level of agreement with the item on a 5-point Likert scale, from 1 (never) to 5 (always).

The average score for work pace demands was 3.46 (SD = 0.98) on a scale from 1 to 5, indicating that care workers generally experienced a relatively high intensity of work. Significant differences were found between the groups: home health aides reported the lowest levels of work pace demands, while basic care workers reported the highest.

Figure 199. *Work pace demands results*

Tasks Beyond Care Workers' Duties. The variable assessed the frequency of instances over the past year in which care workers were required to perform tasks that were not included in their job description or the care receivers' care plan (question taken from Karlsson et. al. (2020) study, in which 47% of home care aides agreed or strongly agreed with the statement. In our study, the response options were adapted to be coherent with the rest of the survey. They were instructed to indicate their response on a 5-point Likert scale, ranging from 1 (never or almost never) to 5 (a lot of the time).

The average score for exposure to requests to perform tasks beyond job duties was 2.83 (SD = 1.49) on a scale from 1 to 5, indicating a moderate frequency of such experiences among care workers. Significant differences were found between the groups: professional care workers reported the highest levels of these requests, while home health aides and basic care workers reported significantly lower—and statistically similar—levels. This suggests that professional care workers may be more frequently asked to take on tasks outside their formal role, indicating a broader or less clearly defined scope of responsibilities.

Figure 200. *Requests for tasks beyond care workers' duties results*

Emotional Risk Factors

Emotional Demands. The construct pertains to the psychological demands that arise from the interpersonal relationships involved in the work, which require care workers to engage in emotionally charged situations. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were employed to assess the aforementioned job demand. An illustrative item is "Do you have to deal with other people's personal problems as part of your work?" The respondents were requested to respond on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The average score for emotional demands was 3.32 (SD = 0.98) on a scale from 1 to 5, indicating that care workers frequently encountered emotionally challenging situations in the course of their work. No significant differences were observed between the groups, suggesting that the emotional demands of the job were experienced at similar levels across

the care groups.

Demands for Hiding Emotions. The variable in question alludes to the psychological demand associated with the necessity of maintaining a neutral demeanour in the face of unpredictable behaviour exhibited by care receivers, colleagues, superiors, family members, and other individuals within the professional setting. Four items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this job demand. An illustrative item is, "Are you required to be kind and open towards everyone – regardless of how they behave towards you?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The average score for demands for hiding emotions was 3.62 (SD = 1.05) on a scale from 1 to 5, indicating that care workers often felt required to suppress their emotional reactions in professional settings. No significant differences were found between the study groups, suggesting that this emotional regulation demand was consistently experienced across different care groups.

Relational Risk Factors

Exposure to Workplace Violence. The variable in question was designed to assess the frequency of instances in which care workers were exposed to violent behaviours or attitudes directed towards them in the workplace. Specifically, respondents were asked to respond to one question - In the last year, how often have you been exposed at work to violence from patients and/or their family members?. The respondents were required to indicate their level of agreement with the statement on a five-point Likert scale, with 1 representing "never" and 5 representing "everyday".

The average score for exposure to workplace violence was 2.22 (SD = 1.17) on a scale from 1 to 5, suggesting that care workers encountered incidents of violence from patients or their family members occasionally, though not frequently. Significant differences were observed between the groups: home health aides reported the lowest levels of exposure, while both basic care workers and professional care workers reported significantly higher levels, with no statistical difference between the two. These findings suggest that workplace violence is more common in institutional settings than in home-based care, indicating greater interpersonal risk for staff in those environments.

Figure 201. *Cross-target exposure to workplace violence comparative results*

Exposure to Discrimination. This variable assessed the frequency with which care workers had experienced discriminatory behaviour or attitudes that made them feel vulnerable because of their gender, ethnicity or colour in the past year. This was measured on a 4-point scale (0 - never; 1 - once; 2 - two or three times; and 3 - four or more times). The question was adapted from the Experiences of Discrimination Scale (EOD) developed by Williams et al. (1997).

As shown in the figure below, 34 out of 157 participants (21.7%) working in Spain reported experiencing discrimination in their workplace within the past year. The most commonly perceived reasons for this discrimination were: nationality (n = 12), education or income level (n = 7), weight or height (n = 6), skin colour (n = 3), age (n = 3), gender (n = 2), ethnicity (n = 2), and religion (n = 1), listed in order from most to least frequently mentioned.

Figure 202. *Exposure to discrimination variable results*

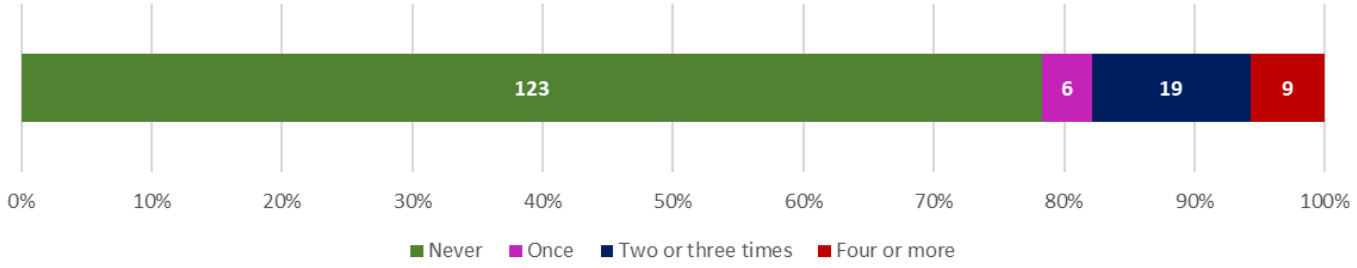
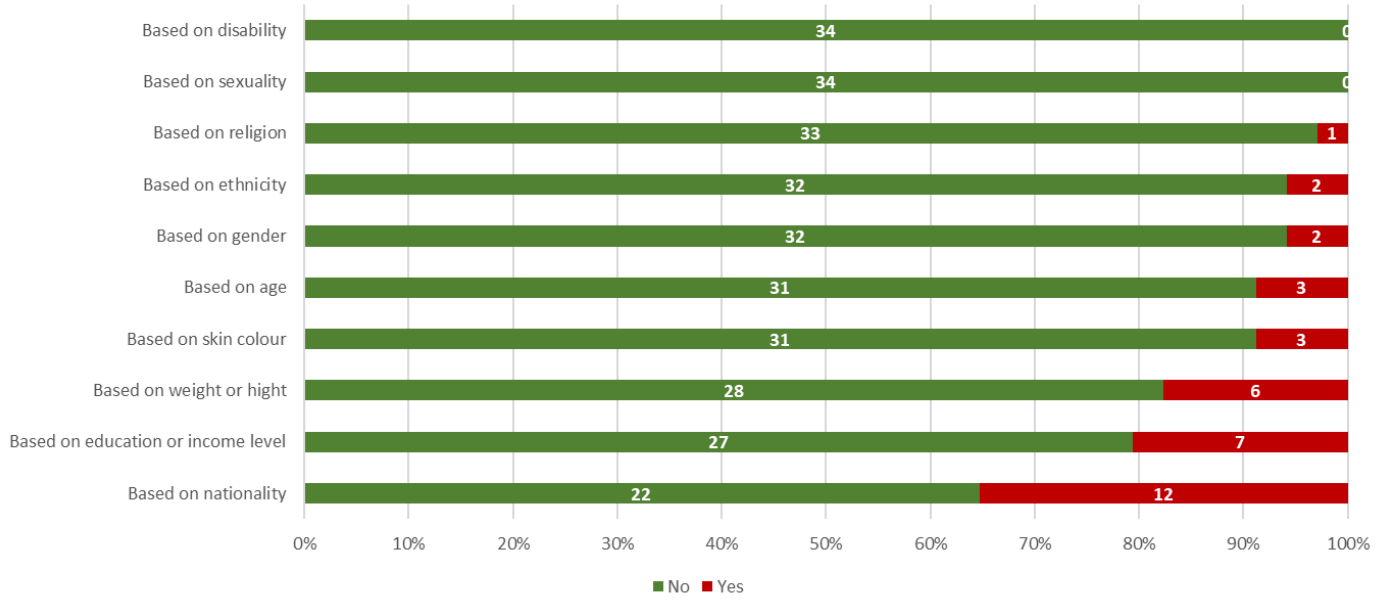


Figure 203. *Perceived motive of discrimination of those who experienced it*



The average score for exposure to discrimination was 0.45 (SD = 0.92) on a scale from 0 to 3, indicating that most care workers experienced such incidents infrequently, if at all, over the past year. Significant differences were found between the groups: home health aides reported the highest levels of exposure, while professional care workers reported the lowest. Given that home health aides include a substantial proportion of migrant care workers, this finding may reflect heightened vulnerability to discriminatory treatment among this group, particularly in the context of home-based care.

Figure 204. *Cross-target exposure to discrimination comparative results*

Intragroup Conflict. The construct refers to the frequency with which carers experience conflict within a team, with the care receiver, their family members or other people at work, where members clash over work procedures or due to personality clashes. The 8-item scale was adapted from Jehn (1995). Participants were asked to respond on a 5-point Likert scale from 1 (none) to 5 (a lot).

The average score for exposure to conflict was 2.33 (SD = 0.87) on a scale from 1 to 5, indicating a moderate frequency of interpersonal or procedural conflicts in the workplace. Significant differences were found between the groups: professional care workers reported the highest levels of conflict, while home health aides reported the lowest.

Figure 205. *Cross-target intragroup conflict comparative results*

Workplace Incivility. The variable is defined as low-intensity deviant behaviour (by care receivers, family members, colleagues, etc.) with ambiguous intent to harm the target (the care worker), in violation of workplace norms of mutual respect. The 4-item scale shortened by Matthews & Ritter (2016) from Cortina et al. (2013) was used to assess this construct. An example item is "In the past year, have you been in a situation where people you interact with at work made jokes at your expense?" Participants were asked to respond on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The average score for exposure to workplace incivility was 2.07 (SD = 0.77) on a scale from 1 to 5, suggesting that care workers occasionally encountered disrespectful or inappropriate behaviour in the workplace. No significant differences were found between the study targets, indicating that such experiences were reported at similar levels across different care settings.

7.2.3. Protective Factors in the Care Sector

This section focuses on the resources available to care workers to help them cope with the demands of their work. As in the previous section, both overall results and comparisons between different target groups are presented.

Table 27. *Job, emotional and relational protective factors*

Protective factors	Target	Mean	S.D.	N
Possibilities for Development	Target A	3.95	1.04	106
	Target B	4.13	0.84	30
	Target C	4.03	1.02	21
	Mean	**3.99**	**1.00**	**157**
Variation of Work	Target A	2.41	0.84	106
	Target B	2.35	0.97	30
	Target C	3.48	0.98	21
	Mean	**2.54**	**0.95**	**157**
Control over Working Time	Target A	2.25	0.66	106
	Target B	2.38	0.65	30
	Target C	3.10	0.86	21
	Mean	**2.39**	**0.74**	**157**
Predictability	Target A	3.41	1.19	106
	Target B	3.73	1.02	30
	Target C	3.60	1.02	21
	Mean	**3.49**	**1.14**	**157**
Autonomy	Target A	3.05	0.63	106
	Target B	3.02	0.59	30
	Target C	3.17	0.77	21
	Mean	**3.06**	**0.64**	**157**
Meaning of Work	Target A	4.50	0.66	106
	Target B	4.58	0.70	30
	Target C	4.50	0.67	21
	Mean	**4.52**	**0.66**	**157**
Recognition	Target A	3.88	0.95	106
	Target B	4.11	0.75	30
	Target C	4.10	0.82	21
	Mean	**3.95**	**0.90**	**157**
Emotional Social Support	Target A	3.51	0.94	106
	Target B	3.47	1.07	30
	Target C	3.68	1.00	21
	Mean	**3.53**	**0.97**	**157**
Instrumental Social Support	Target A	2.57	0.85	106
	Target B	2.79	0.89	30
	Target C	3.06	1.05	21
	Mean	**2.68**	**0.90**	**157**

Job-related Protective Factors

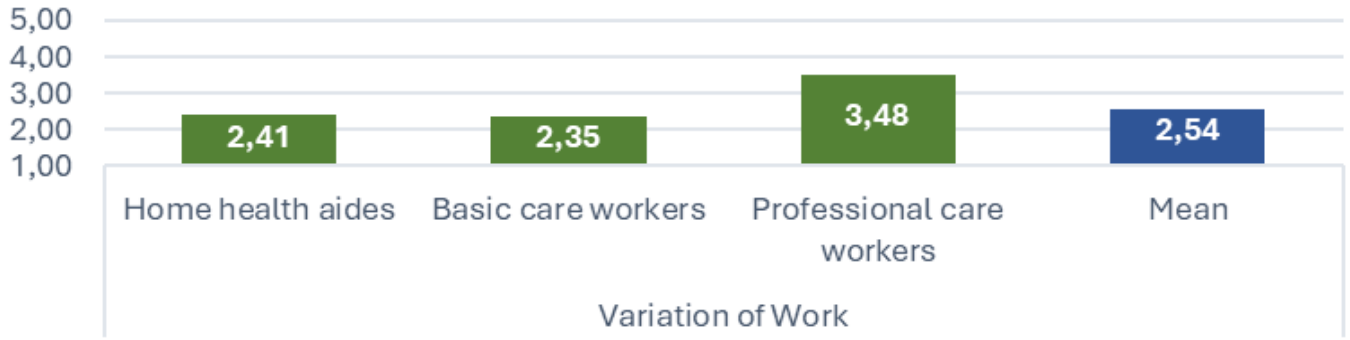
Possibilities for Development. The variable in question refers to the extent to which job performance provides opportunities for care workers to put their knowledge, skills and experience into practice and to acquire new knowledge, skills and experience. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. An illustrative item is "Do you have the possibility of learning new things through your work?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The average score for possibilities for development was 3.99 (SD = 1.00) on a scale from 1 to 5, indicating that care workers generally perceived a high level of opportunity to apply and expand their skills in the workplace. No significant differences were found between the study targets, suggesting that access to development opportunities was consistently reported across care groups.

Variation of Work. The construct refers to whether care work tasks are repetitive or, on the contrary, diverse or varied. Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. An illustrative item is "Do you have to do the same thing over and over again?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The average score for variation of work was 2.54 (SD = 0.95) on a scale from 1 to 5, suggesting that care workers generally experienced a moderate degree of task variety, with many performing repetitive tasks in their daily roles. Significant differences were found between the groups: home health aides and basic care workers - who tend to have lower to intermediate levels of formal education in care - reported the lowest levels of task variety. In contrast, professional care workers, who are typically more highly qualified and often work in institutional settings, reported the highest levels. This indicates that both the nature of the care setting and the worker's level of qualification may contribute to the diversity of tasks they perform.

Figure 206. *Cross-target variation of work comparative results*



Control over Working Time. The construct refers to care workers" control over their working time in aspects such as starting and ending the working day, when to take breaks, days off, holidays, and control over whether, when and how much overtime to work. 5 items from the long version of the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) were selected to assess this resource. An illustrative item is "Can you decide when to take a break?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The average score for control over working time was 2.39 (SD = 0.74) on a scale from 1 to 5, indicating that care workers generally reported low to moderate autonomy in managing their schedules, including start and end times, breaks, and days off. Significant differences were observed between the groups: home health aides and basic care workers, who typically have lower levels of formal education in care, reported the least control, while professional care workers - who tend to have higher qualifications and work in institutional settings - reported the greatest control. This suggests that both the setting and level of professional training may influence workers' ability to manage their working hours.

Figure 207. *Cross-target control over working time comparative results*

Predictability. Work is predictable if the worker has adequate, sufficient and timely information to be able to perform the job correctly and to adapt to changes (future restructuring, new technologies, new tasks, new methods and the like). Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected for the assessment of this resource. One illustrative item is, "Do you receive all the information you need in order to do your work well?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The average score for predictability was 3.49 (SD = 1.14) on a scale from 1 to 5, indicating that care workers generally felt they had a moderate to high level of timely and sufficient information to perform their tasks and adapt to changes. No significant differences were found between the study targets, suggesting a similar degree of predictability across care groups.

Autonomy. The construct refers to the degree of influence or decision latitude that the care worker has in the day-to-day activities, particularly in relation to the tasks to be carried out and the manner in which they are to be carried out. The three-item scale from Bakker and Bal (2010), adapted from Karasek et al. (1985), was used to quantify this resource. An illustrative item is "I have a lot of freedom in the execution of my work". The responses ranged from 1 (strongly disagree) to 4 (strongly agree).

The average score for autonomy was 3.06 (SD = 0.64) on a scale from 1 to 5, indicating a moderate level of decision-making freedom in how care workers performed their day-to-day tasks. No significant differences were observed between the study targets, suggesting that perceptions of autonomy were relatively consistent across different care settings.

Emotional Protective Factors

Meaning of Work. The variable is defined as the relationship that work has to values other than those associated with having a job and earning an income. These include the utility, importance or social value, or learning involved. Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected for the assessment of this resource. One illustrative item is, "Are you required to be kind and open towards everyone – regardless of how they behave towards you?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The average score for meaning of work was 4.52 (SD = 0.66) on a scale from 1 to 5, indicating that care workers across the sample strongly perceived their work as meaningful and valuable beyond its financial aspects. No significant differences were found between the study targets, suggesting that this sense of purpose and social contribution was consistently shared across care settings and qualification levels.

Relational Protective Factors

Recognition. The term denotes the appreciation, respect and fair treatment afforded to care workers by their supervisors in the workplace. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. One illustrative item is, "Is your work recognised and appreciated by the management/supervisor?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The average score for recognition was 3.95 (SD = 0.90) on a scale from 1 to 5, indicating that care workers generally felt appreciated, respected, and fairly treated by their supervisors. No significant differences were observed between the study targets, suggesting that perceptions of recognition were consistent across care settings and qualification levels.

Social Support. The variable can be defined as the degree to which care workers receive emotional and instrumental (help with job tasks) support from the individuals with whom they interact at their place of work. The 8-item scale was adapted from that used by Peeters et al. (1995) for the purpose of measuring this resource. An example item is, "The people you interact with at work showed that they appreciated the way you do your work". The responses were measured on a scale ranging from 1 (not at all) to 5 (a lot).

Care workers reported moderate to high levels of emotional support (M = 3.53, SD = 0.97) and lower levels of instrumental support (M = 2.68, SD = 0.90) on a scale from 1 to 5. This suggests that while workers generally felt emotionally supported by colleagues or others in the workplace, they received less consistent help with practical or task-related aspects of their job. No significant differences were found between the study targets, indicating that these patterns of support were experienced similarly across care settings.

7.2.4. Summary: Main Differences Across Targets in Spain

Table 28. *Summary of prevalence results in Spain*

Dimension		Variable	Overall level	Cross-target differences
Well-being indicators	***Negative well-being indicators***	Burnout (Disengagement and Exhaustion)	Moderate-High	No differences
		Physical Exertion	Moderate-High	B > A > C
		Turnover Intentions	Low	No differences
		Work–Private Life Conflict	Moderate	No differences
	Positive well-being indicators	Work–Private Life Enrichment	Moderate-High	No differences
		Happiness	Moderate-High	No differences
		Flourishing	High	No differences
Risk factors	***Job-related risk factors***	Physical Demands	High	B > A > C
		Quantitative Demands	Moderate	C > B > A
		Work Pace Demands	Moderate-High	B > C > A
		Tasks Beyond Job Duties	Moderate	C > A, B
	Emotional risk factors	Emotional Demands	Moderate-High	No differences
		Demands for Hiding Emotions	Moderate-High	No differences
	Relational risk factors	Exposure to Workplace Violence	Low-Moderate	B, C > A
		Exposure to Discrimination	Low	A > B > C
		Intragroup Conflict	Moderate	C > B > A
		Workplace Incivility	Low	No differences
Protective factors	***Job protective factors***	Possibilities for Development	High	No differences
		Variation of Work	Moderate	C > A, B
		Control Over Time	Low-Moderate	C > A, B
		Predictability	Moderate-High	No differences
		Autonomy	Moderate	No differences
	Emotional protective factors	Meaning of Work	High	No differences
	Relational protective factors	Recognition	High	No differences
		Emotional Support	Moderate-High	No differences
		Instrumental Support	Moderate	No differences

Note: Consider the sample sizes for each group (106 home health aides - A; 30 basic care workers - B; and 21 professional care workers - C)

The experiences of care workers in Spain paint a complex picture. On the one hand, many report high levels of psychological well-being - they find meaning in their work, are satisfied with their lives and, for the most part, are not actively considering leaving their jobs. Flourishing and enrichment of work and personal lives were commonly reported, suggesting that for many, the benefits of care work extend beyond the job itself. However, these positive aspects are accompanied by significant pressures. Burnout, particularly in the form of exhaustion and disengagement, was moderately high. Physical and emotional demands were a consistent reality across all roles. Tasks often required both physical effort and emotional strain - both from emotionally charged situations and the need to hide one's feelings.

Workload pressures were not evenly distributed. Professional care workers and basic care workers, both largely employed in institutional settings, reported the highest levels of quantitative demands and fast-paced work. Institutional settings also stood out for higher levels of task variety and more frequent requests to perform duties beyond formal job roles - an unexpected finding, given assumptions that home-based care typically involves broader and less clearly defined responsibilities. This may be due to greater role expectations placed on staff or the more structured and hierarchical nature of institutional care settings. Exposure to risk also varied. Workplace violence was more commonly reported by those in institutional settings, while discrimination was more commonly experienced by home health aides, a group that includes a large number of migrant workers. These patterns suggest different forms of vulnerability: some workers face behavioural risks from patients or colleagues, while others are more exposed to alienation or prejudice based on identity or background.

When it came to workplace protective factors, the picture was mixed. Most workers felt recognised by their supervisors and emotionally supported by those around them. But instrumental support - practical help with tasks - was often lacking. Autonomy and predictability were rated as moderate, although control over working time was limited, particularly for less trained care workers and those working in home care. Opportunities for growth were generally seen as positive, but task variety was lowest among the less formally trained, suggesting a more repetitive work experience for these groups.

In short, Spanish care workers show a strong commitment to their roles and derive meaning and well-being from their work. However, this sense of purpose exists alongside high emotional and physical demands, limited practical support and limited control over working hours. Differences between care settings and qualification levels are important. Institutional care workers are more likely to experience workload intensity and extra tasks they weren't formally assigned, while home-based and migrant workers face less structural support and greater exposure to discrimination. These findings point to the need for targeted, tailored strategies that respond to the real challenges faced by each group - to ensure that all care workers are respected, supported, and equipped to do their work safely and sustainably.

Chapter 8. Qualitative Data Set: Making Sense of the Findings Through Workers' Voices

8.1. Profile of the Care Workforce: Focus Group Sample

A total of 71 care workers from Spain participated in the study, 15 from Target A (in red, home health aides), 12 from Target B (in green, basic care workers) and 4 participants from Target C. Among home health aides who answered their work modality 14 (30.43%) were live-in home care workers while 31 (69.57%) were live-out home care workers.

Figure 208. *Participants per target group*

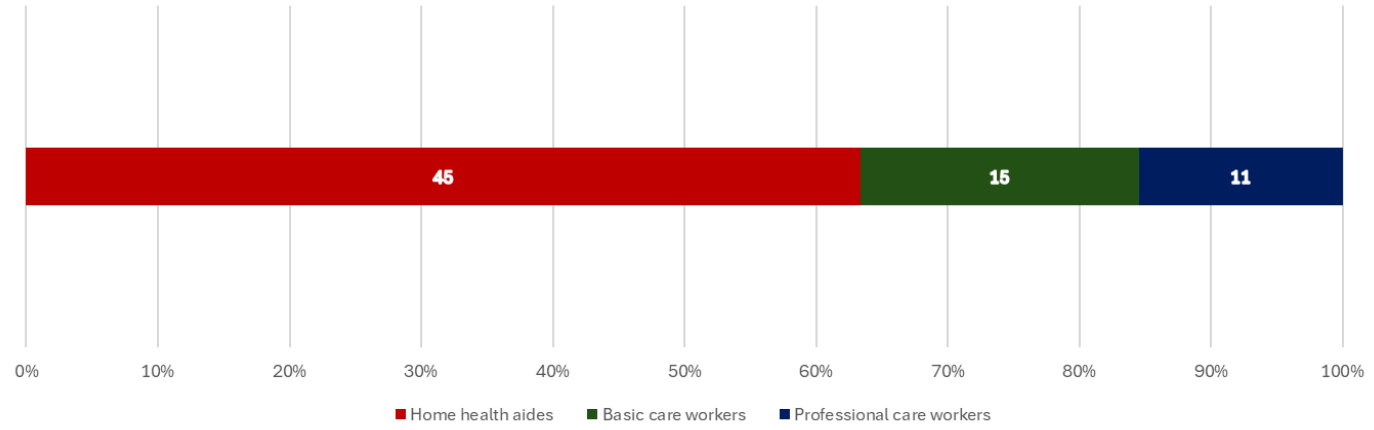
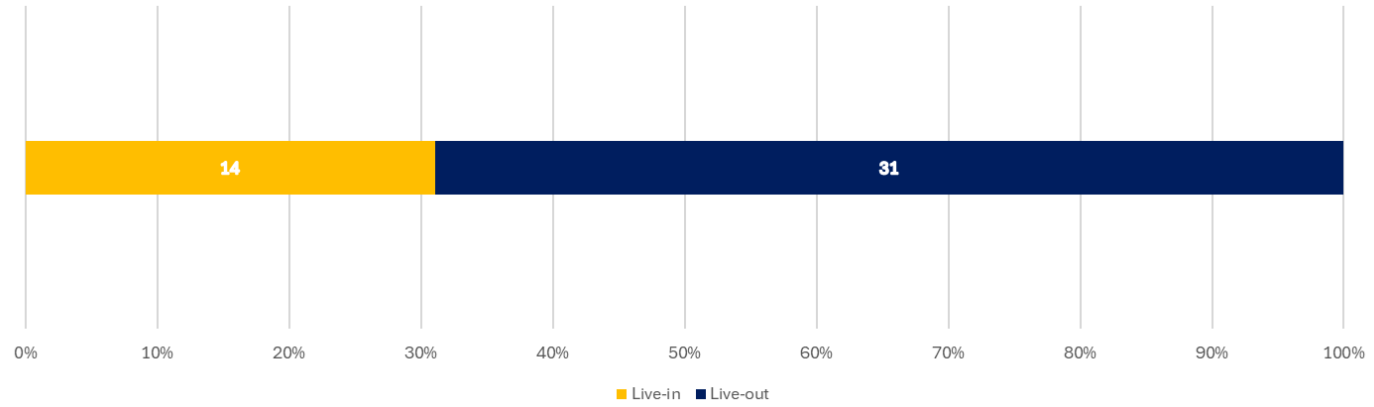


Figure 209. *Modality of home care*



The average age of the Spanish participants was 41.59 years and the majority were women (91.6%). Among age groups 22.53% were younger adults, 53.52% were adults and 23.95% were middle-aged adults.

Figure 210. *Age groups*

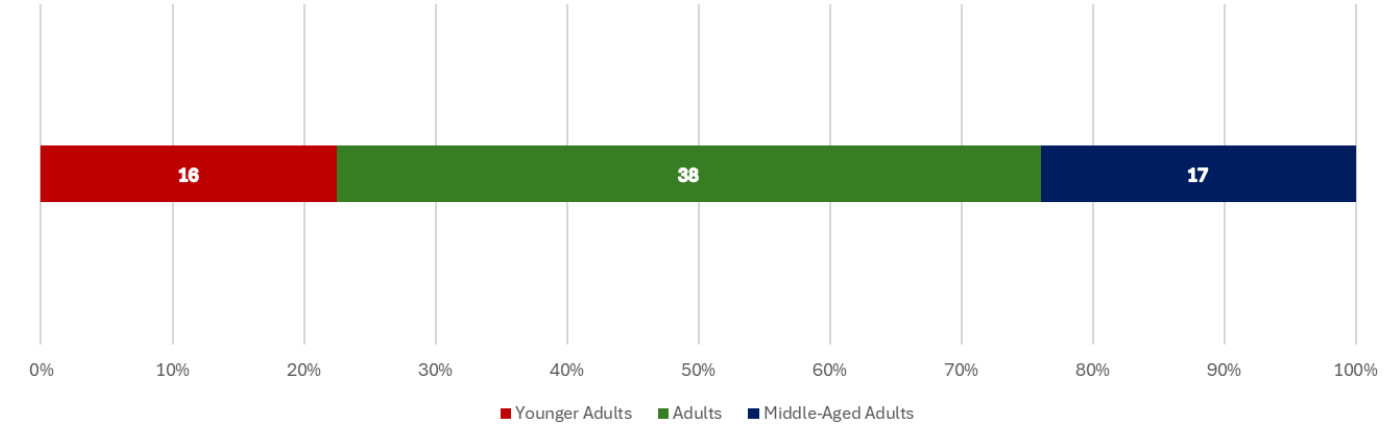
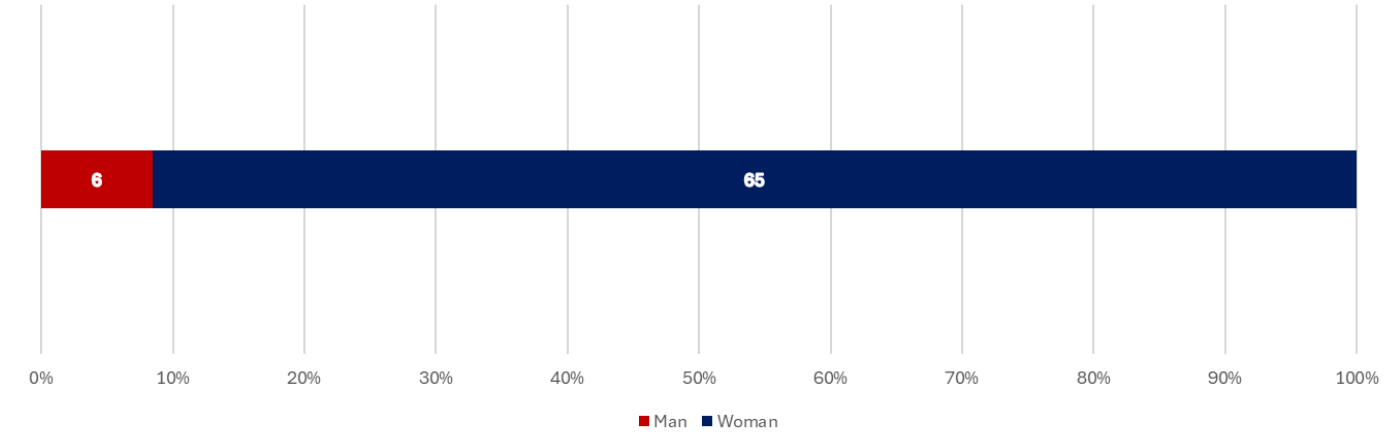


Figure 211. *Gender*



Most participants were Spanish (77.5%). A small number of participants reported being from an African country: Morocco. The rest were born in South America (Colombia, Honduras, Nicaragua, Paraguay and Peru).

Table 29. *Country of origin*

Country	Participants	Percentage
Spain	55	77.5
Colombia	7	9.8
Honduras	1	1.5
Morocco	1	1.5
Nicaragua	3	5.2
Paraguay	1	1.5
Peru	2	3
Total	49	100

Figure 212. *Country of origin*

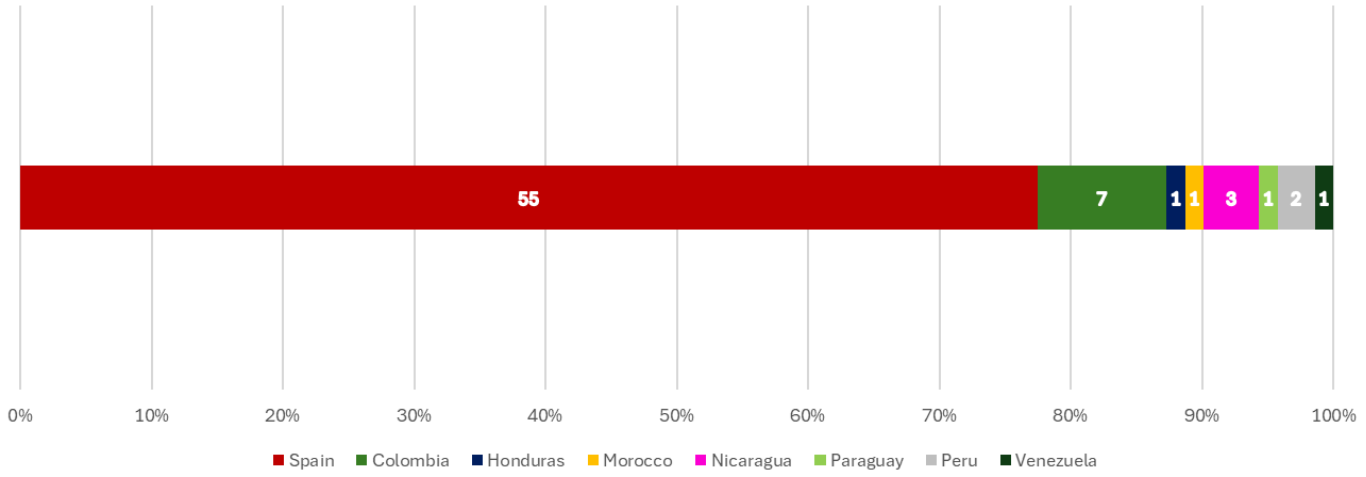
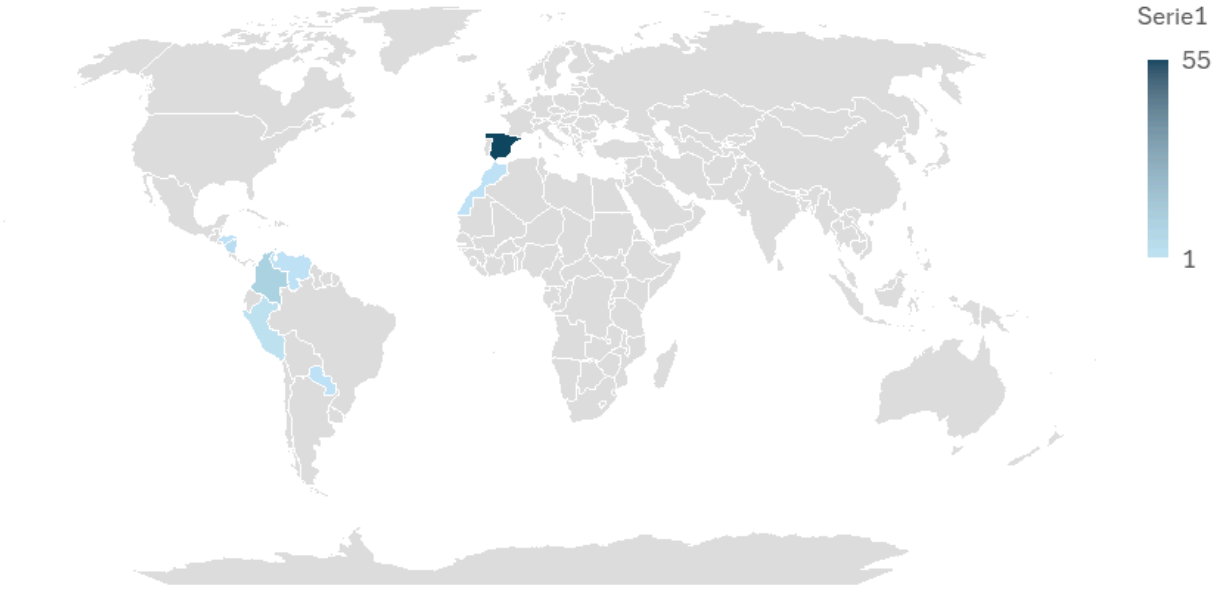
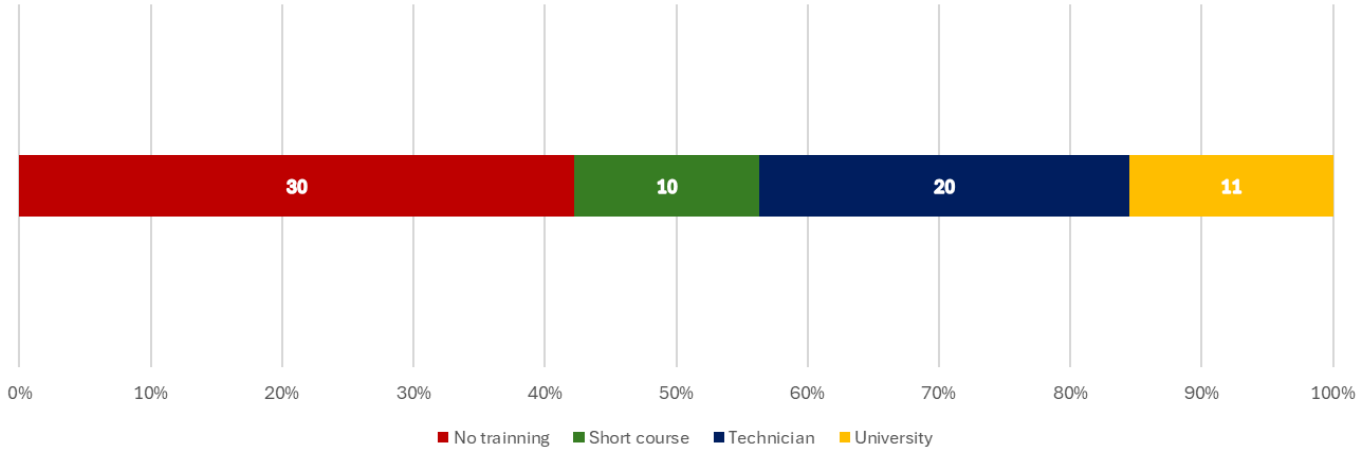


Figure 213. *Country of origin*



Educational levels were diverse: 42.2% had no training in care sector activities, 14% had a short course in care activities, 28.1% were technicians and 15.7% had completed a university degree.

Figure 214. *Educational status*



8.2 Focus Group Findings: Understanding Pressures and Supports Across Worker Groups

The qualitative results are presented by the target group. Within each group, risk factors (demands) and protective factors (resources) have been identified. Three domains have been differentiated for both: job, relational (where applicable) and personal. The most salient codes are highlighted to ensure consistency with the quantitative results and clarify subjective experiences. Each domain is depicted using a Sankey diagram indicating code frequencies.

Table 30. Spanish *focus group index*

Name of FG	Target		N	Gender		Age average	Country of origin	Modality
				F	M			
FG 1 ES A	A		7	7	0	50.29	Spain	Online
FG 2 ES A	A		9	9	0	40.73	Spain	Face-to-face
FG 3 ES A	A		6	6	0	46.92	Spain	Face-to-face
FG 4 ES A	A		8	8	0	30.5	Spain	Online
FG 5 ES A	A		9	8	1	41.33	Colombia, Morocco, Nicaragua and Peru	Online
FG 6 ES BC	B (5)	C (5)	10	8	2	40	Spain	Face-to-face
FG 7 ES BC	B (5)	C (4)	9	6	3	43.11	Spain	Face-to-face
FG 8 ES BC	B (5)	C (2)	7	7	0	44.71	Spain	Online
FG 9 ES A	A		8	8	0	46.12	Colombia, Honduras, Nicaragua, Paraguay and Spain	Face-to-face

8.2.1. Home Care: Risk and Protective Factors

The information in the following section is based on the testimonies of home care workers. They are nursing and care professionals working in domestic and outpatient settings, lacking specific training, who provide care for elderly, sick or other individuals requiring home care.

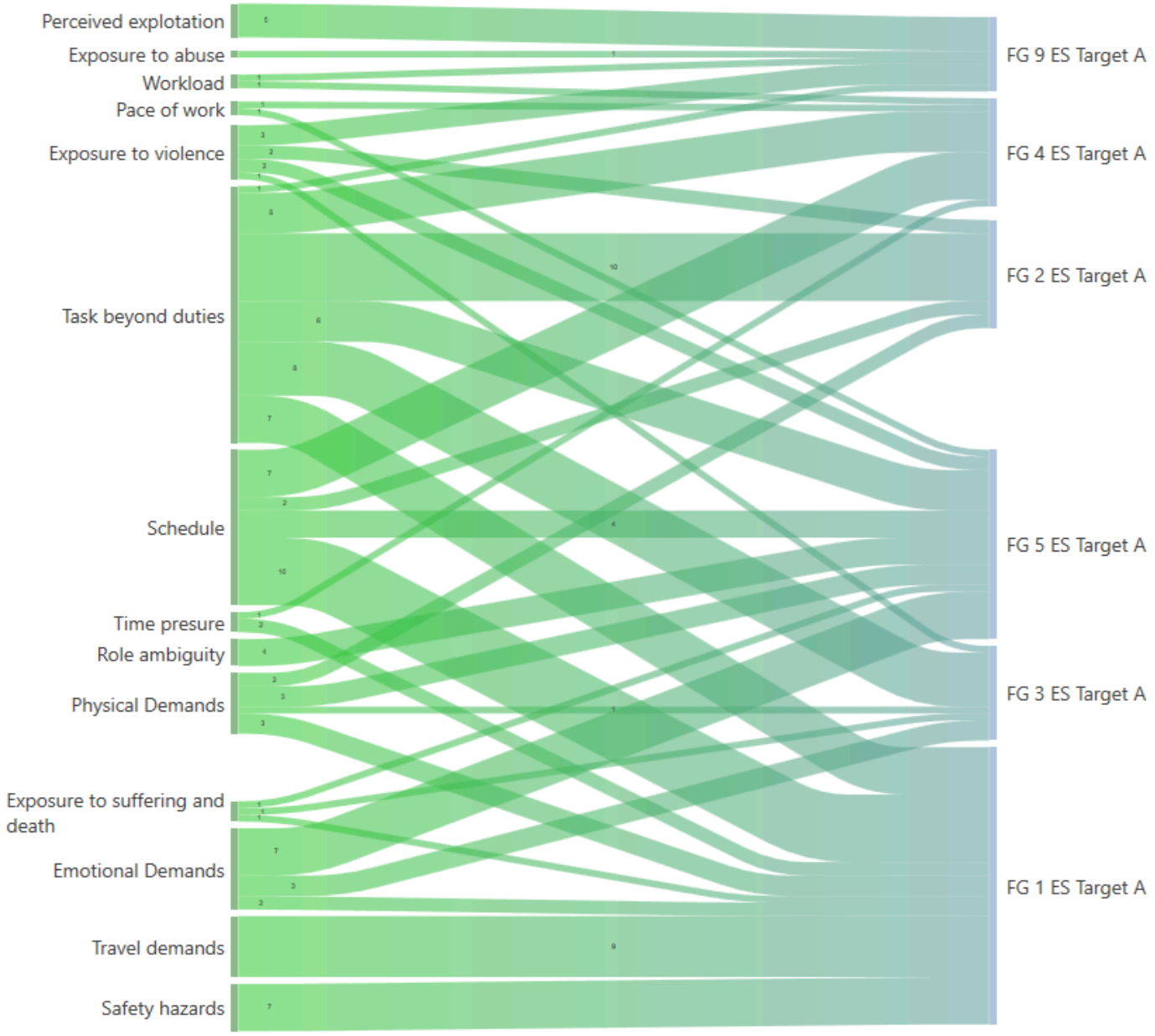
Risk Factors

Job-related Risk Factors

This diagram highlights work pace and physical demands as the most prominent job-related risks, with the thickest flows connecting these codes across several focus groups (*FG1 ES Target A*, *FG3 ES Target A*). Participants described their working conditions as a heavy workload characterised by repetitive, physically demanding tasks and limited recovery time. Task beyond duties also appears as a central code, showing that many home care workers perform tasks outside their formal responsibilities, further intensifying workload and physical strain.

Medium-width flows correspond to role ambiguity and schedule, which are frequently intertwined: unclear job boundaries often lead to irregular hours and unpredictable schedules. These, in turn, force workers to adapt continuously, increasing exhaustion. Overall, the figure portrays a professional setting marked by excessive workload, physical strain, and unclear task allocation, generating fatigue and undermining work–life balance.

Figure 215. *Job-related risk factors among home care workers group in Spain*

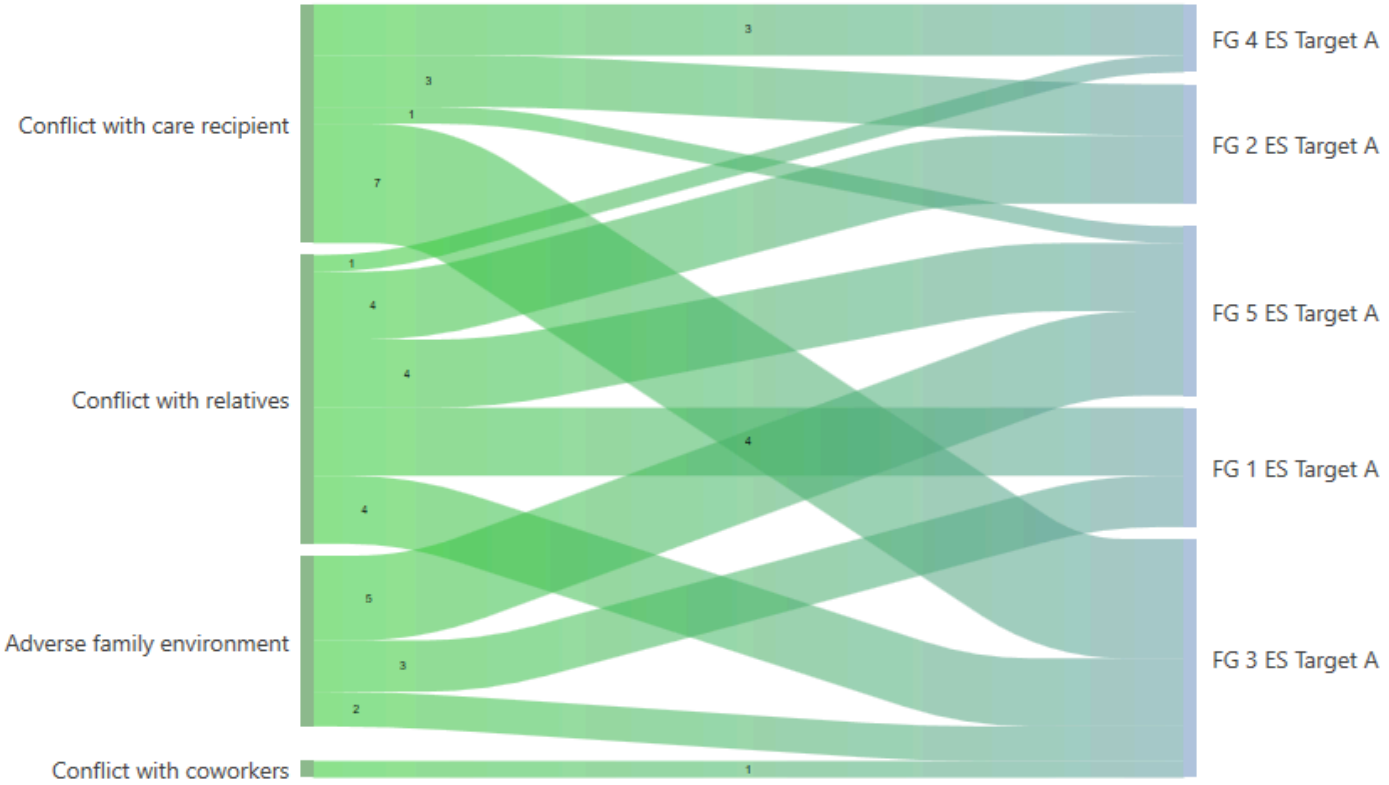


Relational Risk Factors

This diagram displays relational challenges that affect home care workers. The thickest flows correspond to conflict with relatives and relatives' expectations, showing that interactions with families of care receivers are the most frequent relational stressors. Workers reported feeling pressured by unrealistic expectations, often receiving conflicting instructions from family members and supervisors.

Thinner flows correspond to conflict with care receivers, which, although less frequent, reflect emotionally difficult interactions with the people they care for. The figure highlights that tensions with families—rather than with coworkers or supervisors—constitute the most salient relational challenge for Spanish home care workers, particularly when expectations and communication are poorly aligned.

Figure 216. *Relational risk factors among home care workers group in Spain*



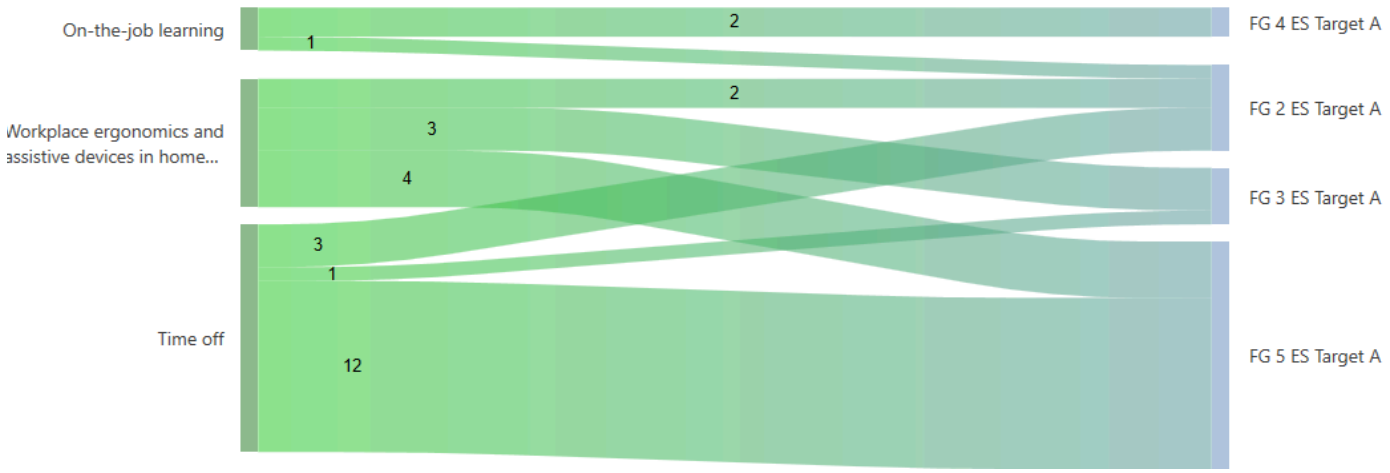
Protective Factors

Job Protective Factors

The diagram identifies respect for time off as the main job-related protective factor, represented by the thickest flow. This theme appears consistently across focus groups, reflecting that adequate rest and predictable free time are essential for recovery and mental health.

Medium-width flows correspond to on-the-job learning and autonomy, showing that opportunities for continuous learning and a certain level of self-organisation are also valued resources. Thinner flows are associated with workplace ergonomics and assistive devices in homes, mentioned as helpful but inconsistently available. In general, the figure indicates that rest, learning, and autonomy serve as key organisational supports that allow workers to recover physically and maintain engagement despite high workloads.

Figure 217. *Job related protective factors among home care workers group in Spain*



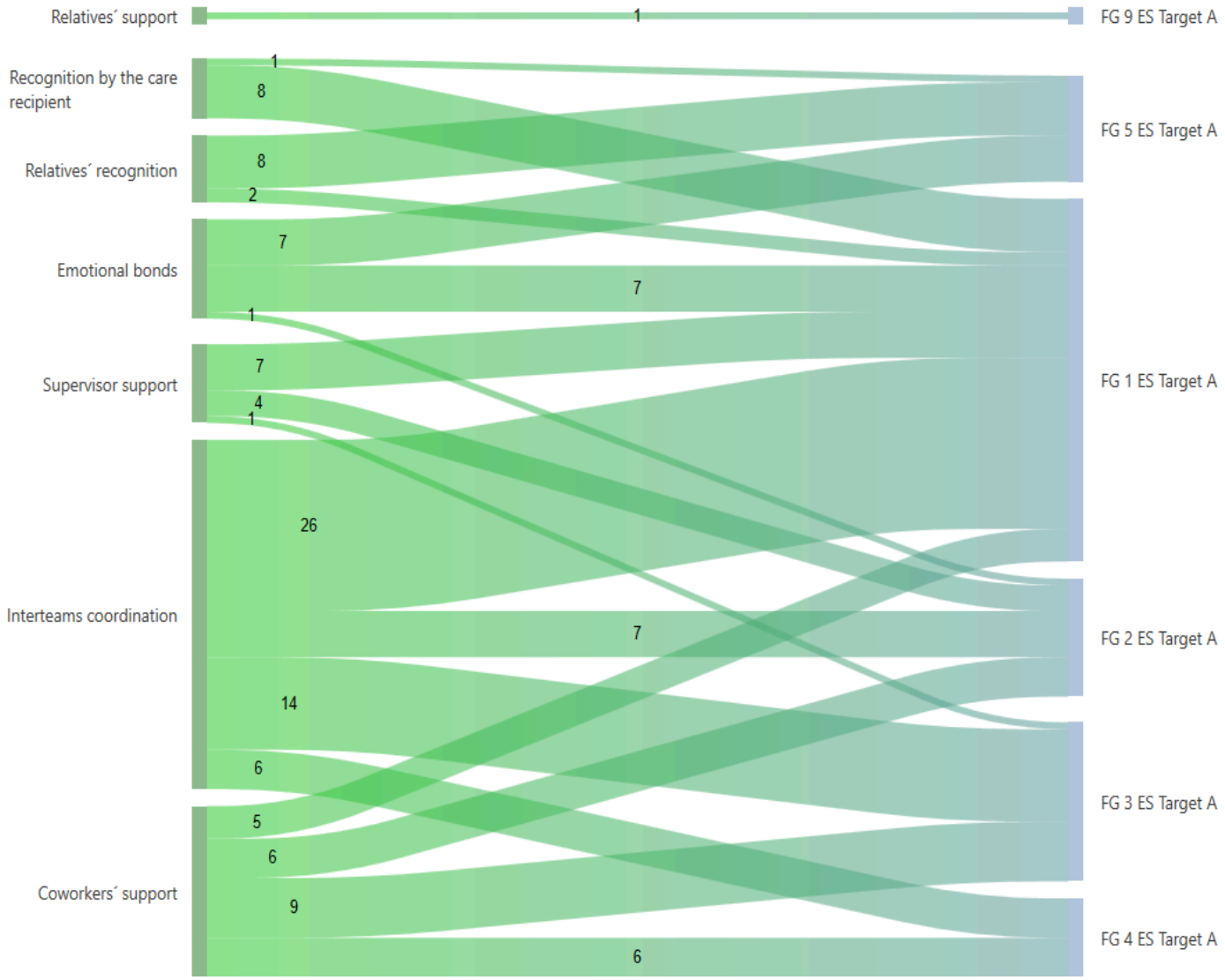
Relational Protective Factors

This diagram highlights interpersonal resources within the workplace. The thickest flow corresponds to interteams coordination, which encompasses communication and collaboration among coworkers. This theme appears across multiple focus groups (*FG2 ES Target A*, *FG4 ES Target A*) and represents the most valued relational protective factor. Medium-width flows link to coworkers' support and recognition by the care receiver, indicating that peer solidarity and appreciation from those receiving care contribute to emotional stability.

The overall pattern suggests that team collaboration and mutual support are crucial for maintaining motivation and preventing isolation in the Spanish home care sector, where

workers often operate alone in households but benefit from occasional coordination and shared experiences with colleagues.

Figure 218. *Relational protective factors among home care workers group in Spain*



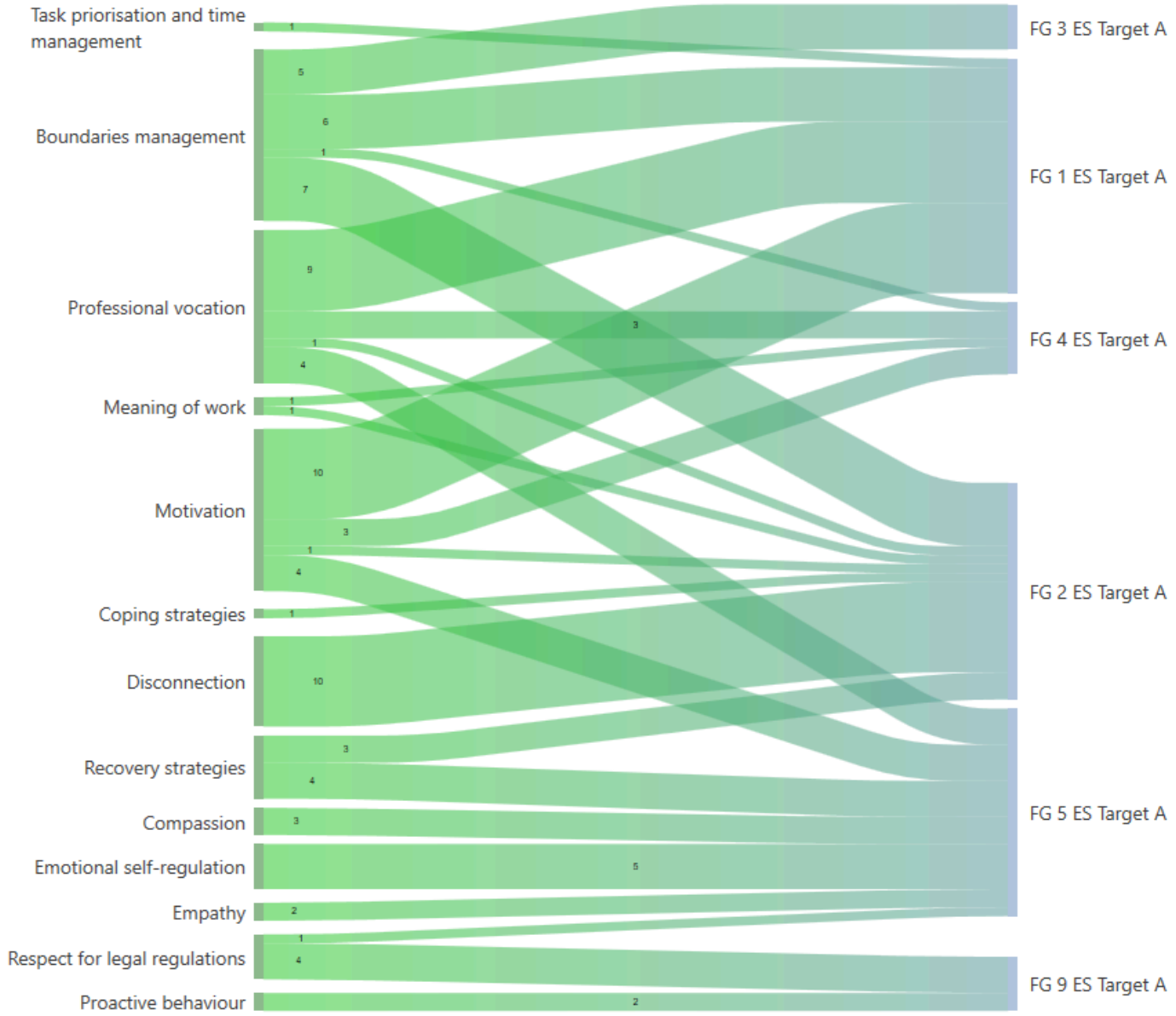
Personal Protective Factors

This diagram visualises personal and psychological strengths that sustain Spanish home care workers. The thickest flows correspond to motivation, professional vocation, and meaning of work, which together represent the moral and emotional foundation of their engagement in caregiving.

Medium-width flows appear for emotional management, coping, and autonomy, reflecting the importance of regulating emotions and maintaining self-efficacy under pressure.

Disconnection and recovery strategies are represented by thinner flows but remain significant, as they point to deliberate efforts to protect emotional well-being and prevent burnout. The diagram thus underscores that intrinsic motivation and a sense of purpose, complemented by self-care and emotional regulation, form the core of individual resilience among Spanish home care workers.

Figure 219. *Personal protective factors among home care workers group in Spain*



Spanish home care workers operate within demanding physical and relational conditions, yet they sustain their well-being through motivation, solidarity, and adaptive emotional strategies. The Sankey diagrams collectively depict a workforce driven by moral commitment and personal purpose, capable of maintaining engagement despite structural challenges in workload and recognition.

8.2.2. Institutional Care: Risk and Protective Factors

This part encompasses a mixed target: Basic care workers (target B: nursing and care staff who work in hospitals, retirement homes, nursing homes or day care centres and who have been trained in at least one short course) and Professional care workers (target C: specialists in the nursing or healthcare sector with vocational training or a Bachelor's degree).

Risk Factors

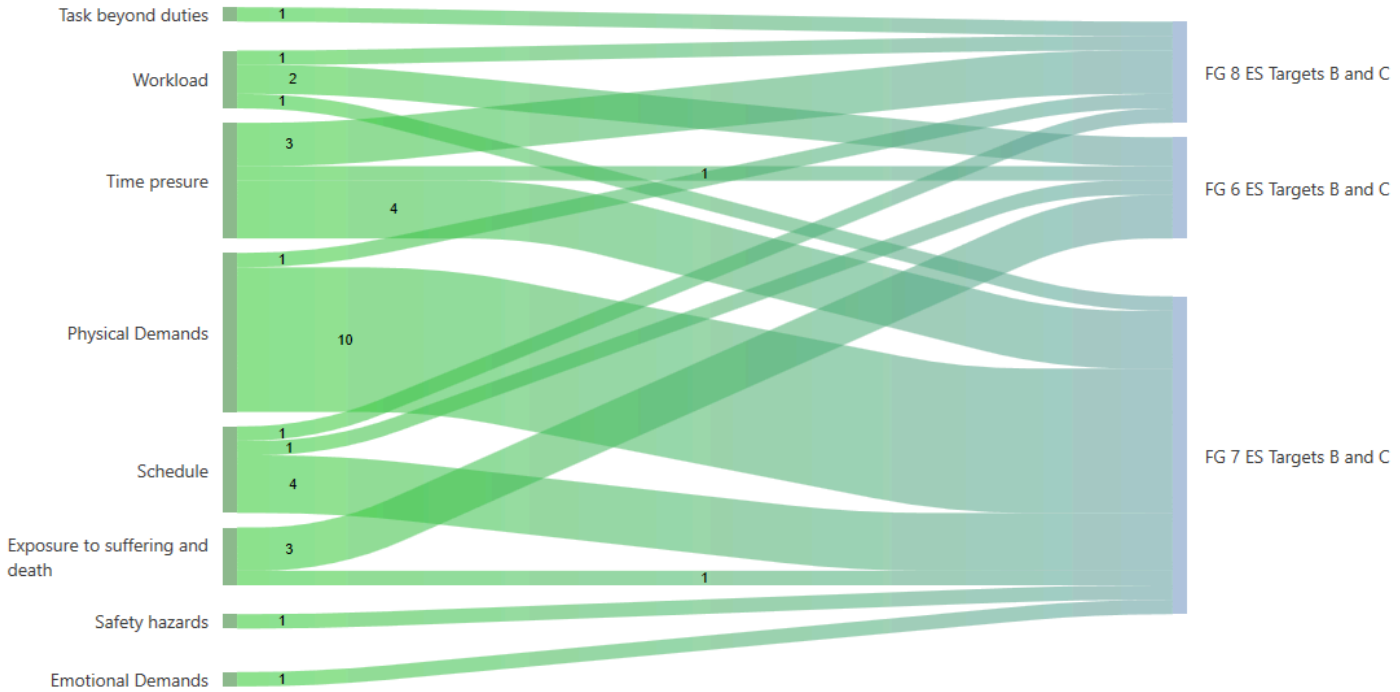
Job-Related Risk Factors

This diagram identifies physical demands as the most frequent risk factor, represented by the thickest flow across several focus groups (*FG5 ES Target B*, *FG6 ES Target C*). Workers described experiencing significant physical strain caused by the continuous movement, lifting, and handling of dependent individuals. This often results in fatigue and musculoskeletal pain.

Medium-width flows correspond to workload, time pressure, and schedule, which are closely interrelated. Heavy workload and short staffing produce high temporal pressure and irregular working hours. Tasks beyond duties appear with thinner yet visible flows, showing that many care workers are required to perform tasks outside their contractual roles, further contributing to fatigue and frustration. Safety hazards also emerge, pointing to the risk of physical overstrain in contexts where safety protocols or assistive equipment are insufficient.

Overall, the diagram reveals a work environment defined by high physical effort, insufficient time, and task overload, leading to both physical and psychological exhaustion.

Figure 220. *Job related risk factors among basic and professional care workers group in Spain*



Relational Risk Factors

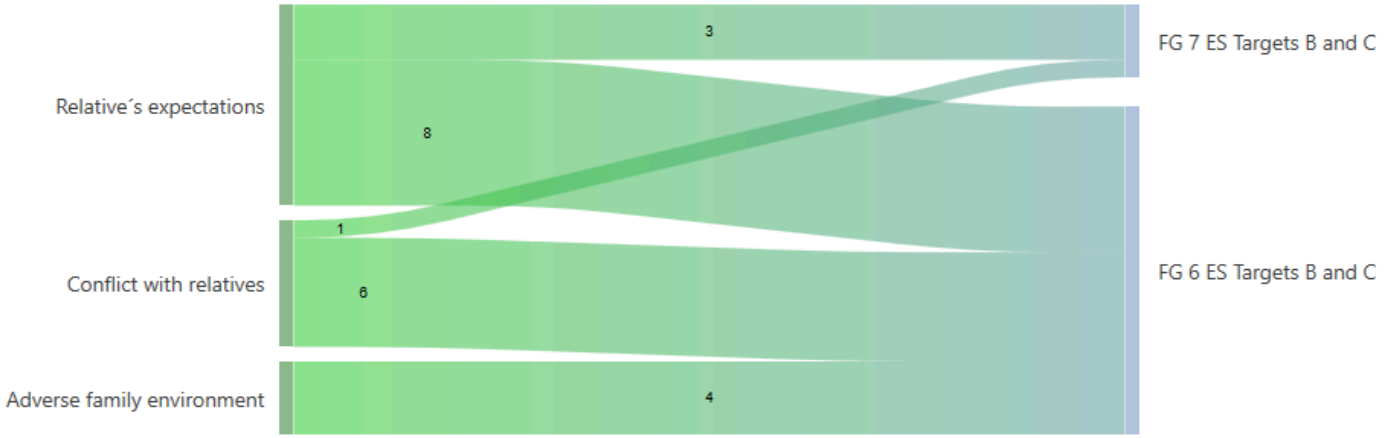
Expectations and conflict with family members emerges as additional to the intragroup conflict.

The relational risk factors diagram highlights intragroup conflict as the most frequent source of relational tension, represented by the thickest flow. This reflects difficulties in teamwork and communication among colleagues, particularly under stressful and understaffed conditions.

Medium-width flows for expectations and conflict with family members show that interpersonal difficulties also extend beyond the workplace to interactions with relatives of patients or residents. These conflicts often stem from differing perceptions of care quality and emotional overinvolvement from families.

Overall, the diagram shows that relational risks in Spanish institutions arise both within teams (peer conflict and lack of coordination) and between workers and families, where unclear expectations and emotional pressure exacerbate tension.

Figure 221. *Relational risk factors among basic and professional care workers group in Spain*



Protective Factors

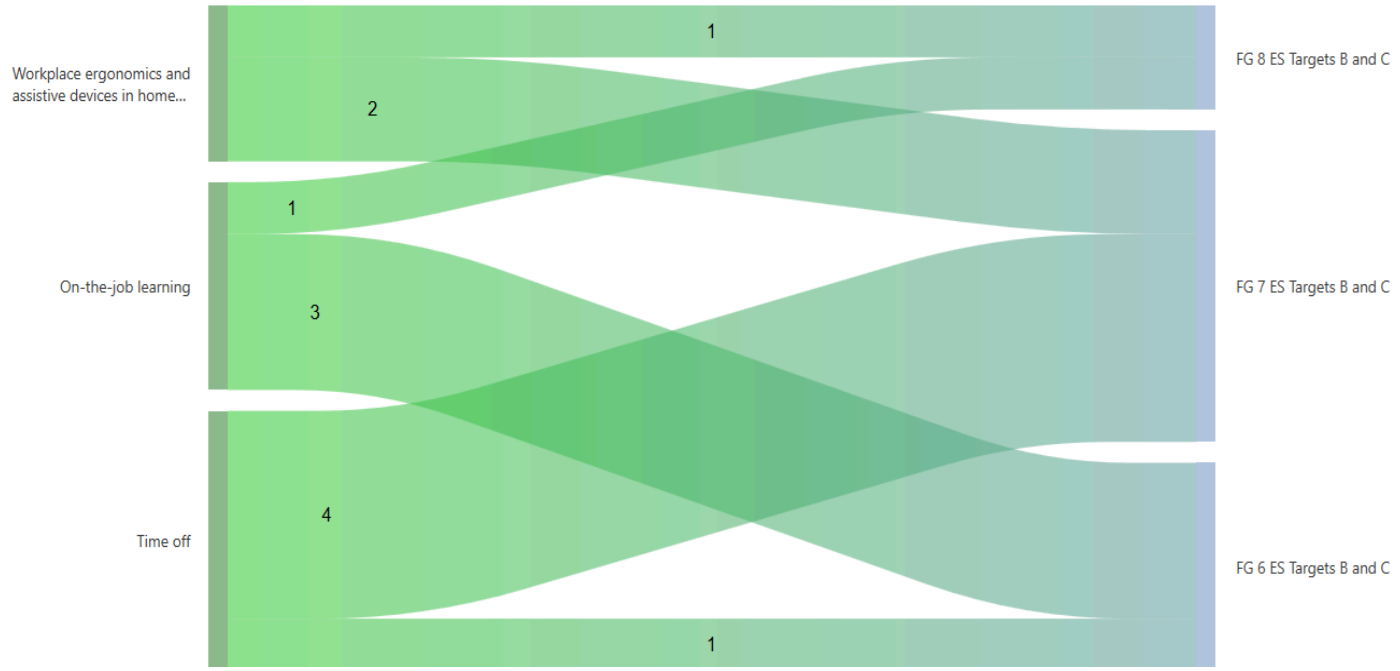
Job Protective Factors

This diagram displays the organisational resources perceived as protective. The thickest flow corresponds to on-the-job learning, described as the opportunity to learn continuously through daily practice. This reflects the workers' appreciation for professional development and skill enhancement, which reinforce competence and confidence.

Medium-width flows link to possibilities for development and workplace ergonomics, both connected to structural aspects of the job that support well-being. The combination of these codes suggests that institutional care workers view professional growth and safe working conditions as key organisational buffers that increase motivation and reduce strain.

Overall, the figure highlights that learning opportunities, career development, and ergonomics function as the most valued institutional supports in the Spanish care sector.

Figure 222. *Job related protective factors among basic and professional care workers group in Spain*



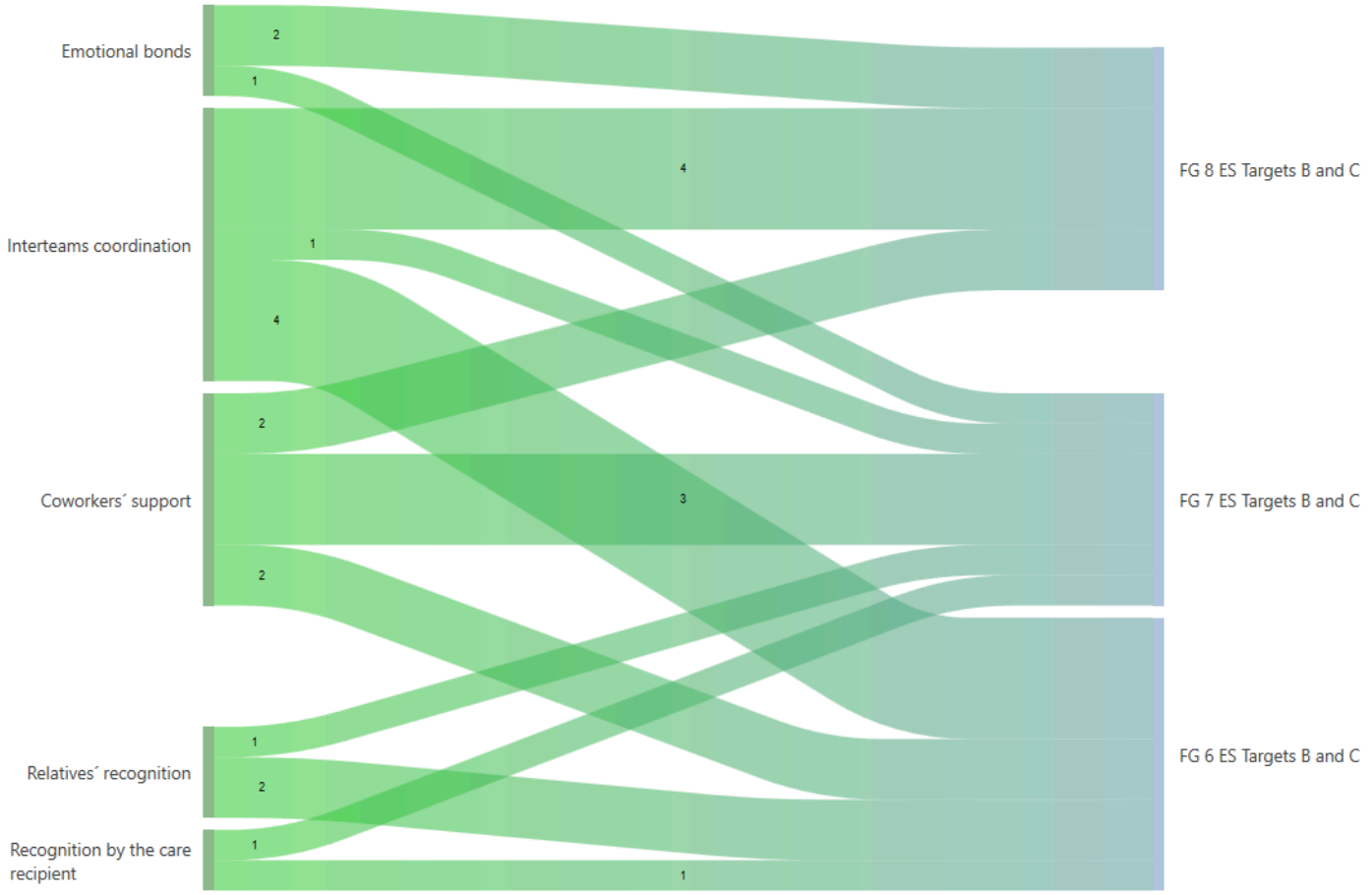
Relational Protective Factors

This diagram visualises relational resources in the workplace. The thickest flows correspond to coworkers' support and recognition, both essential for maintaining emotional balance. Coworkers' support appears across multiple focus groups (*FG5 ES Target B*, *FG6 ES Target C*), showing that solidarity, help, and empathy among colleagues are central to workers' well-being.

Medium-width flows correspond to recognition by family members and recognition by care receivers, indicating that positive feedback from others provides moral validation and reinforces workers' professional identity. Thinner flows appear for emotional bonds and interteams coordination, highlighting the broader web of relational connections that sustain motivation and belonging.

The overall pattern demonstrates that mutual support and recognition—from colleagues, families, and recipients—act as powerful protective resources in institutional care settings.

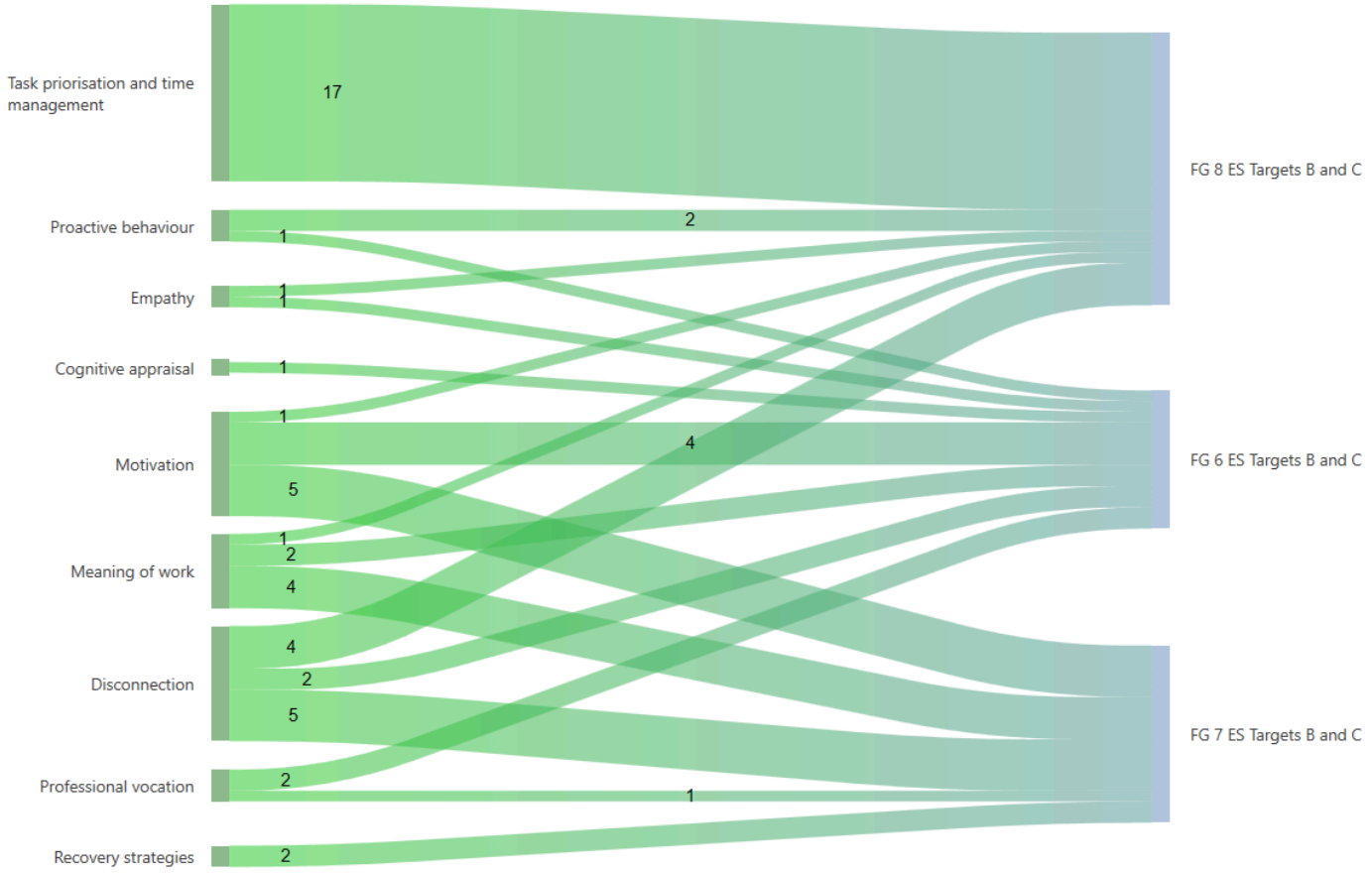
Figure 223. *Relational protective factors among basic and professional care workers group in Spain*



Personal Protective Factors

The personal protective factors diagram shows task prioritisation and time management as the most salient individual resource, represented by the thickest flow. These abilities are essential in helping workers organise competing demands and cope with workload pressure.
Medium-width flows link to autonomy, proactive behaviour, and coping strategies, which together reflect self-regulation and adaptive decision-making under stress. Thinner flows for emotional management, recovery strategies, and boundaries management show the role of emotional control and self-care in maintaining balance between personal and professional life.
Overall, the figure illustrates that Spanish institutional care workers rely heavily on organisational and cognitive self-regulation skills—such as planning, prioritisation, and emotional awareness—to sustain performance and protect their mental health.

Figure 224. *Personal protective factors among basic and professional care workers group in Spain*



Spanish institutional care workers face physically demanding, time-constrained, and emotionally complex environments, yet they display strong adaptive capacity supported by learning, collaboration, and personal self-regulation. The Sankey diagrams collectively portray a workforce that endures structural difficulties through a combination of collective solidarity, professional growth, and practical emotional intelligence.

PART 5. CARE WORKERS IN POLAND

Chapter 9. Quantitative Data Set: What the Surveys Revealed About Care Work in Poland

9.1. Profile of the Care Workforce Sample

A total of 78 care workers from Poland participated in the study. By professional category, 17.9% were home health aides (target A, in red), 28.2% were basic care workers (target B, in green) and 53.8% were professional care workers (target C, in dark blue). All participants were Polish nationals and none worked as live-in HCWs. Basic and professional care workers were predominantly employed in institutional settings. The mean age of the participants was 42.15 years (SD = 8.12). By age group, 15.4% were younger adults aged 18-34, 62.8% were adults aged 35-49 and 21.8% were aged 50-64. The sample was predominantly female (92.3%) and 6.4% male. Most caregivers were married or in a civil partnership (82.1%), while 14.1% had never been married and 3.8% were separated or divorced.

Figure 225. *Participants per target group*

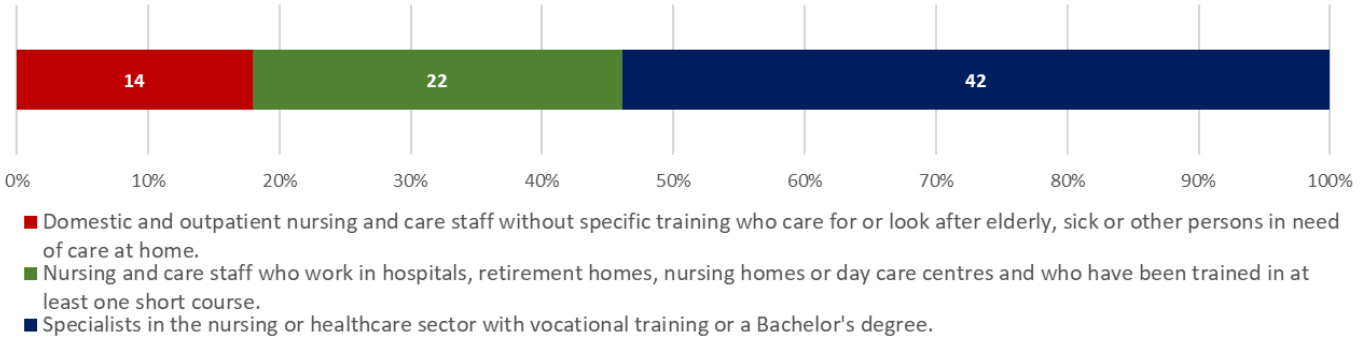


Figure 226. *Age groups*

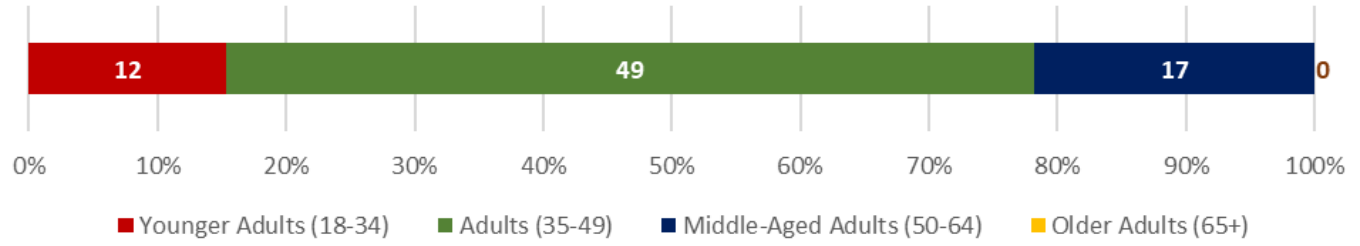


Figure 227. *Gender*

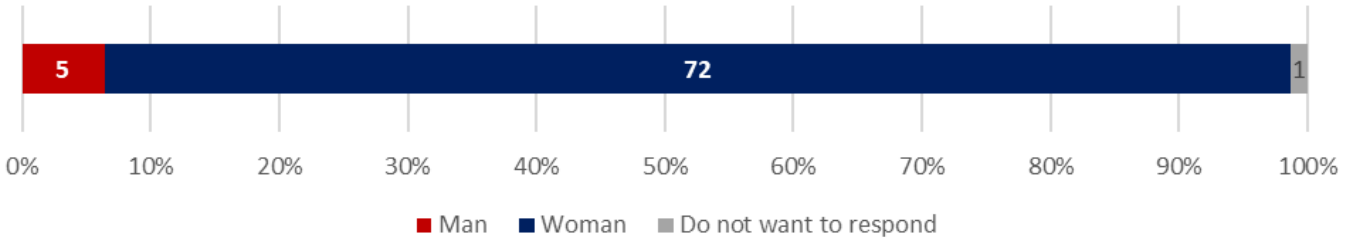


Figure 228. *Marital status*

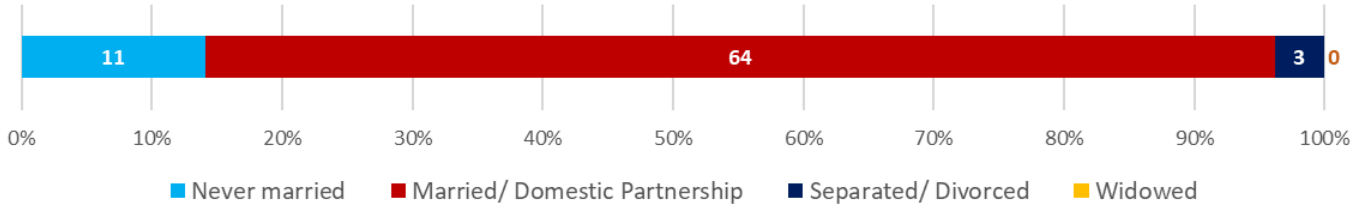


Table 31. *Descriptive statistics of the quantitative variables*

	N	Min	Max	Mean	SD
Age	78	23.00	60.00	42.15	8.12
Tenure in months	78	0.00	435.00	161.04	112.28
Monthly wages all participants	66	170	1664.00	1004.93	214.65
Monthly wages in Institutionalised care	47	620	1664	1019.13	198.23
Monthly wages in home based care	19	170	1200	969.80	253.24
Hours worked in a week	78	7	60.00	38.14	8.60
Number of home care receivers in a week (HCWs)	24	1	70.00	10.17	14.15
Knowledge of benefits (out of 9)	78	0	9	2.81	2.20
Use of benefits (out of 9)	78	0	8	1.65	1.83

In terms of place of work, 74.4% worked in urban areas and 25.6% in rural areas. In terms of educational background, 80.8% had completed three or more years of post-compulsory education, 10.3% had completed up to two years and 9% had completed only secondary education. Just over half (52.6%) had received formal education or training in care services, while 47.4% had not.

Regarding safety training, the majority of participants (79.5%) had received training on safety hazards from their current employer, 9% had learned about safety hazards in previous jobs or through personal initiative, and 11.5% had never received such training. Participants had worked in the care sector for an average of 161.04 months (SD = 112.28).

Figure 229. *Area of work*

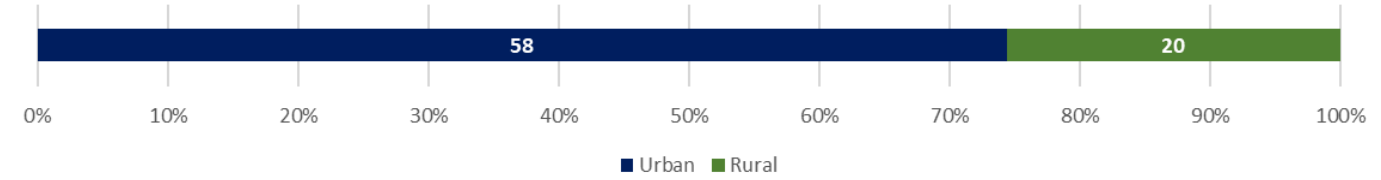


Figure 230. *Nationality*

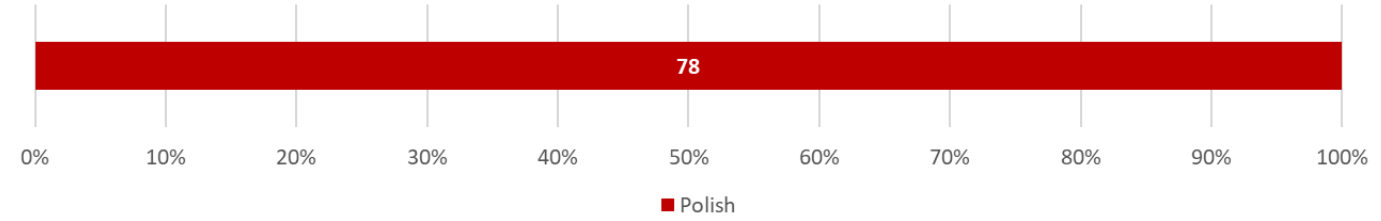


Figure 231. *Educational status*

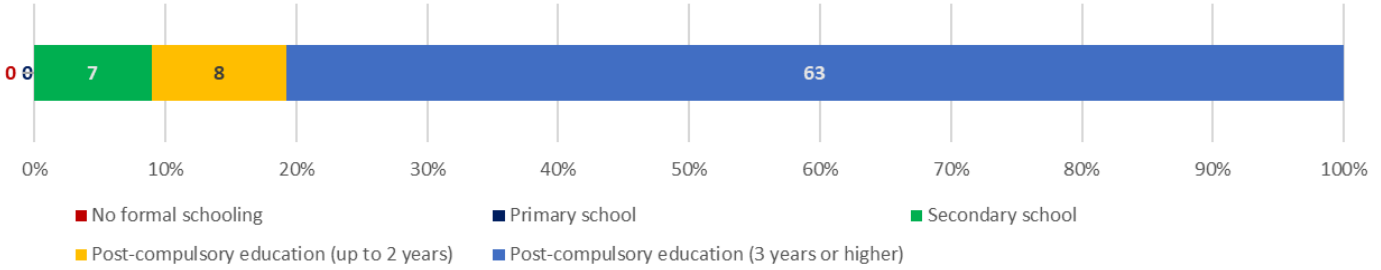


Figure 232. *Formal education in care services*

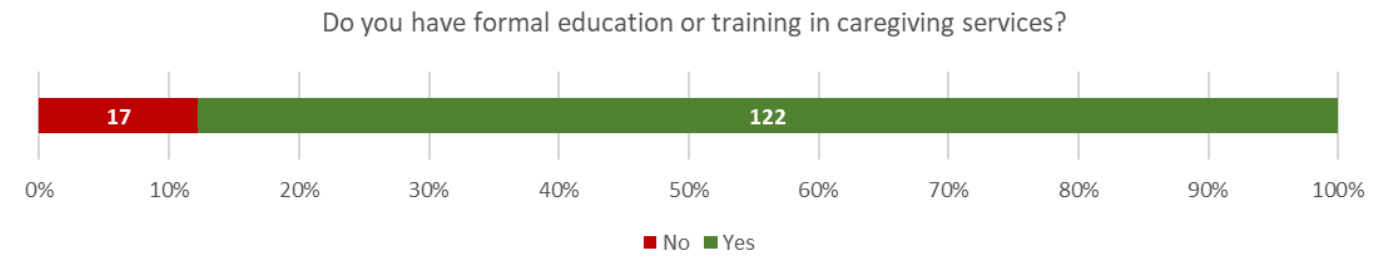
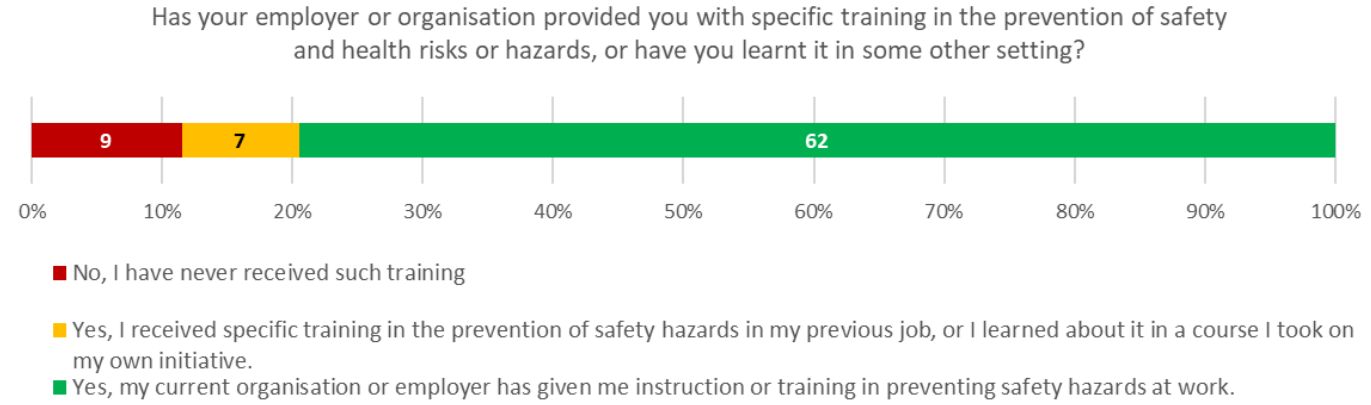


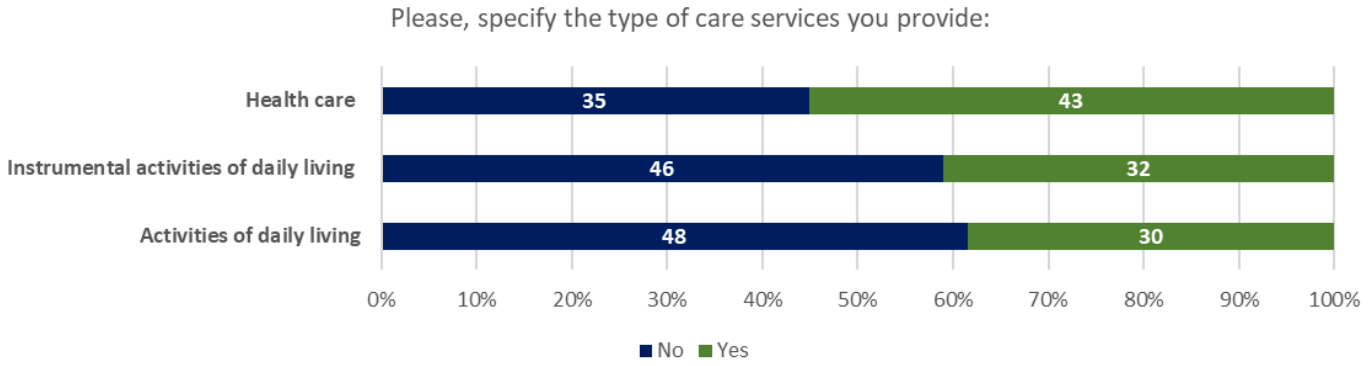
Figure 233. *Safety hazards training*



When asked about the type of care tasks performed, 38.5% reported assisting with activities of daily living (ADLs), 41% with instrumental activities of daily living (IADLs) and 55.1% with health-related care. However, formal training appeared to be misaligned with these tasks. Only 25.6% had training in ADLs, 15.4% in IADLs and 34.6% in health care. Only 21.8% reported having received specific training related to the diagnosis or health condition of the person they were caring for.

The majority of care receivers had complex health conditions: 80.8% had mobility impairments, 80.8% had psychological or neurological disorders, and 74.4% had physical health problems. In contrast, only 30.8% of workers reported caring for people with infectious diseases and 33.3% cared for care receivers without a specific diagnosis.

Figure 234. *Type of care tasks they perform*



Note: **Activities of daily living or ADL** (dressing, toileting, mobility, bowel and bladder management, sleep time regulation, feeding, transferring from one position to another, personal hygiene, walking, caring for pets, personal care bathing, eating, toilet hygiene, grooming, ambulating, companionship and socialisation).
Instrumental activities of daily living or IADL (using the phone, shopping for groceries, managing medication, preparing meals, doing laundry, housekeeping, managing finances, assistance with using transportation).
Health services (nursing, auxiliary services, wound care, infusion therapy, physical or cognitive rehabilitation, injections, diagnostic services, prescriptions, treatment of injuries or illnesses, occupational therapy, hospice care, therapists and social workers.

Figure 235. *Type of formal education in care services*

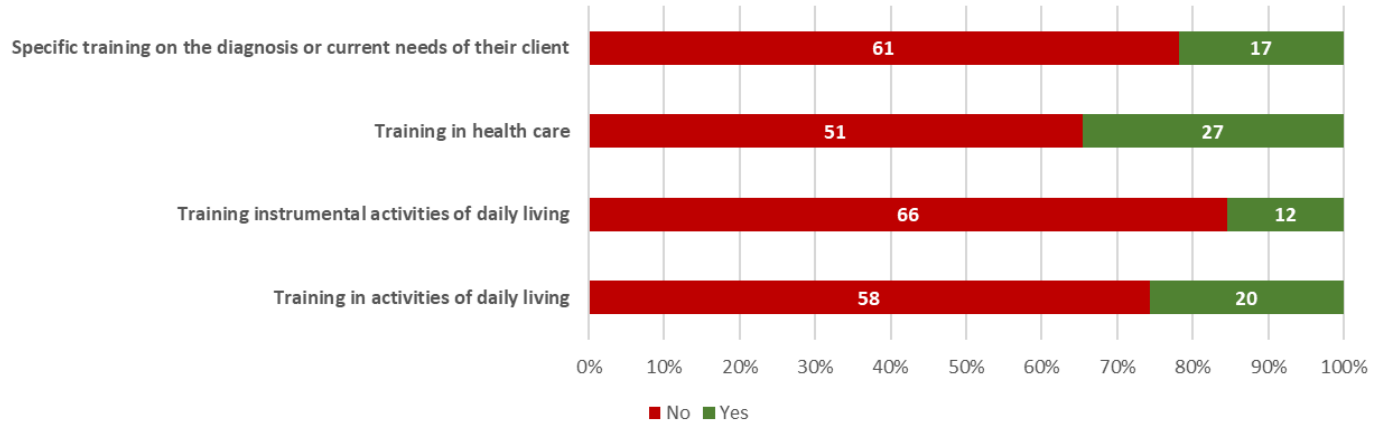
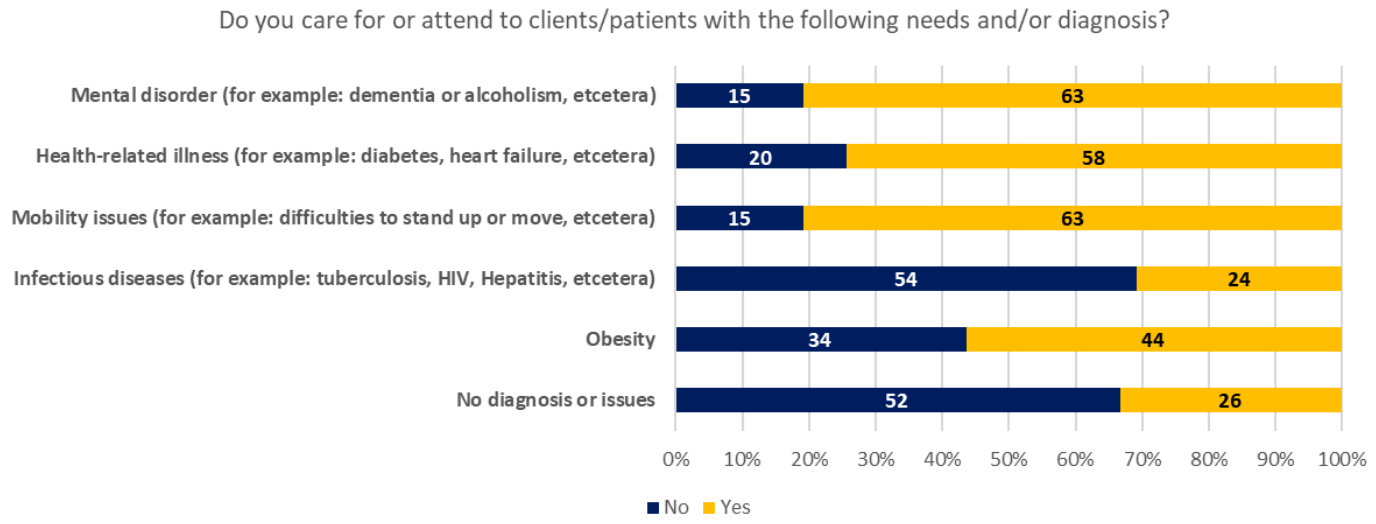


Figure 236. *Type of medical condition of the person receiving care*



Most participants (96.2%) had a supervisor at work and 82.1% worked in teams with colleagues from the same unit. However, 11.5% worked independently with colleagues from other units and 6.4% reported working completely alone. In terms of employment status, only 3.8% were self-employed, 89.7% worked in the public sector and 6.4% in the private sector. 39.7% of care workers reported being members of a trade union or similar organisation, with professional care workers being more likely to be unionised.

Most respondents (87.2%) had full-time contracts, while 7.7% worked on an hourly basis and 5.1% worked part-time. 89.7% had permanent contracts, 7.7% had temporary contracts and 2.6% reported having no legal contract. Fixed hours were most common (84.6%), followed by flexible hours (9%) and shift work (6.4%).

Figure 237. *Supervision*

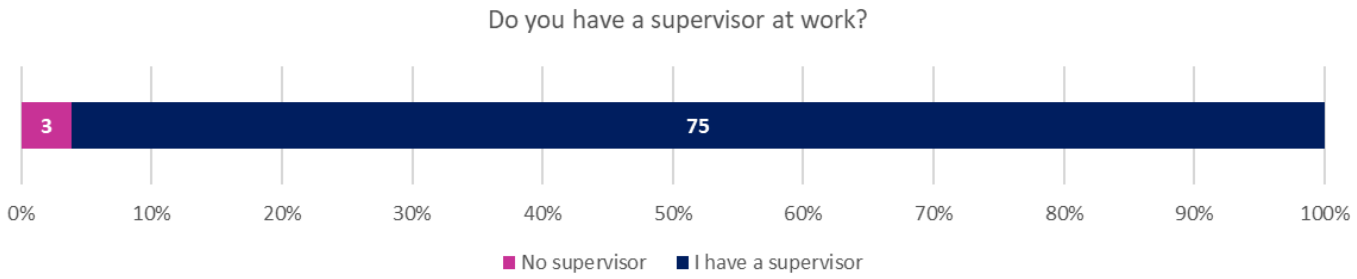


Figure 238. *Teamwork*

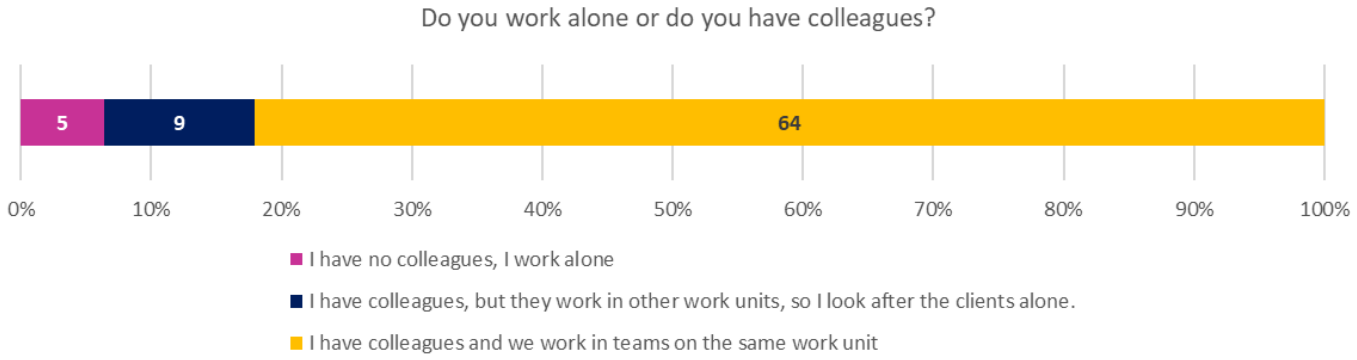


Figure 239. *Employment status*

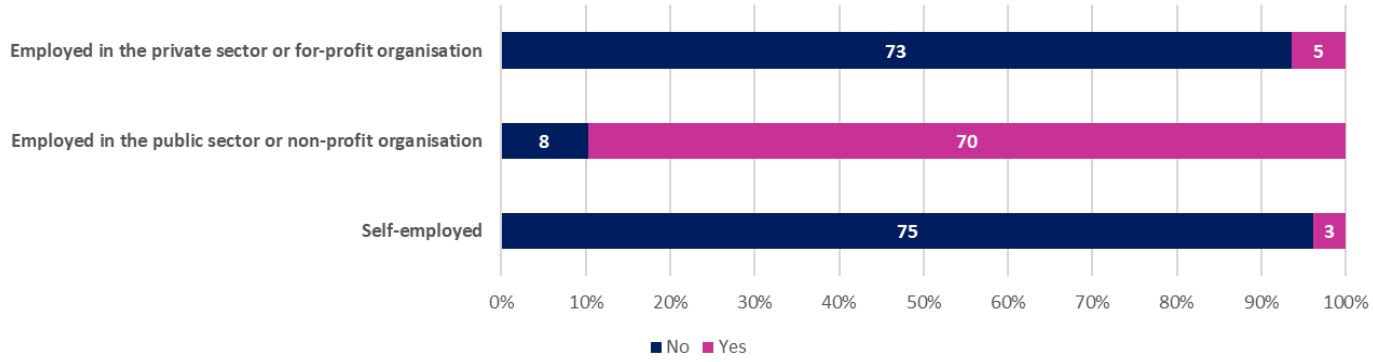


Figure 240. *Belonging to a union or association*

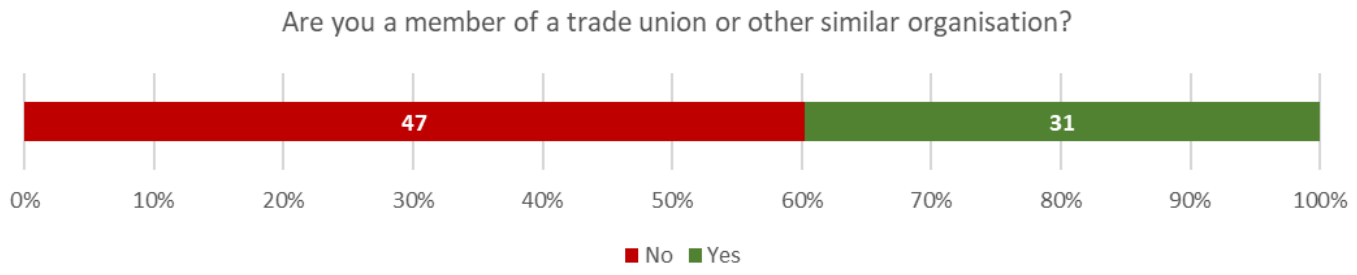


Figure 241. *Type and duration of contract*

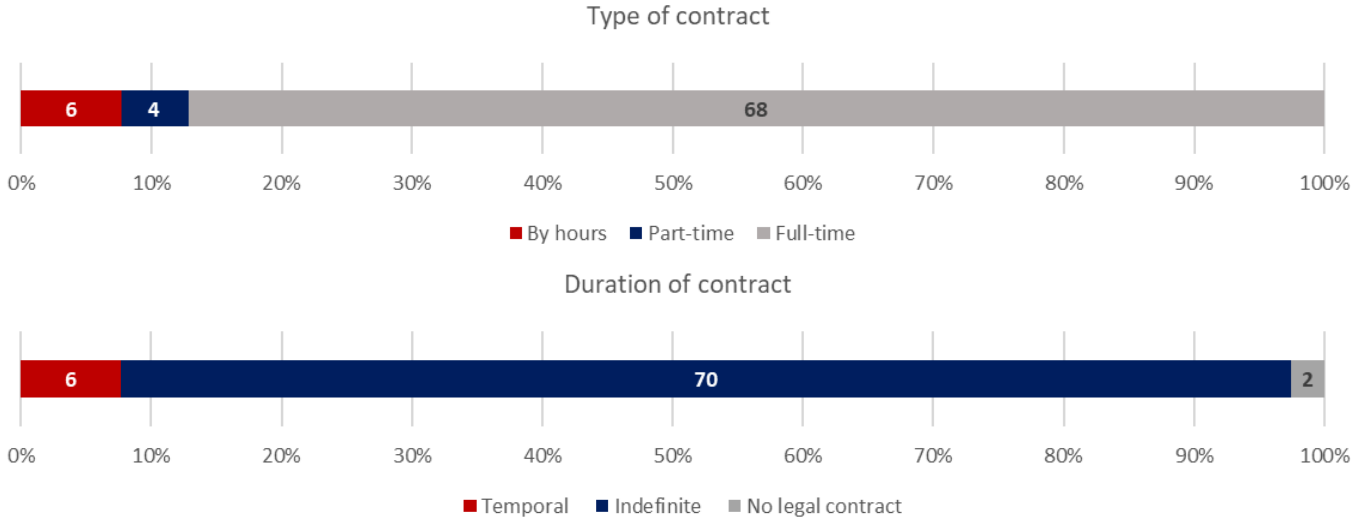
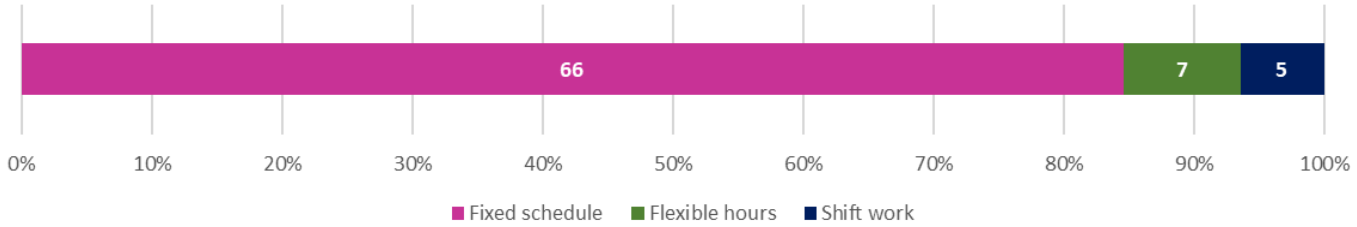


Figure 242. *Type of schedule or work shift*



Most participants (67.9%) used their own car to get to work, 16.7% relied on public transport or car sharing and 15.4% walked or cycled. Only 29.5% reported having access to lifting equipment or mobility aids at their workplace.

Access to employment benefits was generally limited. On average, employees were aware of 2.81 out of 9 benefits (SD = 2.20) and used 1.65 (SD = 1.83). The most commonly known benefits were paid holidays (61.5%), paid sick leave (59%) and performance bonuses (32.1%), but even these were not universally used. While 39.7% reported using paid holidays and paid sick leave, fewer reported using performance bonuses (16.7%), fuel reimbursement (17.9%) or travel vouchers (14.1%).

Figure 243. *Access to lifting aids or equipment*

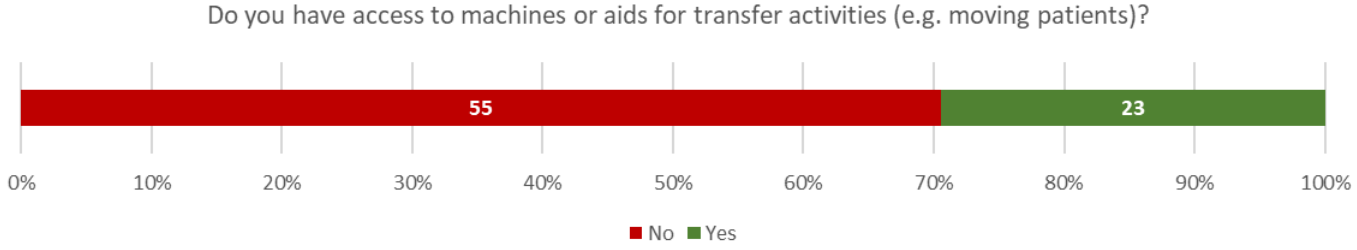


Figure 244. *Transport or commuting to work*

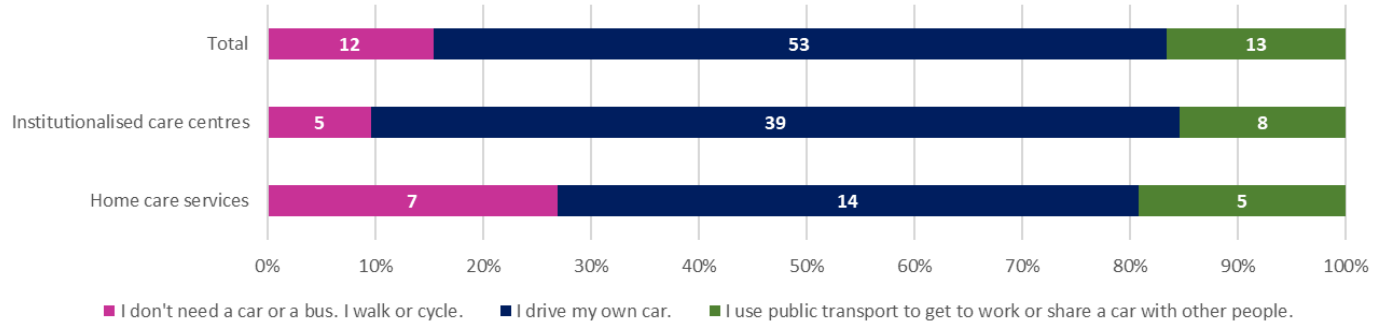
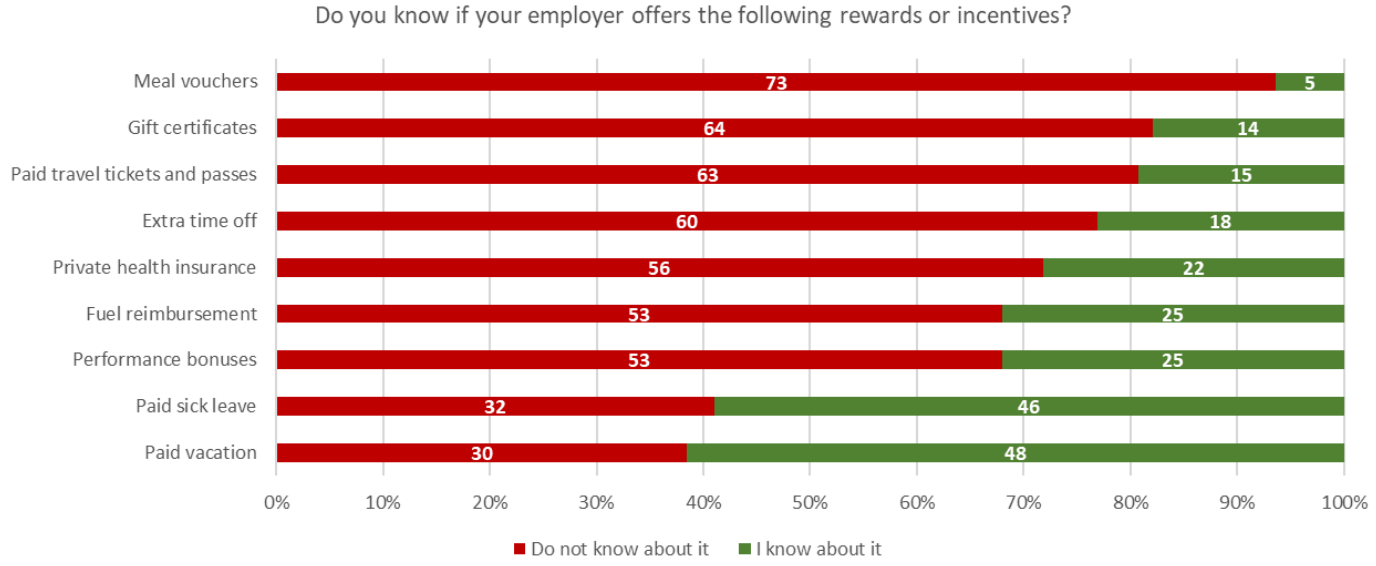
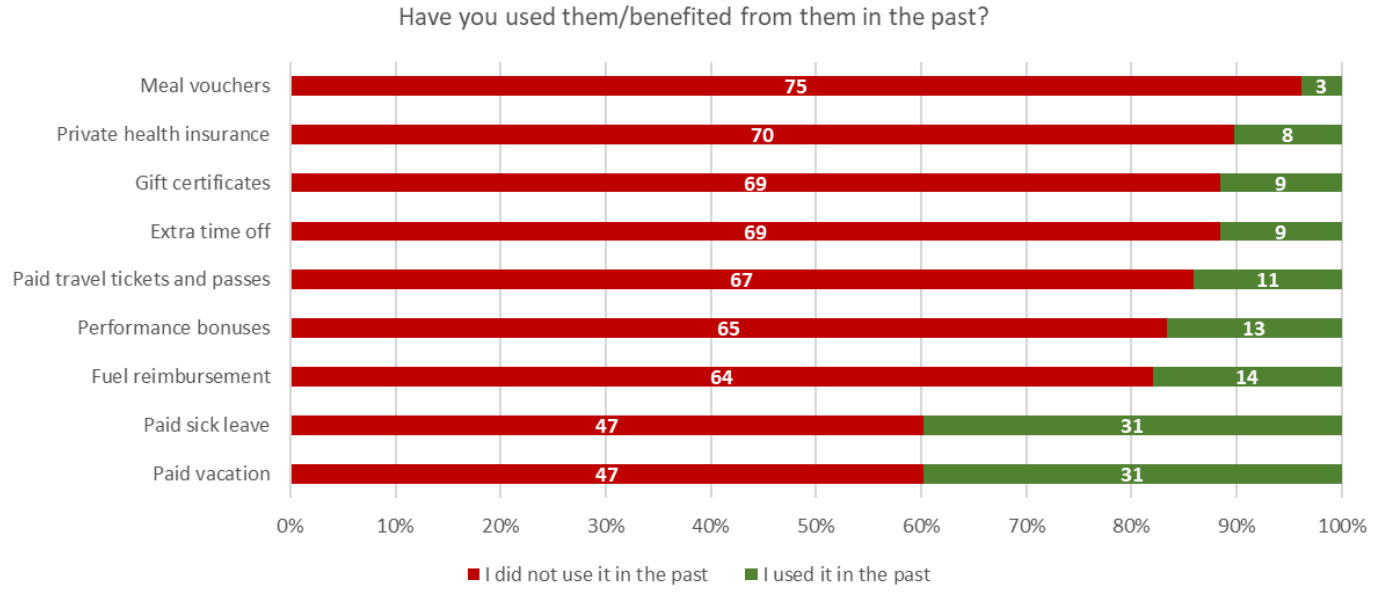


Figure 245. *Knowledge and use of workplace benefits and/or rewards*





On average, care workers worked 38.14 hours per week (SD = 8.60). Most (66.7%) worked in institutional care, while 33.3% worked in home care. Of those in home care, all were in live-out arrangements. In terms of continuity of care, 61.5% of home care workers reported caring for the same care receivers for more than one year, 19.2% for one to six months, 11.5% for three to six months and 7.7% for less than three months.

Figure 246. *Place of work*

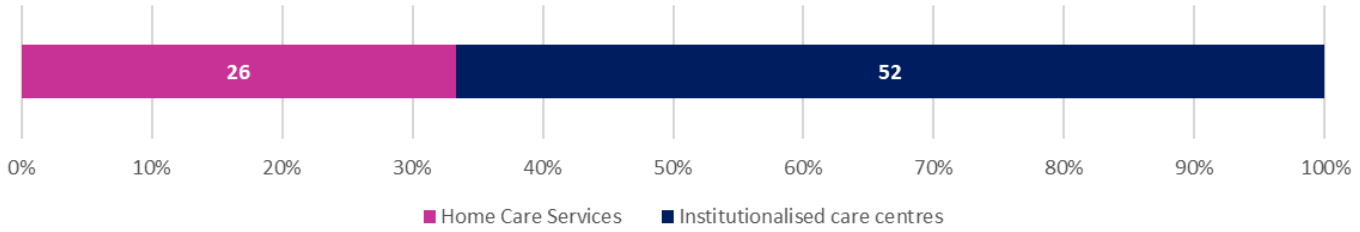


Figure 247. *Modality of home care work (HCWs)*

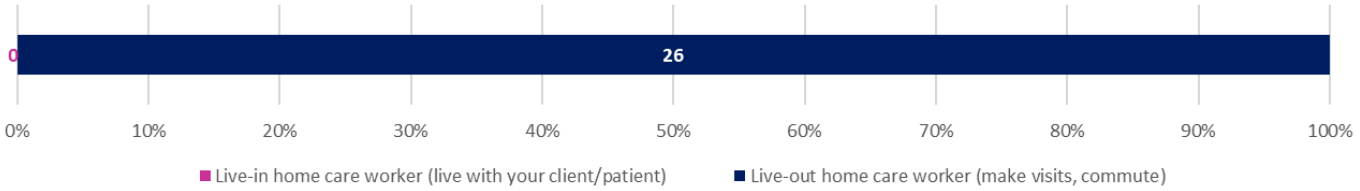
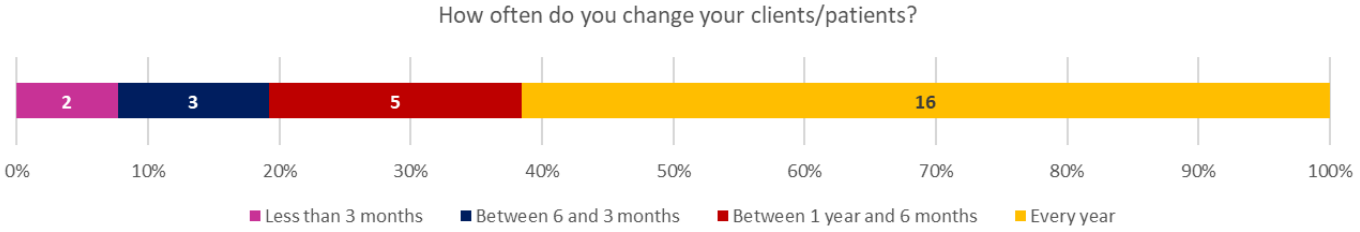


Figure 248. *Continuity of home care work (HCWs)*



Although all participants were Polish, the survey included a question about language dominance. 65.4% said they had no difficulty speaking or understanding the language used at work and 34.6% said they could understand and communicate using the vocabulary needed to do their job correctly.

Figure 249. *Immigration status*

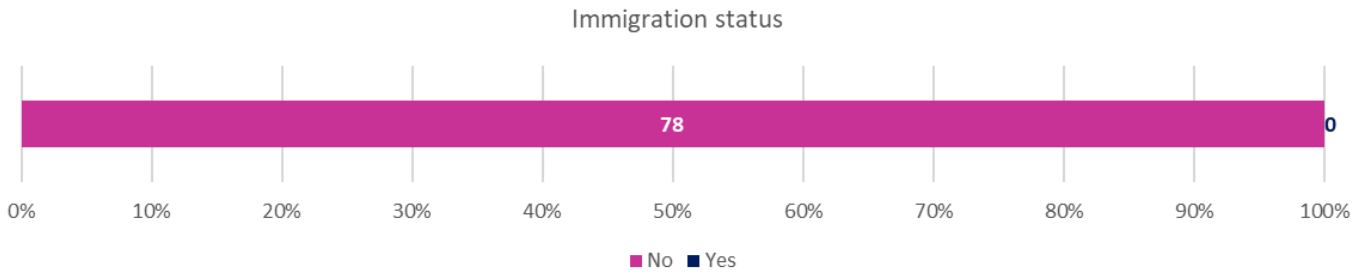
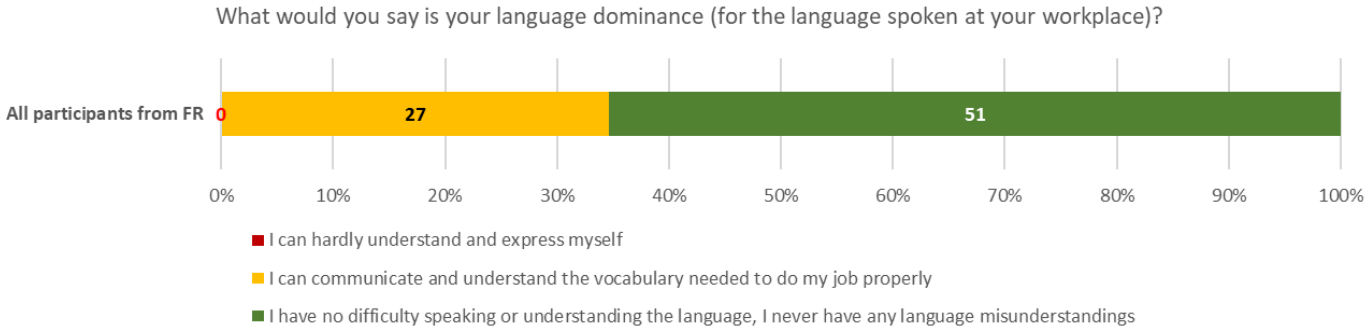


Figure 250. *Language dominance at the workplace*



The demographic and employment data from the Polish sample suggest a relatively experienced and qualified care workforce, although one with notable limitations. Most participants were middle-aged women with higher education, working full-time in the public sector on indefinite contracts. Despite this apparent job stability, less than half had formal training in care services and only one in five had training specific to care receivers' health conditions - despite the high prevalence of complex care needs such as mobility problems, psychiatric or neurological disorders and physical health conditions.

Although the majority reported having supervisors and working in teams, particularly in institutional settings, access to practical benefits was limited. Only 29.5% had access to lifting equipment and overall awareness or use of employment benefits - such as sick leave, holiday pay or travel support - was low.

The findings suggest that while the Polish care workforce is experienced and generally highly educated, improvements in job-specific training, equipment availability, and access to employment benefits are needed to better support those providing both home-based and institutional care.

9.2. Findings on Prevalence: Comparing Well-Being, Risks and Protective Factors Across Targets

9.2.1. Well-Being Results

In this section, the outcomes of work are examined, considering both its positive and negative dimensions. The positive dimension is captured through indicators of psychological well-being or flourishing, while the negative dimension focuses on burnout and perceived strain. In addition, the impact of work on personal life is explored, concluding with a report on employees' expressed desire to leave their job if given the opportunity.

Table 32. *Main results of Wellbeing*

Outcome	Target	Mean	S.D.	N
Burnout (Disengagement and Exhaustion)	Target A	2.88	0.36	14
	Target B	2.57	0.34	22
	Target C	2.76	0.38	42
	Mean	**2.73**	**0.38**	**78**
Perceived Exertion	Target A	7.07	1.39	14
	Target B	6.55	2.48	22
	Target C	5.17	2.62	42
	Mean	**5.90**	**2.52**	**78**
Turnover intentions	Target A	2.40	1.06	14
	Target B	2.35	1.11	22
	Target C	2.72	1.15	42
	Mean	**2.56**	**1.12**	**78**
Work-Private Life Conflict	Target A	2.66	0.81	14
	Target B	2.45	0.97	22
	Target C	2.63	0.72	42
	Mean	**2.58**	**0.81**	**78**
Work-Private Life Enrichment	Target A	3.33	0.57	14
	Target B	3.53	0.74	22
	Target C	3.68	0.63	42
	Mean	**3.58**	**0.66**	**78**
Happiness	Target A	7.36	1.69	14
	Target B	7.41	1.74	22
	Target C	7.33	1.43	42
	Mean	**7.36**	**1.55**	**78**
Flourishing	Target A	5.23	0.88	14
	Target B	5.30	1.00	22
	Target C	5.43	0.86	42
	Mean	**5.36**	**0.90**	**78**

Note: Target A: Home health aides; Target B: Basic care workers; Target C: Professional care workers.

Negative Indicators: Where Workers Are Struggling

Burnout Results. Burnout is a job-related syndrome that has been defined as a state of physical, emotional and mental exhaustion that results from prolonged exposure to chronic workplace stress that has not been successfully managed. This variable was assessed with the Oldenburg Burnout Inventory OLBI (Demerouti, et al. (2010). Two scales: disengagement (8 items) and psychological exhaustion (8 items). The responses ranged from 1 (strongly disagree) to 4 (strongly agree).

The average level of burnout among Polish care workers was moderate to moderately high (M = 2.73, SD = 0.38) on a scale of 1 to 4, indicating frequent experiences of exhaustion and disengagement. Significant differences were observed between professional groups: home health aides reported the highest levels of burnout, followed by professional care workers, while basic care workers reported the lowest levels. These differences may reflect the particular pressures and isolation often associated with home care, where workers tend to work independently with less structural support.

Figure 251. *Cross-target burnout comparative results*

Physical Exertion Results. This construct refers to the perceived level of physical effort required from care workers during their working hours. In other words, it quantifies the degree of exertion that care workers perceive themselves to be experiencing in relation to the physical demands of their work. This variable was measured using the Borg Rating of Perceived Exertion Scale (RPE) (1970). The scale ranges from 1 (no exertion) to 11 (maximal exertion).

Polish care workers reported moderate levels of perceived physical strain, with an average score of 5.90 on a scale of 1 to 11. However, there were significant differences between professional groups. Home health aides reported the highest levels of exertion, followed by basic care workers, while professional care workers reported the lowest levels. These findings suggest that the physical effort required at work may vary according to the type of care provided and the setting in which it takes place - particularly with home-based roles requiring more physical effort.

Figure 252. *Cross-target physical exertion comparative results*

Turnover Intentions Results. This variable examined the intention or desire of care workers to leave or abandon their role within the care profession. It was measured using the Intention to Quit Questionnaire (ITQ), which was developed by Rahnfeld et al. (2016) and adapted from Price (1997). The ITQ comprises three items (example item 'despite the obligations I have made to my employer, I want to quit my job as soon as possible') that assess workers' intentions to quit their care job. Participants were asked to indicate the frequency of their intention to quit on a five-point Likert scale, with responses ranging from 1 (almost never) to 5 (almost always).

The average turnover intention score for Polish care workers was 2.56 on a scale of 1-5, indicating a moderate level of desire to leave their current job. Although not particularly high, this suggests that a notable proportion of workers may be considering leaving the profession or changing jobs. No significant differences were found between home health aides, basic care workers and professional care workers, suggesting that this feeling is shared across different roles and settings.

Work-Private Life Conflict Results. This construct represents a form of inter-role conflict, characterised by a clash between the risk factors of one's professional role and those of their personal or familial responsibilities. The scale from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version, comprising five items (e.g., 'Do you feel that your work drains so much of your energy that it has a negative effect on your private life?'), was employed to measure the variable. The responses ranged from 1 (never) to 5 (always).

The average score for work-life conflict was 2.58 (SD = 0.81) on a scale of 1 to 5, suggesting that Polish care workers experience a moderate level of conflict between their professional and personal responsibilities. This means that while many manage to balance both domains, some experience difficulties in doing so. No significant differences were observed between home health aides, basic care workers and professional care workers, suggesting a broadly similar experience across groups.

Positive Indicators: Signs of Strength

Work-Private Life Enrichment Results. This variable pertains to a process at the work-private life intersection, in which experience or involvement in one role enhances the quality or performance in the other role. The six-item scale Work-family enrichment, as originally proposed by Carlson et al. (2006) and subsequently abbreviated by Kacmar et al. (2014), was employed to assess the variable in question. Participants were invited to indicate their level of agreement with each item on a five-point Likert scale, with responses ranging from 1 (strongly disagree) to 5 (strongly agree).

The average score for work-life enrichment was 3.58 (SD = 0.66) on a scale of 1 to 5, indicating that Polish care workers generally perceive a positive interaction between their work and personal lives. This means that their experiences in one area often help to enhance or support the other - for example, skills or fulfilment gained at work can benefit their personal life and vice versa. No significant differences were found between the three professional groups, suggesting that this sense of mutual reinforcement is shared across all care settings and levels of qualification.

Happiness results. This construct was designed to assess care workers' general levels of happiness and their attitudes towards their own lives. The variable was assessed using a single item: 'taken everything together, how happy are you with your life?'. Participants were instructed to indicate their level of satisfaction on a scale from 0 (totally unhappy) to 10 (extremely happy).

Care workers in Poland reported moderately high levels of happiness, with an average score of 7.36 on a scale of 0-10. This suggests that, overall, participants felt relatively positive about their lives. There were no significant differences between the groups, suggesting that levels of happiness were similar for home health aides, basic care workers and professional care workers.

Flourishing results. The concept of flourishing can be defined as the combination of subjective and psychological well-being, in which the individual is in a positive emotional state, experiencing feelings of engagement, meaning (or purpose), having personal resources and positive interpersonal relationships. It is measured using a scale comprising eight statements (example items are 'I am optimistic about my future' and 'I lead a purposeful and meaningful life') (Diener et al., 2009), with respondents indicating their level of agreement on a scale from 1 (strongly disagree) to 7 (strongly agree).

The average flourishing score for the Polish care workers was 5.36 (SD = 0.90) on a scale of 1 to 7, reflecting a generally high level of psychological well-being. This suggests that most participants reported feeling that their lives had meaning and purpose, that they had personal strengths, and that they had positive relationships with others. No significant

differences were found between home health aides, basic care workers and professional care workers, suggesting that this sense of well-being was consistent across different care roles and qualifications.

9.2.2. Risk Factors among Care Workers

Drawing on the Job Demands–Resources (JD-R) theory (Bakker & Demerouti, 2011), which serves as the theoretical framework for this research, this section examines key findings related to job demands or risk factors as perceived by care workers.

Table 33. *Job, emotional and relational risk factors*

Risk factors	Target	Mean	S.D.	N
Physical Demands	Target A	3.50	1.23	14
	Target B	2.95	1.59	22
	Target C	3.24	1.39	42
	Mean	**3.21**	**1.42**	**78**
Quantitative Demands	Target A	2.96	0.84	14
	Target B	2.95	0.73	22
	Target C	3.00	0.64	42
	Mean	**2.98**	**0.69**	**78**
Work Pace	Target A	3.38	0.75	14
	Target B	3.56	0.76	22
	Target C	3.56	0.61	42
	Mean	**3.53**	**0.68**	**78**
Tasks Beyond Care Workers' duties	Target A	2.93	0.92	14
	Target B	2.95	1.13	22
	Target C	2.98	1.00	42
	Mean	**2.96**	**1.01**	**78**
Emotional Demands	Target A	3.67	0.52	14
	Target B	3.94	0.83	22
	Target C	4.23	0.49	42
	Mean	**4.05**	**0.64**	**78**
Demands for Hiding Emotions	Target A	4.04	0.59	14
	Target B	4.10	0.69	22
	Target C	4.17	0.65	42
	Mean	**4.13**	**0.65**	**78**
Exposure to Workplace Violence	Target A	1.71	0.73	14
	Target B	2.41	1.14	22
	Target C	2.17	1.01	42
	Mean	**2.15**	**1.02**	**78**
Exposure to Discrimination	Target A	0.21	0.80	14
	Target B	0.23	0.75	22
	Target C	0.21	0.68	42
	Mean	**0.22**	**0.71**	**78**
Intragroup Conflict	Target A	2.21	0.65	14
	Target B	2.55	0.81	22
	Target C	2.93	0.75	42
	Mean	**2.69**	**0.79**	**78**

Continuation Table 33.

Demand	Target	Mean	S.D.	N
Workplace Incivility	Target A	2.09	0.62	14
	Target B	2.32	0.85	22
	Target C	2.49	0.75	42
	Mean	**2.37**	**0.77**	**78**

Job-related Risk Factors

Physical Demands. This variable pertains to the frequency of physical activity that care workers are required to perform in order to fulfil the duties inherent to their role. These activities may include, but are not limited to, walking, lifting, carrying, reaching, pushing and pulling. Participants were asked to respond on a 5-point Likert scale, from 1 (never) to 5 (everyday).

Care workers in Poland reported a moderate frequency of physical demands in their role, with an average score of 3.21 on a five-point scale. This suggests that tasks requiring physical effort - such as lifting, transferring or supporting care receivers - are a regular, although not constant, aspect of their daily work. No significant differences were observed between home health aides, basic care workers and professional care workers, suggesting that these physically demanding tasks are experienced similarly across all care settings and levels of professional qualification.

Quantitative Demands. Defined as the psychological demands that arise from the amount of work that must be completed within a given timeframe. These demands are typically high when the volume of work exceeds the capacity to complete it within the specified period. Four items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were employed to assess the job demand in question. An illustrative item is "Is your workload unevenly distributed so it piles up?". The respondents were asked to respond on a 5-point Likert scale, from 1 (never) to 5 (always).

Polish care workers reported a moderate level of quantitative demands, with an average score of 2.98 on a five-point scale. This reflects the perception that the amount of work expected in a given period of time is manageable for most participants, although it is still a source of pressure. No significant differences were found between home health aides, basic care workers and professional care workers, suggesting that workload expectations are relatively similar across roles and care settings.

Work Pace Demands. The term is defined as the psychological demand associated with the intensity of the work. To assess this job demand, three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were used. An illustrative item is, "Do you work at a high pace throughout the day?" Respondents were asked to indicate

their level of agreement with the item on a 5-point Likert scale, from 1 (never) to 5 (always).

Polish care workers reported moderately high demands on the pace of work, with an average score of 3.53 out of 5. This suggests that many participants experienced their work as requiring sustained intensity and speed. There were no significant differences between home health aides, basic care workers and professional care workers, suggesting that the pressure to work at a fast pace is common across different roles and settings in the care sector.

Tasks Beyond Care Workers' Duties. The variable assessed the frequency of instances over the past year in which care workers were required to perform tasks that were not included in their job description or the care receivers' care plan (question taken from Karlsson et. al. (2020) study, in which 47% of home care aides agreed or strongly agreed with the statement. In our study, the response options were adapted to be coherent with the rest of the survey. They were instructed to indicate their response on a 5-point Likert scale, ranging from 1 (never or almost never) to 5 (a lot of the time).

Polish care workers reported a moderate frequency of being asked to perform tasks beyond their formal care duties, with a mean score of 2.96 (SD = 1.01) on a scale of 1 to 5. This suggests that such requests are not uncommon, but not extremely frequent. No significant differences were found between home health aides, basic care workers and professional care workers, suggesting that this experience is relatively consistent across roles and care settings.

Emotional Risk Factors

Emotional Demands. The construct pertains to the psychological demands that arise from the interpersonal relationships involved in the work, which require care workers to engage in emotionally charged situations. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were employed to assess the aforementioned job demand. An illustrative item is "Do you have to deal with other people's personal problems as part of your work?" The respondents were requested to respond on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

Emotional demands were high across the Polish sample, with an average score of 4.05 out of 5. This suggests that most care workers are frequently faced with emotionally challenging situations in their role. There were significant differences between groups: professional care workers reported the highest emotional demands, followed by basic care workers, while home health aides reported the lowest. Despite these differences, all three groups experienced consistently high levels of emotional distress, reflecting the relational and often emotionally taxing nature of care work across settings.

Figure 253. *Cross-target emotional demands comparative results*

Demands for Hiding Emotions. The variable in question alludes to the psychological demand associated with the necessity of maintaining a neutral demeanour in the face of unpredictable behaviour exhibited by care receivers, colleagues, superiors, family members, and other individuals within the professional setting. Four items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this job demand. An illustrative item is, "Are you required to be kind and open towards everyone – regardless of how they behave towards you?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

Care workers in Poland reported consistently high levels of demands to conceal emotions, with an average score of 4.13 (SD = 0.65) out of 5. This suggests that regardless of the care setting or professional role, workers often feel the need to suppress their emotional responses in order to maintain a neutral or composed demeanour when interacting with care receivers, families or colleagues. No significant differences were found between the groups, suggesting that this need for emotional regulation is a common feature of the profession at all levels of qualification.

Relational Risk Factors

Exposure to Workplace Violence. The variable in question was designed to assess the frequency of instances in which care workers were exposed to violent behaviours or attitudes directed towards them in the workplace. Specifically, respondents were asked to respond to one question - In the last year, how often have you been exposed at work to violence from patients and/or their family members?. The respondents were required to indicate their level of agreement with the statement on a five-point Likert scale, with 1 representing "never" and 5 representing "everyday".

Polish care workers reported occasional exposure to violence in the workplace, with a mean score of 2.15 (SD = 1.02) on a scale of 1 to 5. This suggests that incidents of aggression or hostility from care receivers or their families do occur, although not frequently. No significant differences were observed between home health aides, basic care workers and professional care workers, suggesting that this risk is experienced similarly across different roles and settings within the care sector.

Exposure to Discrimination. This variable assessed the frequency with which care workers had experienced discriminatory behaviour or attitudes that made them feel vulnerable because of their gender, ethnicity or colour in the past year. This was measured on a 4-point scale (0 - never; 1 - once; 2 - two or three times; and 3 - four or more times). The question was adapted from the Experiences of Discrimination Scale (EOD) developed by Williams et al. (1997).

A small number of Polish care workers (7 out of 78 or 9%) reported experiencing discrimination in the past year. Of these, four reported experiencing it two or three times and three reported experiencing it four or more times. The most commonly perceived reasons for this discrimination were related to education or income level, and disability.

Figure 254. *Exposure to discrimination variable results*

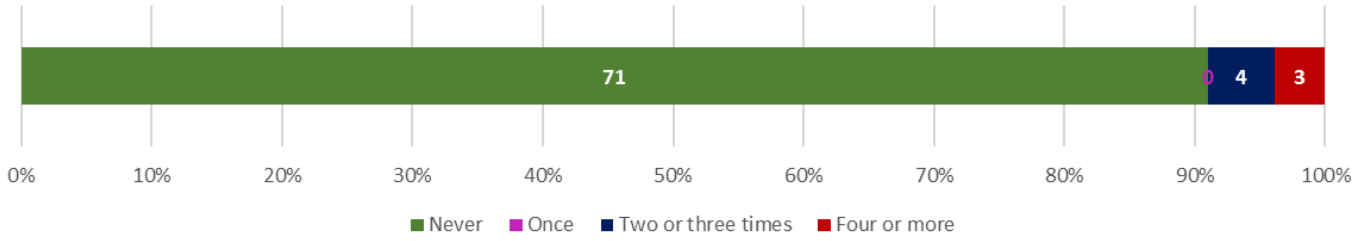
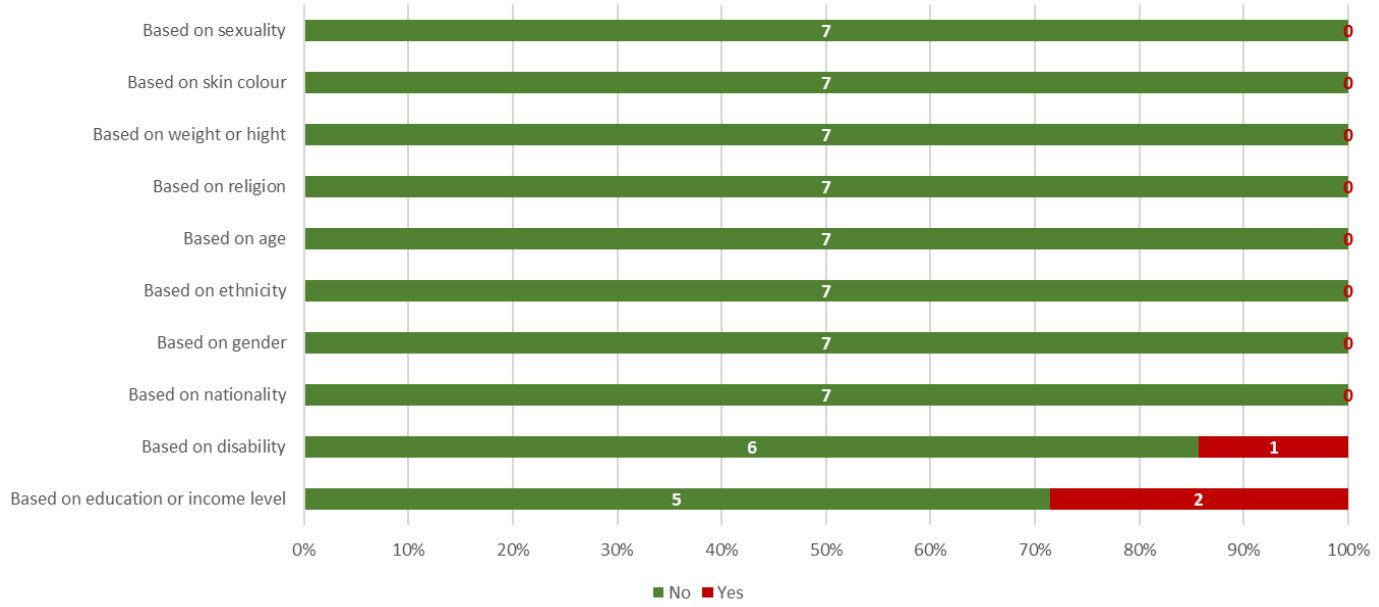


Figure 255. *Perceived motive of discrimination of those who experienced it*



The mean score was low (M = 0.22, SD = 0.71) on a scale of 0 to 3, suggesting overall low reporting. However, this finding should be interpreted with caution. The absence of reported discrimination does not necessarily imply its absence in reality. Low levels of reporting may be influenced by factors such as under-identification, social desirability, or the particular characteristics of the sample - in particular, the fact that all participants were Polish nationals and no migrant workers were represented. This lack of ethnic or linguistic diversity may have reduced the likelihood of discrimination being reported within this particular group. No significant differences were found between home health aides, basic care workers and professional care workers.

Intragroup Conflict. The construct refers to the frequency with which carers experience conflict within a team, with the care receiver, their family members or other people at work, where members clash over work procedures or due to personality clashes. The 8-item scale was adapted from Jehn (1995). Participants were asked to respond on a 5-point Likert scale from 1 (none) to 5 (a lot).

The mean score for intergroup conflict was 2.69 (SD = 0.79) on a scale of 1 to 5, indicating a moderate level of perceived tension or disagreement in workplace relationships. Significant differences were found between the groups: professional care workers reported the highest levels of conflict, basic care workers fell in the middle and home health aides reported the lowest levels. These patterns may reflect the more complex organisational environments in which professional care workers work, where collaboration in multidisciplinary teams is common and expectations may be more demanding. Conversely, Polish home health aides in this sample often work more independently, which may reduce the exposure to interpersonal conflicts.

Figure 256. *Cross-target intragroup conflict comparative results*

Workplace Incivility. The variable is defined as low-intensity deviant behaviour (by care receivers, family members, colleagues, etc.) with ambiguous intent to harm the target (the care worker), in violation of workplace norms of mutual respect. The 4-item scale shortened by Matthews & Ritter (2016) from Cortina et al. (2013) was used to assess this construct. An example item is "In the past year, have you been in a situation where people you interact with at work made jokes at your expense?" Participants were asked to respond on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The average score for workplace incivility among Polish care workers was 2.37 (SD = 0.77) on a scale of 1 to 5, indicating that care workers occasionally experienced low-intensity but disrespectful or inappropriate behaviour in the workplace. These behaviours, which may include rudeness, dismissiveness or violations of norms of mutual respect, were reported at similar levels across all occupational groups. There were no significant differences between home health aides, basic care workers, and professional care workers.

9.2.3. Protective Factors in the Care Sector

This section focuses on the resources available to care workers to help them cope with the demands of their work. As in the previous section, both overall results and comparisons between different target groups are presented.

Table 33. *Job, emotional and relational protective factors*

Protective factors	Target	Mean	S.D.	N
Possibilities for Development	Target A	3.64	0.53	14
	Target B	3.86	0.90	22
	Target C	3.81	0.85	42
	Mean	**3.79**	**0.81**	**78**
Variation of Work	Target A	2.96	0.87	14
	Target B	3.00	1.01	22
	Target C	3.38	0.88	42
	Mean	**3.20**	**0.92**	**78**
Control over Working Time	Target A	2.79	0.79	14
	Target B	2.86	0.55	22
	Target C	2.92	0.67	42
	Mean	**2.88**	**0.65**	**78**
Predictability	Target A	3.07	1.11	14
	Target B	3.30	1.07	22
	Target C	2.94	1.00	42
	Mean	**3.06**	**1.04**	**78**
Autonomy	Target A	2.86	0.53	14
	Target B	2.71	0.56	22
	Target C	2.75	0.80	42
	Mean	**2.76**	**0.69**	**78**
Meaning of Work	Target A	4.32	0.75	14
	Target B	4.50	0.82	22
	Target C	3.96	0.75	42
	Mean	**4.18**	**0.80**	**78**
Recognition	Target A	3.67	0.92	14
	Target B	3.44	1.17	22
	Target C	3.07	0.95	42
	Mean	**3.28**	**1.03**	**78**
Emotional Social Support	Target A	3.16	0.81	14
	Target B	3.03	1.01	22
	Target C	3.04	1.02	42
	Mean	**3.06**	**0.97**	**78**
Instrumental Social Support	Target A	2.46	0.70	14
	Target B	2.52	0.92	22
	Target C	2.71	1.08	42
	Mean	**2.62**	**0.97**	**78**

Job-related Protective Factors

Possibilities for Development. The variable in question refers to the extent to which job performance provides opportunities for care workers to put their knowledge, skills and experience into practice and to acquire new knowledge, skills and experience. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. An illustrative item is "Do you have the possibility of learning new things through your work?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

Polish care workers reported generally positive perceptions of their opportunities for professional growth and skills development. With a mean score of 3.79 (SD = 0.81) on a scale of 1 to 5, most participants felt that they had frequent opportunities to apply their knowledge and learn new skills in the workplace. There were no significant differences between home health aides, basic care workers and professional care workers, suggesting that access to development opportunities was perceived to be fairly consistent across care settings and qualification levels.

Variation of Work. The construct refers to whether care work tasks are repetitive or, on the contrary, diverse or varied. Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. An illustrative item is "Do you have to do the same thing over and over again?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The mean score for task variety was 3.20 (SD = 0.92), suggesting that care workers experienced a moderate level of variation in their daily tasks, with some experiencing repetitive work and others having more varied tasks. No significant differences were observed between the target groups, suggesting a broadly shared experience across care settings and levels of qualification.

Control over Working Time. The construct refers to care workers'' control over their working time in aspects such as starting and ending the working day, when to take breaks, days off, holidays, and control over whether, when and how much overtime to work. 5 items from the long version of the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) were selected to assess this resource. An illustrative item is "Can you decide when to take a break?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

Participants reported a mean score of 2.88 (SD = 0.65) for control over working time, reflecting a moderate degree of control over work schedules, including start and end times, breaks, and time off. No significant differences were found between the target groups, suggesting that this level of control was experienced similarly across roles.

Predictability. Work is predictable if the worker has adequate, sufficient and timely information to be able to perform the job correctly and to adapt to changes (future restructuring, new technologies, new tasks, new methods and the like). Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected for the assessment of this resource. One illustrative item is, "Do you receive all the information you need in order to do your work well?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The mean score for predictability was 3.06 (SD = 1.04), suggesting that workers felt moderately well informed about their tasks and potential changes at work. No significant differences were observed between the target groups, suggesting similar levels across care settings.

Autonomy. The construct refers to the degree of influence or decision latitude that the care worker has in the day-to-day activities, particularly in relation to the tasks to be carried out and the manner in which they are to be carried out. The three-item scale from Bakker and Bal (2010), adapted from Karasek et al. (1985), was used to quantify this resource. An illustrative item is "I have a lot of freedom in the execution of my work". The responses ranged from 1 (strongly disagree) to 4 (strongly agree).

The mean score for autonomy was 2.76 (SD = 0.69) on a scale of 1 to 5, reflecting a moderate degree of freedom for care workers to make decisions about how to carry out their daily tasks. This suggests that while there is some degree of discretion, workers may still face constraints in shaping their routines or approaches. No significant differences were observed between the target groups, suggesting that experiences of autonomy were consistent between home health aides, basic care workers and professional care workers.

Emotional Protective Factors

Meaning of Work. The variable is defined as the relationship that work has to values other than those associated with having a job and earning an income. These include the utility, importance or social value, or learning involved. Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected for the assessment of this resource. One illustrative item is, "Are you required to be kind and open towards everyone – regardless of how they behave towards you?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

Care workers rated the meaningfulness of their work at an average of 4.18 (SD = 0.80), indicating a strong perception that their work had a sense of personal and social value. No significant differences were found between the groups, suggesting that this sense of meaning was experienced consistently across all roles.

Relational Protective Factors

Recognition. The term denotes the appreciation, respect and fair treatment afforded to care workers by their supervisors in the workplace. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. One illustrative item is, "Is your work recognised and appreciated by the management/supervisor?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

Participants reported a mean score of 3.28 (SD = 1.03) for recognition, indicating that they felt moderately valued and treated fairly by their supervisors. No significant differences were found between the groups, suggesting a common experience of supervisor recognition across all roles.

Social Support. The variable can be defined as the degree to which care workers receive emotional and instrumental (help with job tasks) support from the individuals with whom they interact at their place of work. The 8-item scale was adapted from that used by Peeters et al. (1995) for the purpose of measuring this resource. An example item is, "The people you interact with at work showed that they appreciated the way you do your work". The responses were measured on a scale ranging from 1 (not at all) to 5 (a lot).

Care workers reported a mean score of 3.06 (SD = 0.97) for emotional support, indicating a moderate level of perceived encouragement, empathy and understanding from people in their work environment. In contrast, instrumental support - referring to practical help with tasks - was rated slightly lower at 2.62 (SD = 0.97), suggesting that help with work tasks was somewhat less available. No significant differences were found between the target groups, suggesting that both emotional and instrumental support was experienced similarly by home health aides, basic care workers and professional care workers.

9.2.4. Summary: Main Differences Across Targets in Poland

Table 34. *Summary of prevalence results in Poland*

Dimension		Variable	Overall level	Cross-target differences
Well-being indicators	***Negative well-being indicators***	Burnout (Disengagement and Exhaustion)	Moderate-High	A > C > B
		Physical Exertion	Moderate	A > B > C
		Turnover Intentions	Moderate	No differences
		Work–Private Life Conflict	Moderate	No differences
	Positive well-being indicators	Work–Private Life Enrichment	Moderate-High	No differences
		Happiness	High	No differences
		Flourishing	High	No differences
Risk factors	***Job-related risk factors***	Physical Demands	Moderate	No differences
		Quantitative Demands	Moderate	No differences
		Work Pace Demands	Moderate-High	No differences
		Tasks Beyond Job Duties	Moderate	No differences
	Emotional risk factors	Emotional Demands	High	C > B > A
		Demands for Hiding Emotions	High	No differences
	Relational risk factors	Exposure to Workplace Violence	Low	No differences
		Exposure to Discrimination	Low	No differences
		Intragroup Conflict	Moderate	C > B > A
		Workplace Incivility	Low-Moderate	No differences
Protective factors	***Job protective factors***	Possibilities for Development	High	No differences
		Variation of Work	Moderate	No differences
		Control Over Time	Moderate	No differences
		Predictability	Moderate	No differences
		Autonomy	Moderate	No differences
	Emotional protective factors	Meaning of Work	High	No differences
	Relational protective factors	Recognition	Moderate	No differences
		Emotional Support	Moderate	No differences
		Instrumental Support	Low-Moderate	No differences

Note: Consider the sample sizes for each group (14 home health aides - A; 22 basic care workers - B; and 42 professional care workers - C)

The findings from the Polish sample paint a picture of care work that is both rewarding and demanding. Most care workers reported high levels of happiness and psychological well-being, and generally felt that their work was meaningful. Many also described positive interactions between their professional and personal lives, suggesting that care work often enriches their personal life and vice versa.

Nevertheless, there were signs of strain. Levels of burnout were moderate overall, but significantly higher among home health aides, who also reported the highest levels of physical strain. This may reflect the more solitary and physically demanding nature of home care settings. Emotional demands were consistently high across all groups, with professional care workers reporting the highest levels. In addition, all workers often felt the need to hide their emotions in order to remain calm in emotionally charged situations.

In terms of protective factors, most workers felt they had good opportunities for professional development and reported a moderate degree of autonomy in the way they carried out their tasks. Emotional support was generally available, but instrumental support - help with the practical aspects of the job - was perceived as less present. While autonomy and control over working time were not particularly low, neither were they particularly high, indicating a moderate degree of decision latitude. Similarly, recognition and predictability were rated in the intermediate levels, with some workers feeling adequately recognised and kept informed and others less so.

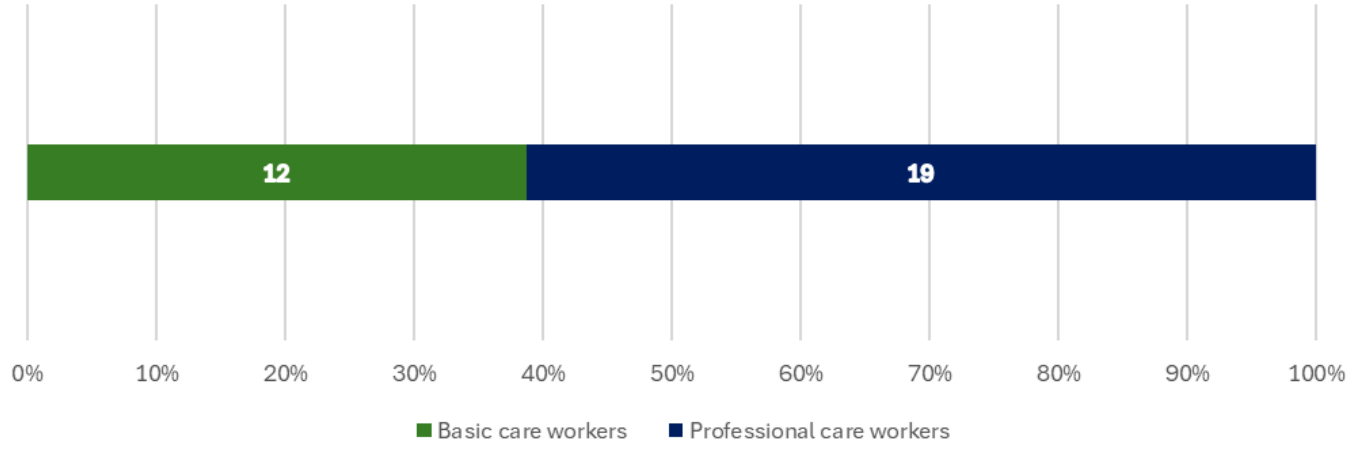
In summary, Polish care workers appear to find personal fulfilment and meaning in their role, despite the significant emotional and physical demands they face. The findings point to the need for better practical support and work flexibility, as well as attention to the specific pressures faced in home-based versus institutional care. Recognising these differences is key to promoting wellbeing and sustainability in the sector.

Chapter 10. Qualitative Data Set: Making Sense of the Findings Through Workers' Voices

10.1. Profile of the Care Workforce: Focus Group Sample

A total of 31 care workers from Poland participated in the study, 12 (38.7%) from Target B (in green, basic care workers) and 19 (61.3%) from Target C.

Figure 257. *Participants per target group*



The average age of the Polish participants was 40.38 years and the majority were women (96.7%). Among age groups 29% were younger adults, 48.4% were adults, 19.3% were middle-aged adults and 3.3% were older adults.

Figure 258. *Age groups*

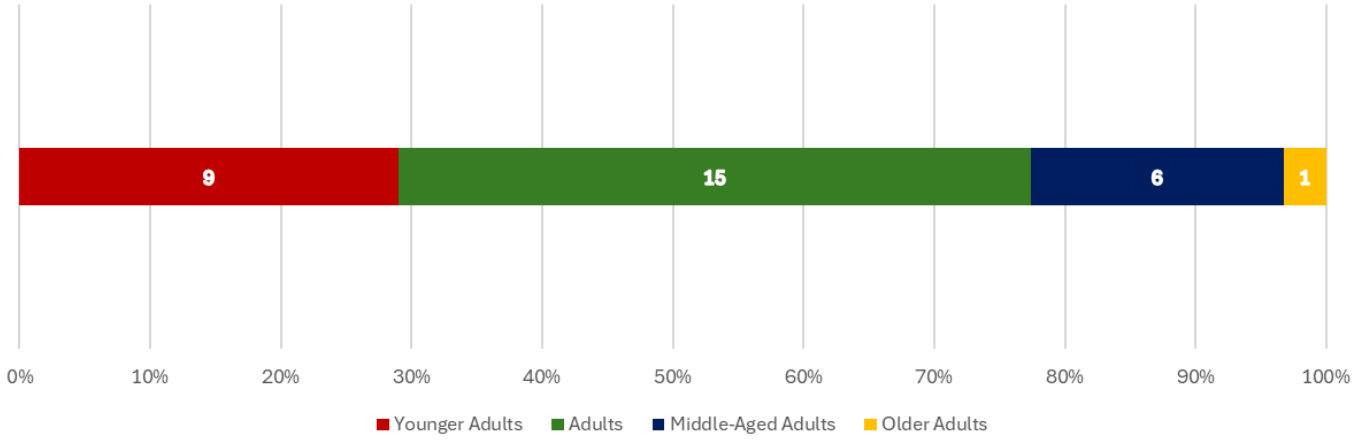
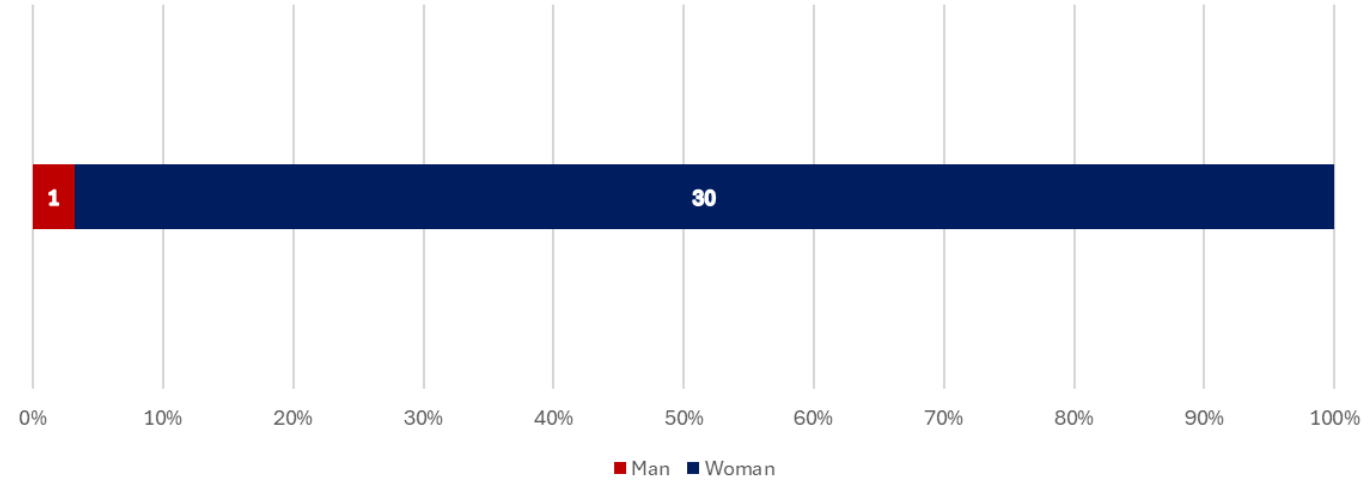


Figure 259. *Gender*



All participants were born in Poland and went to university. Polish workers report the largest level of university attendance.

10.2 Focus Group Findings: Understanding Pressures and Supports Across Worker Groups

The qualitative results are presented by the target group. Within each group, risk factors (demands) and protective factors (resources) have been identified. Three domains have been differentiated for both: job, relational (where applicable) and personal. The most salient codes are highlighted to ensure consistency with the quantitative results and clarify subjective experiences. Each domain is depicted using a Sankey diagram indicating code frequencies.

Table 35. *Polish focus groups index*

Name of FG	Target		N	Gender		Age average	Country of origin	Modality
				F	M			
FG 1 PL C	C		3	3	0	36	Poland	Online
FG 2 PL BC	B (3)	C (3)	6	6	0	39.83	Poland	Face-to-face
FG 3 PL BC	B (3)	C (4)	7	7	0	40.28	Poland	Face-to-face
FG 4 PL BC	B (4)	C (3)	7	7	0	43	Poland	Face-to-face
FG 5 PL BC	B (2)	C (6)	8	7	1	45.12	Poland	Face-to-face

10.2.1. Institutional Care: Risk and Protective Factors

This part encompasses a mixed target: Basic care workers (target B: nursing and care staff who work in hospitals, retirement homes, nursing homes or day care centres and who have been trained in at least one short course) and Professional care workers (target C: specialists in the nursing or healthcare sector with vocational training or a Bachelor's degree).

Risk Factors

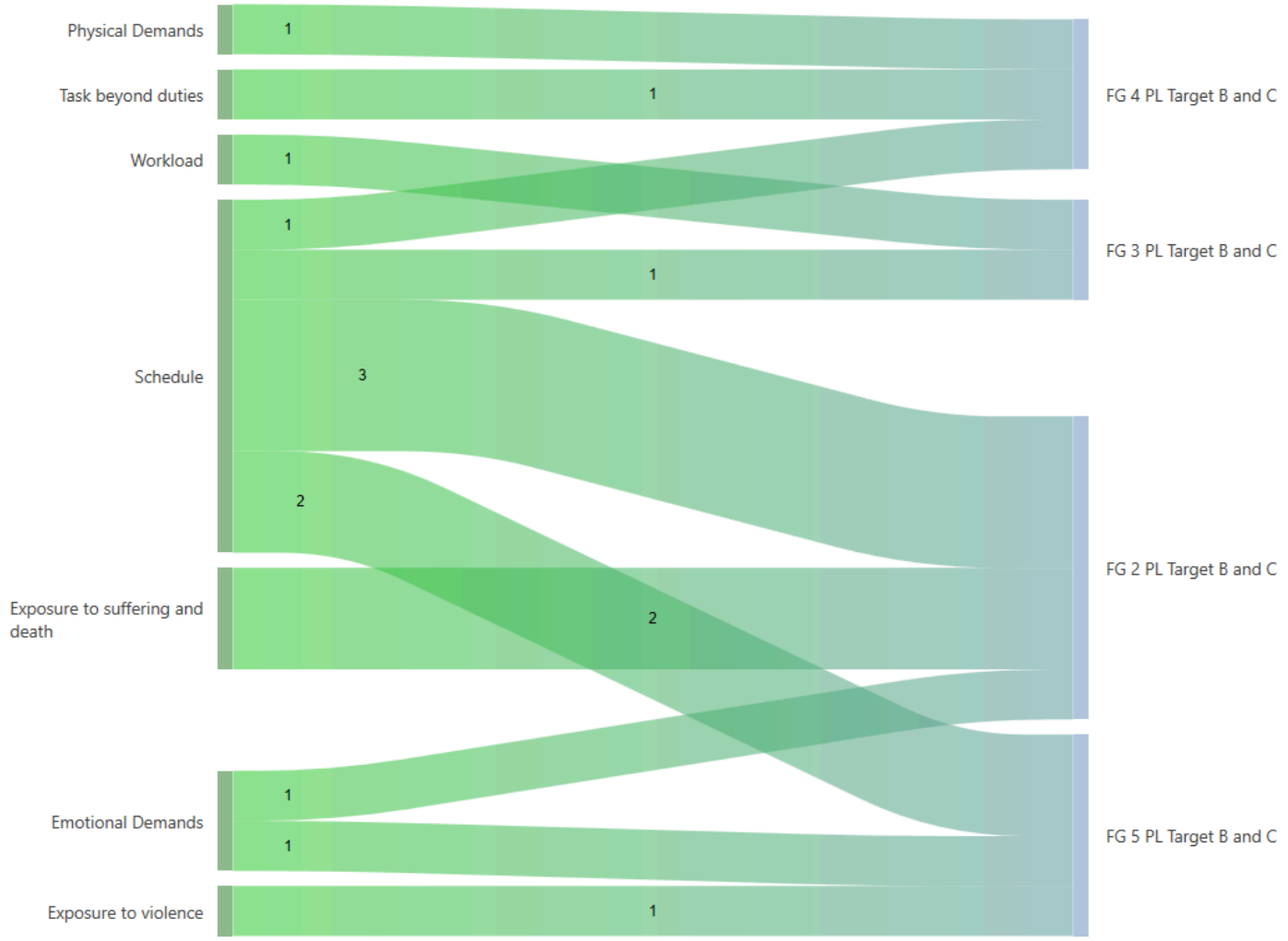
Job-related Risk Factors

This diagram highlights tasks beyond duties as the most prominent job-related risk, represented by the thickest flow across multiple focus groups (*FG1 PL Target B*, *FG3 PL Target C*). The code reflects that Polish care workers frequently perform tasks outside their official scope, often due to staff shortages and unclear division of responsibilities.

Medium-width flows correspond to workload, schedule, and role ambiguity, all of which are closely interlinked. These themes reveal that inadequate planning, excessive responsibilities, and the lack of clearly defined job roles lead to confusion and time pressure. Organisation of work and scope mismatch appear as thinner flows, indicating less frequent but relevant mentions of disorganisation and overlapping duties.

Overall, the diagram shows that Polish care workers operate within a context of structural overload and role confusion, where performing beyond one’s duties has become normalised and directly contributes to exhaustion and dissatisfaction.

Figure 260. *Job-related risk factors among basic and professional care workers group in Poland*



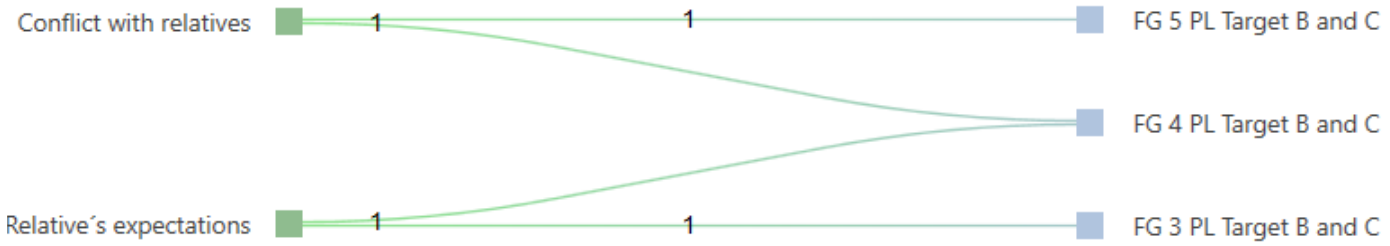
Relational Risk Factors

This diagram presents relational tensions experienced in the Polish care sector. The thickest flow corresponds to conflict with coworkers, highlighting intra-team difficulties such as poor communication, uneven task distribution, and competition within care institutions.

Thinner flows link to conflict with relatives and expectations from family members, suggesting that although external relational issues exist, they are secondary to internal team dynamics.

The overall structure indicates that workplace relationships—particularly those among colleagues—represent the main relational challenge, with team conflict undermining cooperation and emotional well-being.

Figure 261. *Relational risk factors among basic and professional care workers group in Poland*

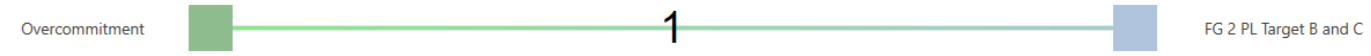


Personal Risk Factors

This diagram shows overcommitment as the main personal risk factor. The thickest flow, present in *FG2 PL Target B*, indicates that excessive emotional and physical dedication to work is a recurring issue. Workers often describe difficulty in separating personal life from professional obligations, leading to mental exhaustion.

Thinner flows correspond to emotional exhaustion and lack of self-care, which appear as complementary risks. Together, these elements reveal that Polish care workers frequently experience psychological overinvolvement in caregiving, which undermines their capacity to recover and maintain emotional balance.

Figure 262. *Personal risk factors among basic and professional care workers group in Poland*



Protective Factors

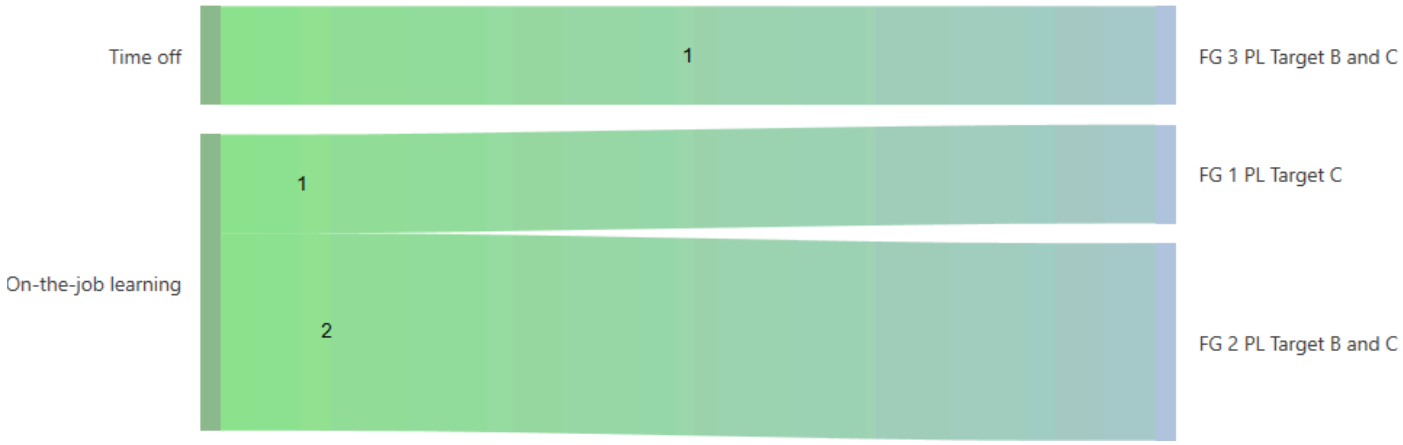
Job-related Protective Factors

The job-related protective factors diagram highlights on-the-job learning and possibilities for development as the most prominent themes. The thickest flows, visible across *FG1 PL Target B* and *FG3 PL Target C*, represent workers' emphasis on training opportunities and professional improvement—both formal and informal—as essential resources for coping with the demands of care work.

Medium-width flows correspond to organisation of work and supervisor support, indicating that clear structures and supportive management enhance stability and confidence. Thinner flows for workplace ergonomics show the value of physical resources and equipment, though mentioned less frequently.

Overall, the figure demonstrates that professional development and well-structured organisation are viewed as the main institutional buffers that sustain motivation and reduce stress among Polish care workers.

Figure 263. *Job-related protective factors among basic and professional care workers group in Poland*



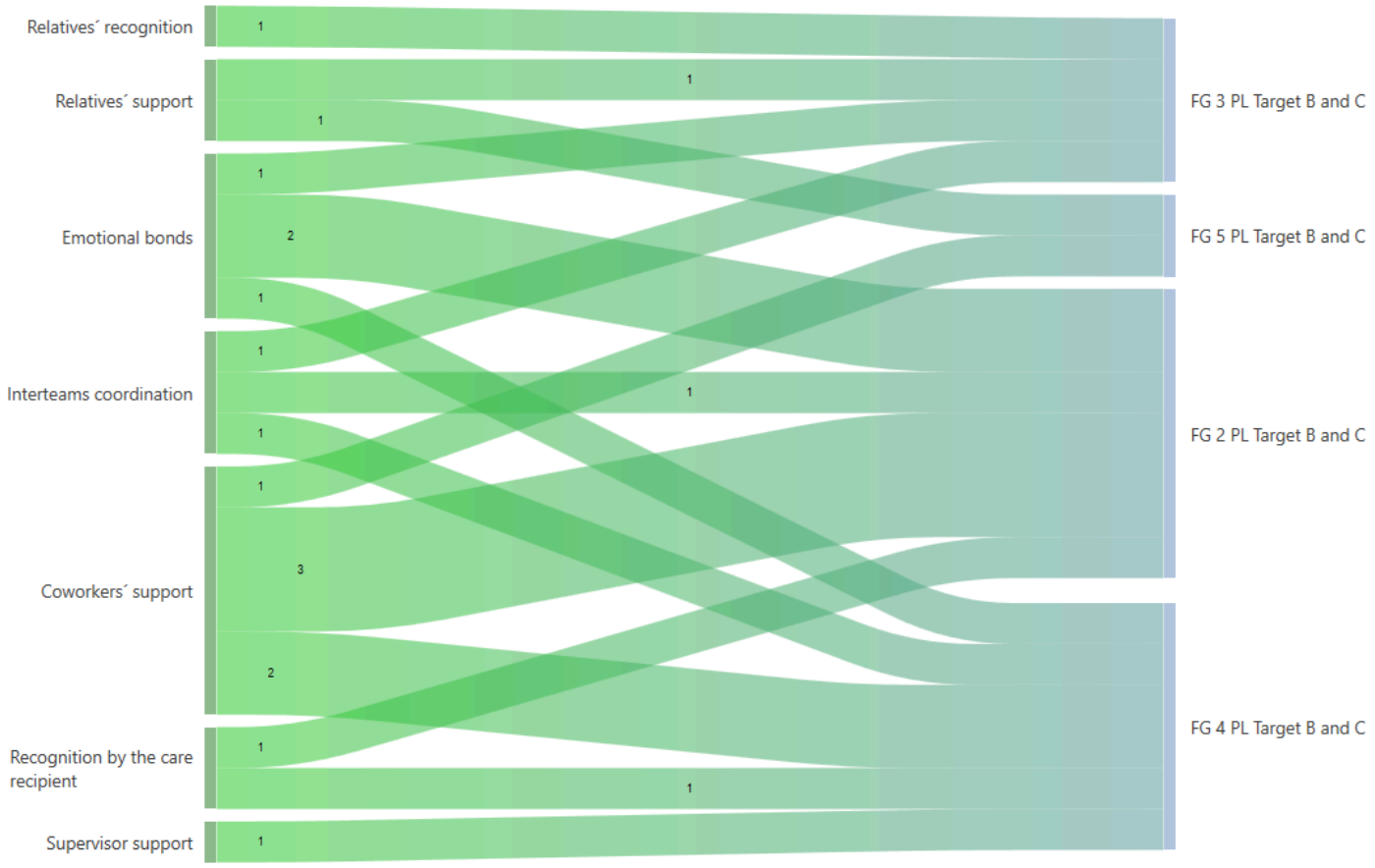
Relational Protective Factors

This diagram visualises the interpersonal and organisational dimensions of support. The thickest flows correspond to coworkers' support and interteams coordination, showing that solidarity and collaboration between colleagues are the core relational protective factors. These themes appear consistently across *FG2 PL Target B* and *FG3 PL Target C*, underscoring the importance of teamwork in mitigating stress.

Medium-width flows for emotional bonds and recognition by the care receivers indicate that emotional closeness and appreciation from beneficiaries also reinforce workers' morale. Thinner flows for supervisor support suggest that managerial involvement, though less frequent, is a valued form of guidance.

In summary, this diagram reveals that Polish care workers rely primarily on peer collaboration and coordinated teamwork, supported by emotional connection and recognition from the people they care for.

Figure 264. *Relational protective factors among basic and professional care workers group in Poland*



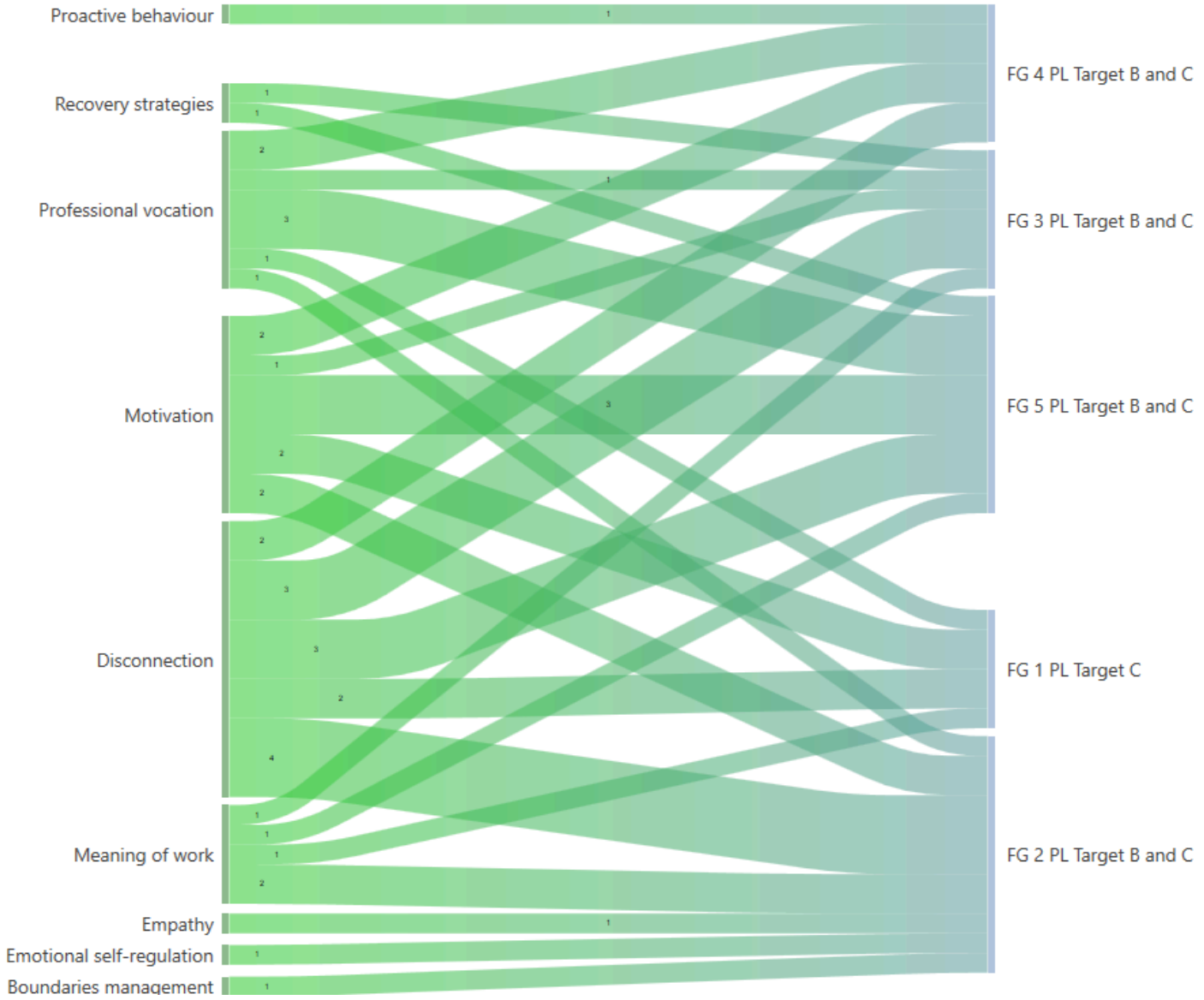
Personal Protective Factors

This diagram presents the personal and psychological resources that sustain workers' engagement. The thickest flows correspond to motivation, professional vocation, and meaning of work, showing that intrinsic purpose and moral commitment are the strongest sources of resilience.

Medium-width flows for disconnection and recovery strategies indicate the recognition of self-care and mental rest as necessary for maintaining long-term engagement. Thinner flows for autonomy, coping strategies, and emotional regulation highlight the workers' ability to adapt and manage stress.

Overall, this figure shows that Polish care workers draw on internal motivation and ethical values, complemented by self-care practices that allow them to reset and preserve emotional stability.

Figure 265. *Personal protective factors among home care workers group in Poland*



Polish care workers operate under high structural and emotional pressure, yet exhibit significant resilience grounded in moral commitment, learning orientation, and collective support. The Sankey diagrams collectively portray a profession that, despite systemic challenges, maintains balance and purpose through intrinsic engagement and interpersonal cooperation

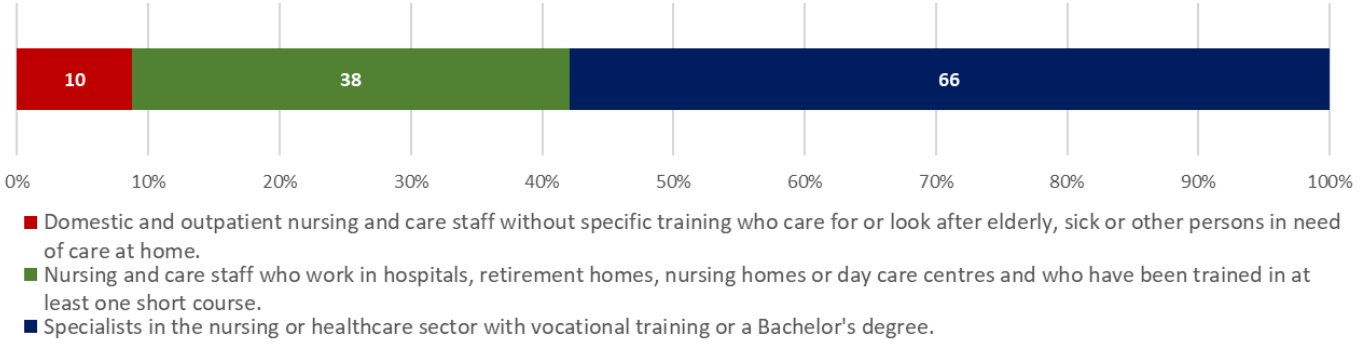
PART 6. CARE WORKERS IN SWEDEN

Chapter 11. Quantitative Data Set: What the Surveys Revealed About Care Work in Sweden

11.1. Profile of the Care Workforce Sample

A total of 114 care workers from Sweden participated in the study, including 10 from target A (home health aides, marked in red), 38 from target B (basic care workers, marked in green), and 66 from target C (professional care workers, marked in dark blue). The mean age of participants was 48.75 years (SD = 11.89; see Figure 266 for the age distribution). Slightly more than half were men (52.6%), and 64.9% were married or in a civil partnership. The majority of participants worked in urban areas (81.6%).

Figure 266. *Participants per target group*



The sample included a majority of Swedish nationals (97.4%), alongside participants born in other countries, including Nordic neighbors such as Finland and Norway, as well as EU countries (Poland, Latvia), Middle Eastern countries (Kurdistan, Lebanon, Syria), and East and Southeast Asian countries (Japan, Indonesia).

Figure 267. *Age groups*

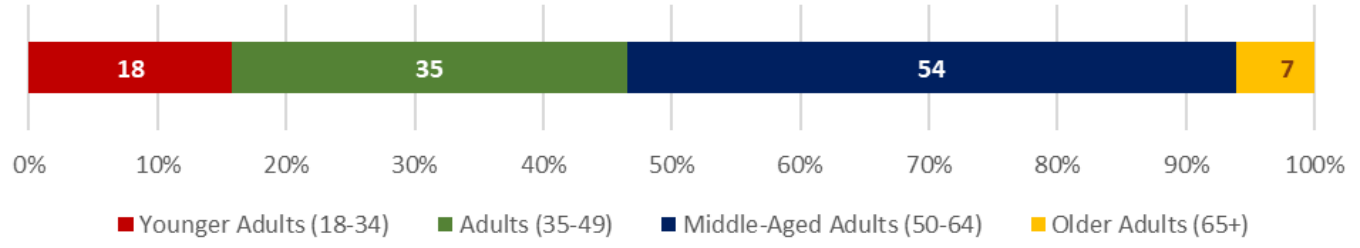


Figure 268. *Gender*

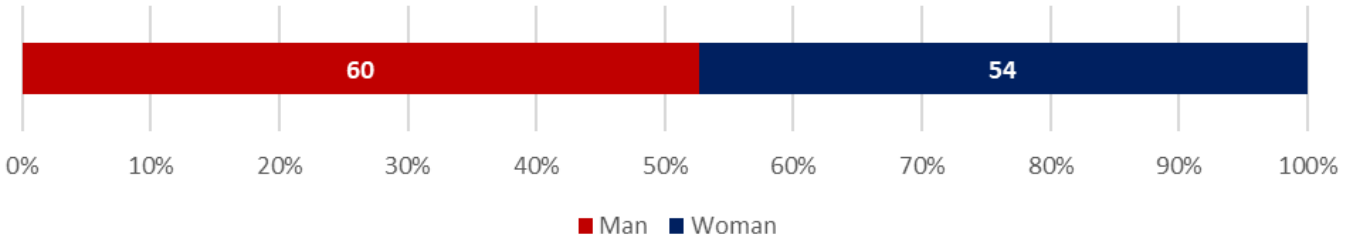


Figure 269. *Marital status*

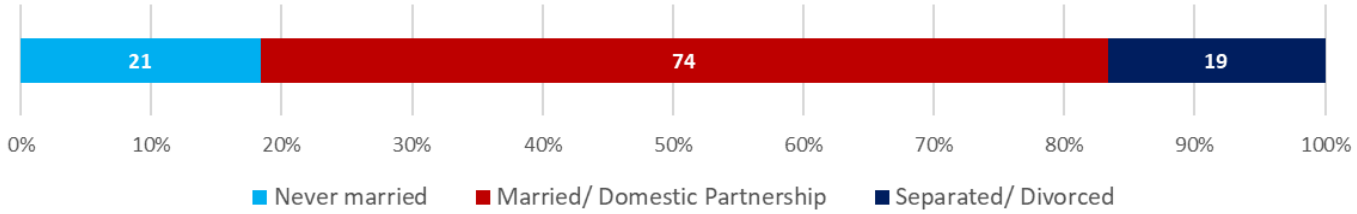


Table 36. *Descriptive statistics of the quantitative variables*

	N	Min	Max	Mean	SD
Age	114	21	67	48.75	11.89
Tenure in months	114	1	564	234.27	156.32
Monthly wages all participants	100	0	7793.58	2635.46	1187.44
Monthly wages in Institutionalised care	81	0	7793.58	2679.93	1278.49
Monthly wages in home based care	19	1359.35	3624.92	2445.87	666.04
Hours worked in a week	114	3	160	37.36	13.35
Number of home care receivers in a week (HCWs)	23	1	110	27.78	25.35
Duration of stay (days in a week for live-in HCWs)	2	0	7	3.50	4.95
Months of residence (migrant workers)	11	252	720	394.18	132.80
Knowledge of benefits (out of 9)	114	0	9	3.01	1.69
Use of benefits (out of 9)	114	0	6	1.03	1.32

Figure 270. *Area of work*

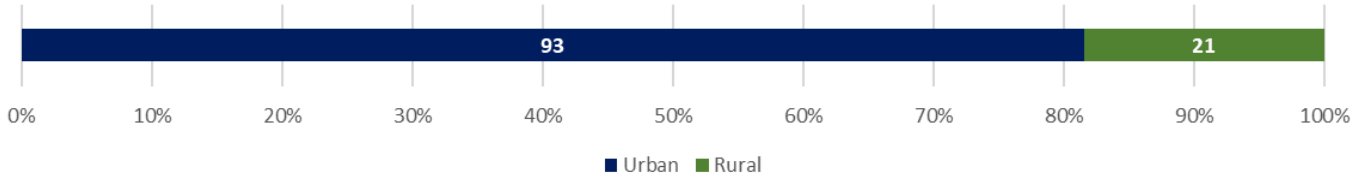


Figure 271. *Nationality*

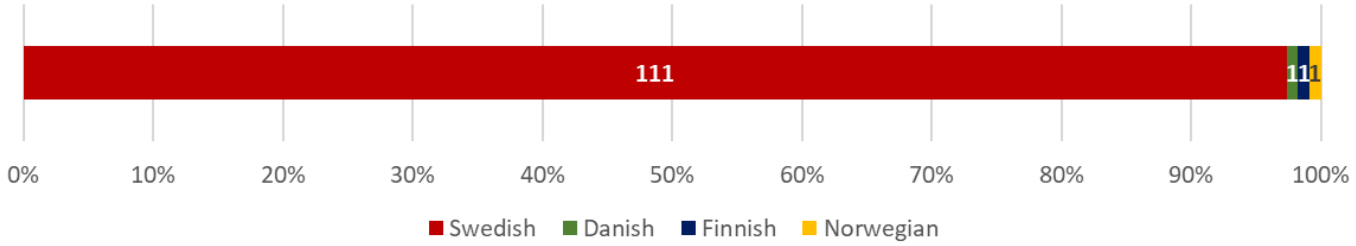
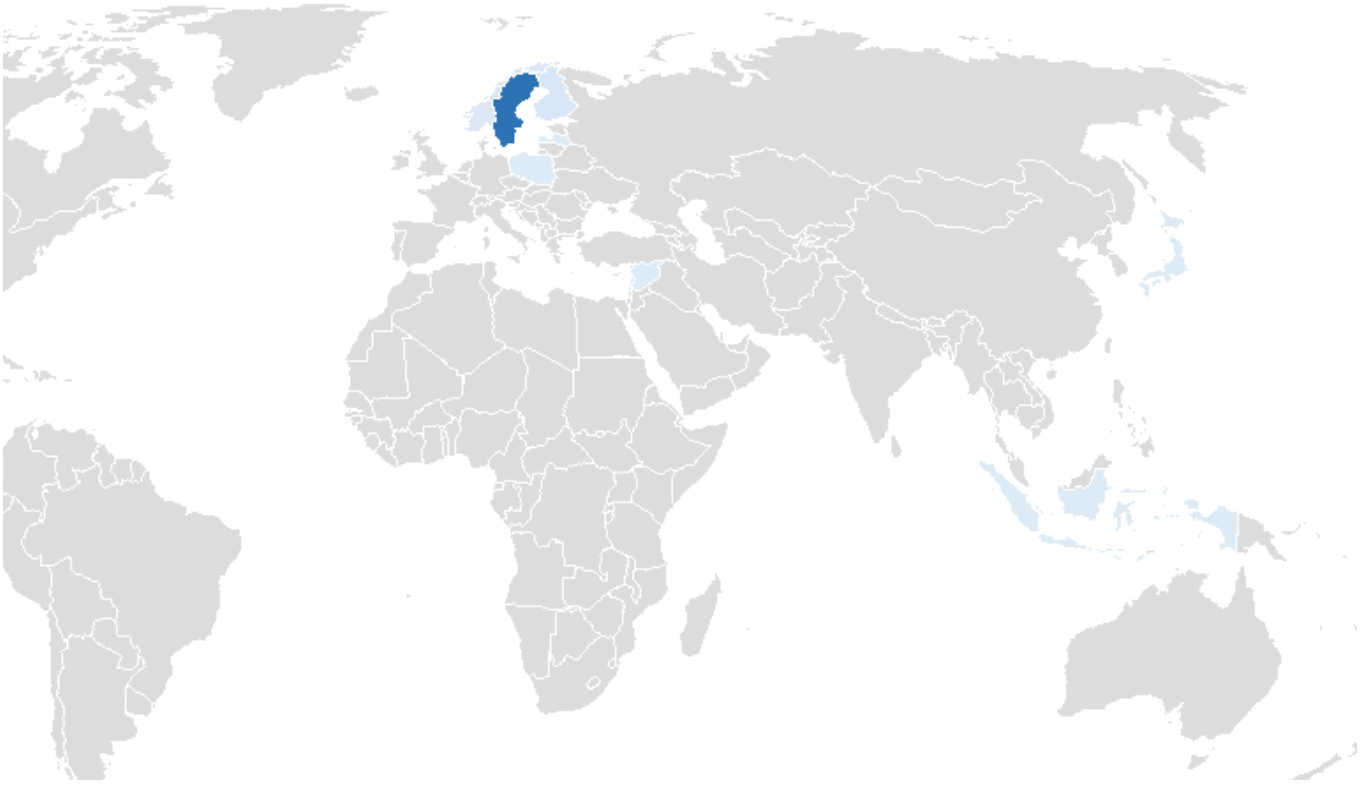


Figure 272. *Country of origin*



In terms of education, 70.2% had completed three or more years of post-compulsory education, 18.4% had completed up to two years, 7.9% had finished secondary education, and 3.5% had completed only primary education. Notably, no participants indicated having received no formal education. Most participants (85.1%) had received formal education or training specifically related to care services.

Workplace safety training was reportedly provided by the current employer for 65.8% of participants. An additional 21.1% had received such training in a previous role or on their own initiative, while 13.2% had never received workplace safety training. Participants had an average tenure of approximately 19 years in the care sector (Mean = 234.27 months; SD = 156.32).

Figure 273. *Educational status*

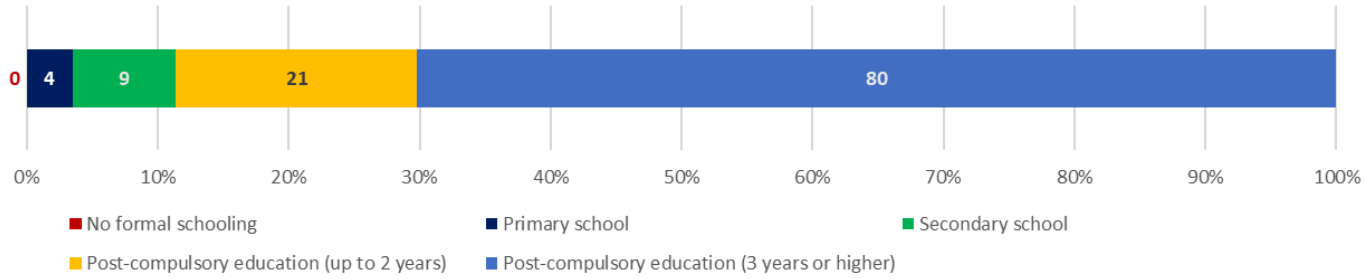


Figure 274. *Formal education in care services*

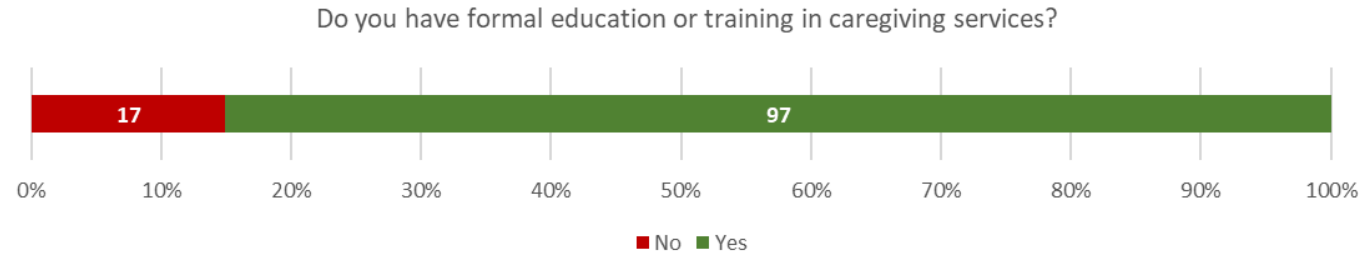
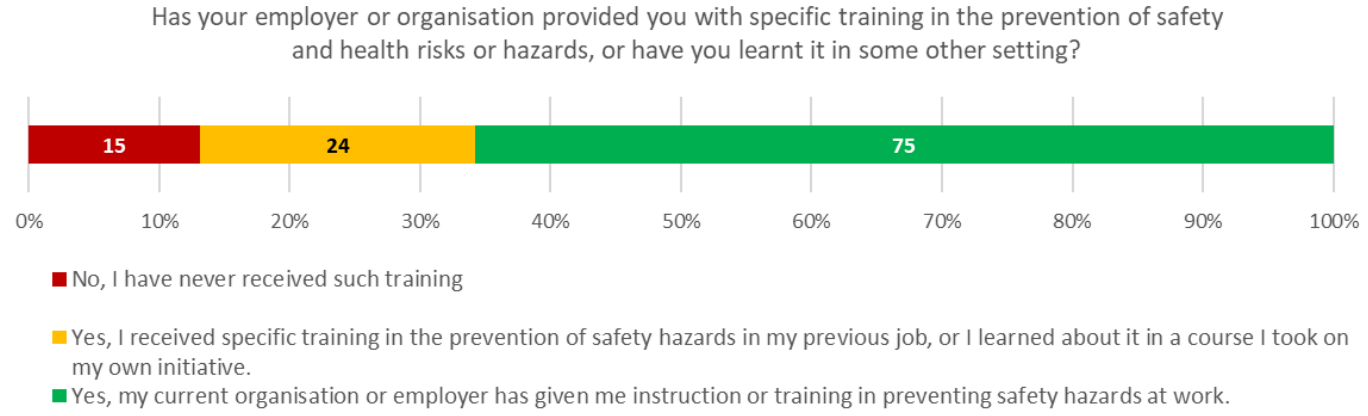
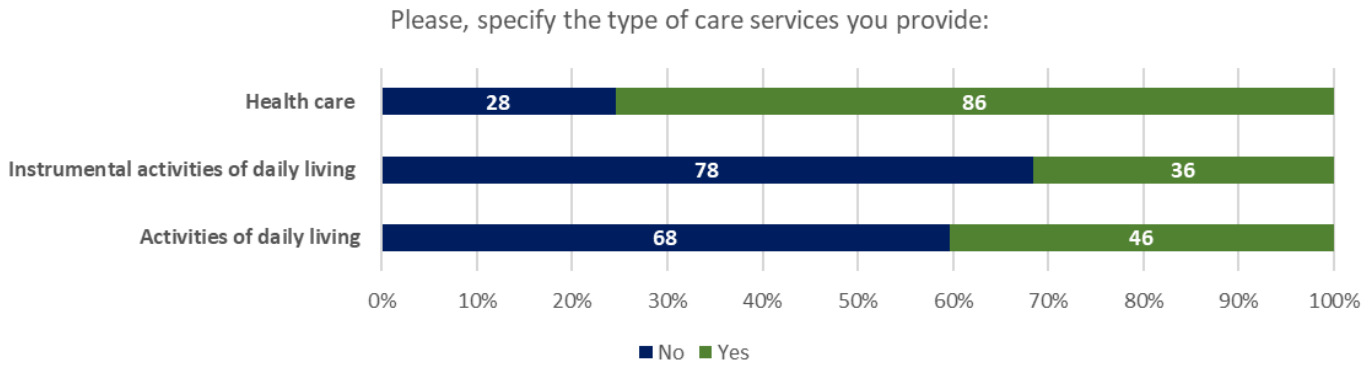


Figure 275. *Safety hazards training*



Most participants reported providing healthcare tasks (75.4%), while also performing activities of daily living (ADLs) (40.4%) and instrumental activities of daily living (IADLs) (31.6%). However, substantial proportions of participants had not received training in certain care areas: 69.3% had not received training in IADLs and 53.5% in ADLs. In contrast, 78.1% had received training in healthcare tasks, and 56.1% had received training tailored to the specific health conditions or diagnoses of their care receivers. This training is particularly important, as most care workers support care receivers with a range of specific conditions (78.1%), including mobility problems (67.5%), physical health conditions (69.3%), behavioural or psychiatric disorders (68.4%), obesity (67.5%), and infectious diseases (32.5%).

Figure 276. *Type of care tasks they perform*



Note: **Activities of daily living or ADL** (dressing, toileting, mobility, bowel and bladder management, sleep time regulation, feeding, transferring from one position to another, personal hygiene, walking, caring for pets, personal care bathing, eating, toilet hygiene, grooming, ambulating, companionship and socialisation).
Instrumental activities of daily living or IADL (using the phone, shopping for groceries, managing medication, preparing meals, doing laundry, housekeeping, managing finances, assistance with using transportation).
Health services (nursing, auxiliary services, wound care, infusion therapy, physical or cognitive rehabilitation, injections, diagnostic services, prescriptions, treatment of injuries or illnesses, occupational therapy, hospice care, therapists and social workers.

Figure 277. *Type of formal education in care services*

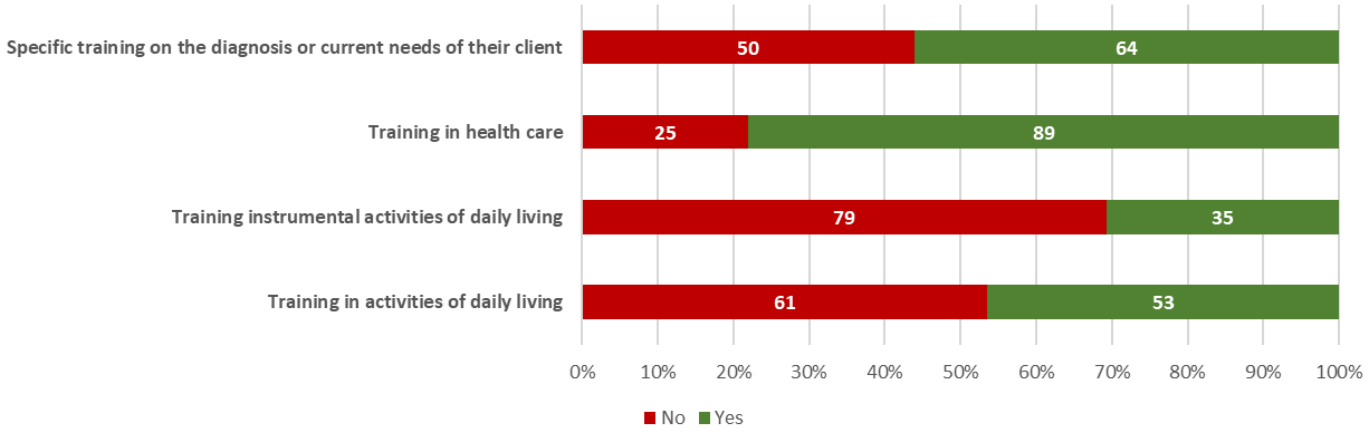
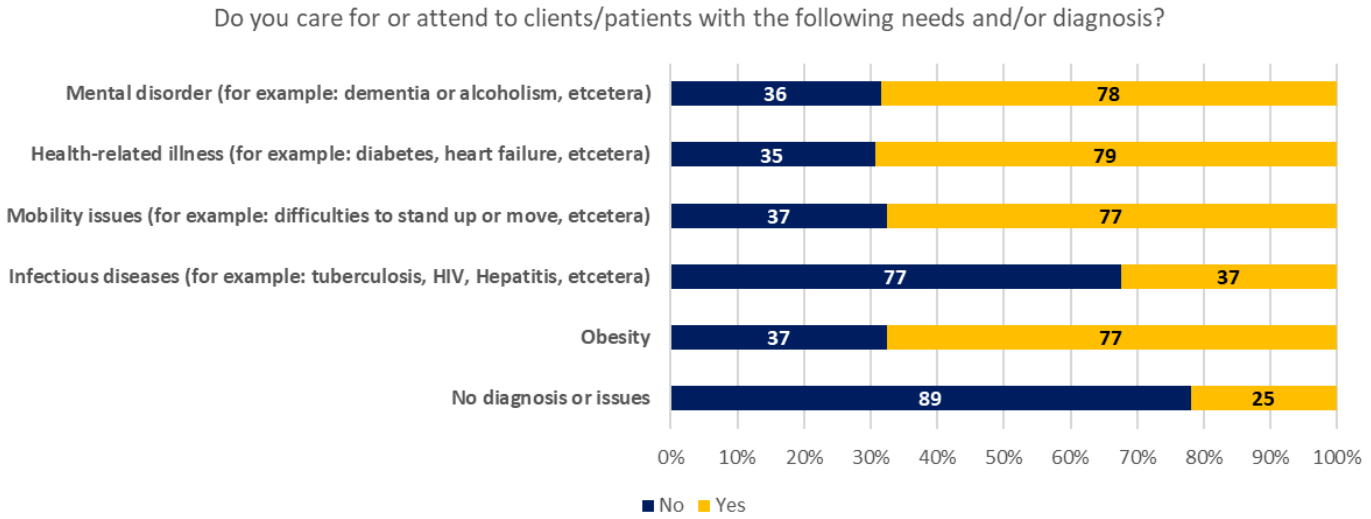


Figure 278. *Type of medical condition of the person receiving care*



Supervision was common, with 58.8% of participants reporting that they received some form of oversight during their shifts.Despite this, 15.8% of participants worked alone, whereas 84.2% worked in teams. The majority were employed in the public or non-profit sector (78.9%), while 20.2% worked in the private or for-profit sector, and 1.8% were self-employed. The majority of participants (62.3%) reported being members of a trade union or a similar professional association.

Regarding employment conditions, most participants were employed full-time (75.4%), with smaller proportions working part-time (13.2%) or on an hourly basis (11.4%). Permanent contracts were the most common (86%), followed by temporary contracts (10.5%) and informal or no contracts (3.5%). Work schedules were predominantly fixed (63.2%), with 25.4% reporting flexible hours and 11.4% working shifts.

Figure 279. *Supervision*

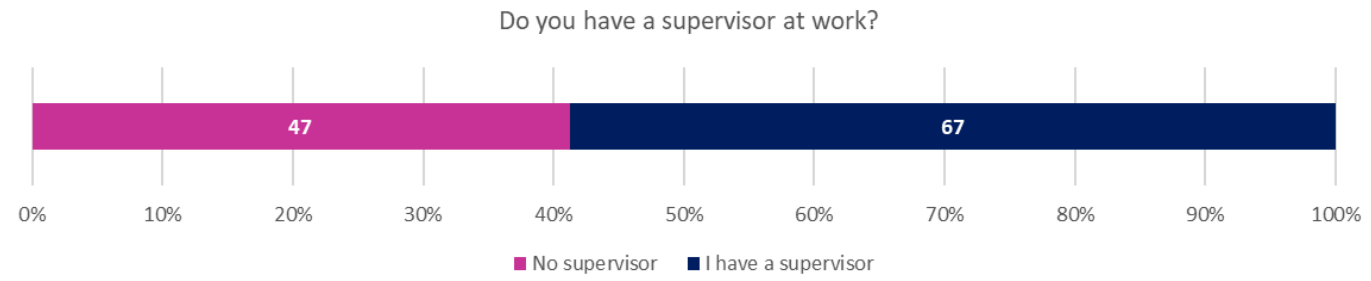


Figure 280. *Teamwork*

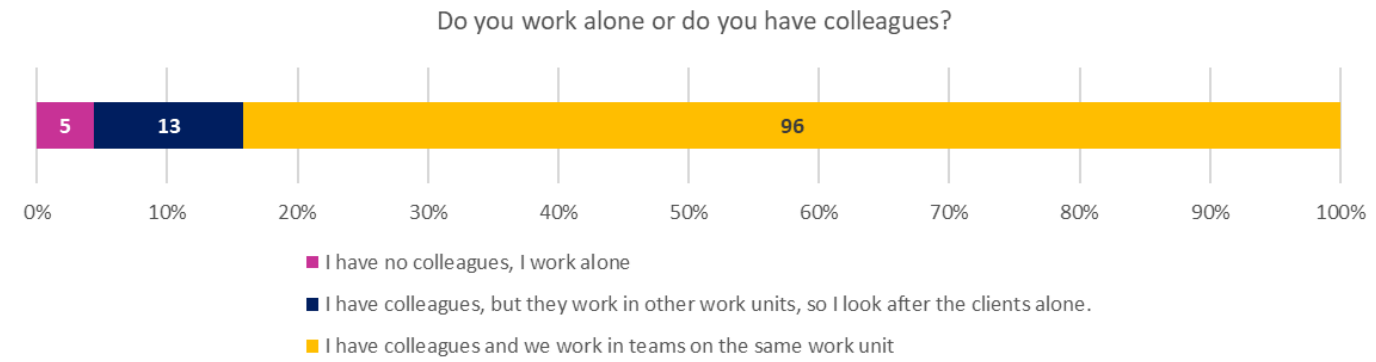


Figure 281. *Employment status*

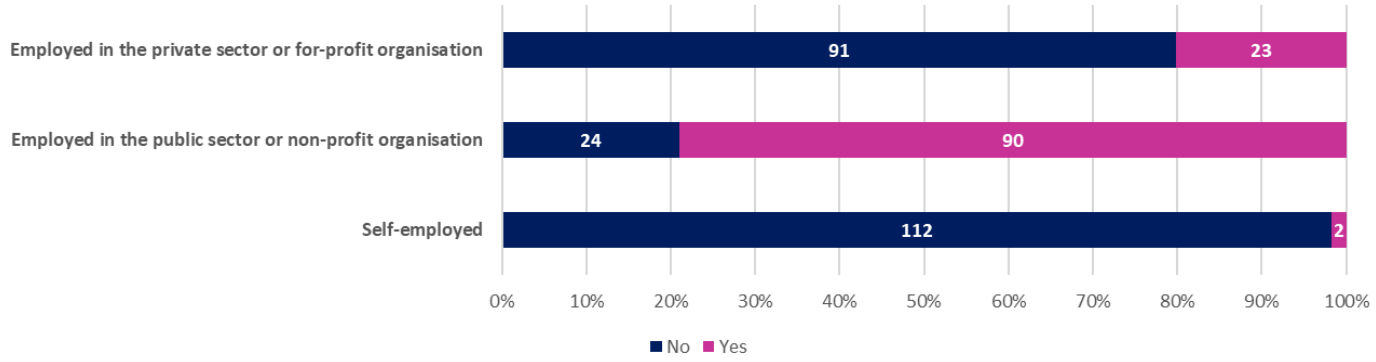


Figure 282. *Belonging to a union or association*

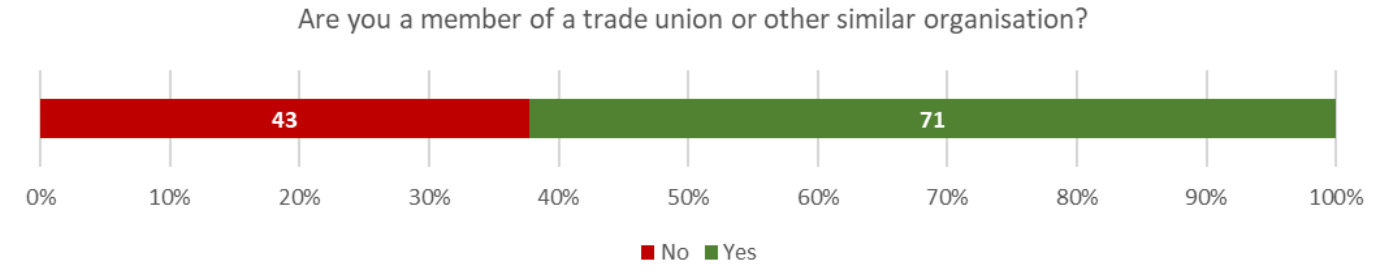
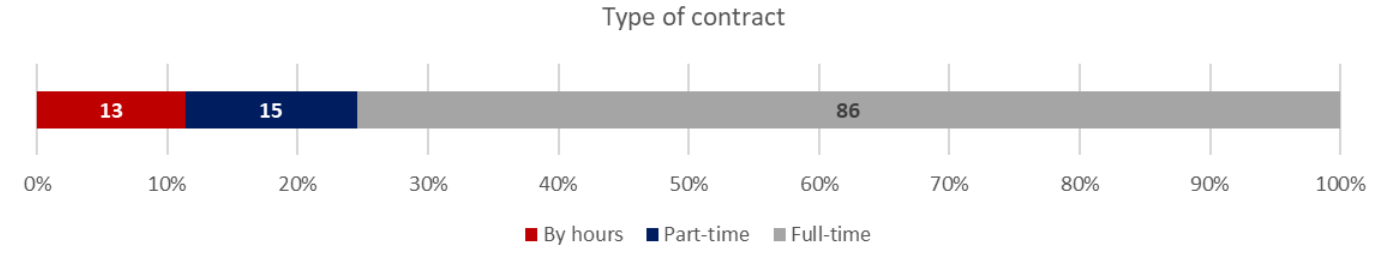


Figure 283. *Type and duration of contract*



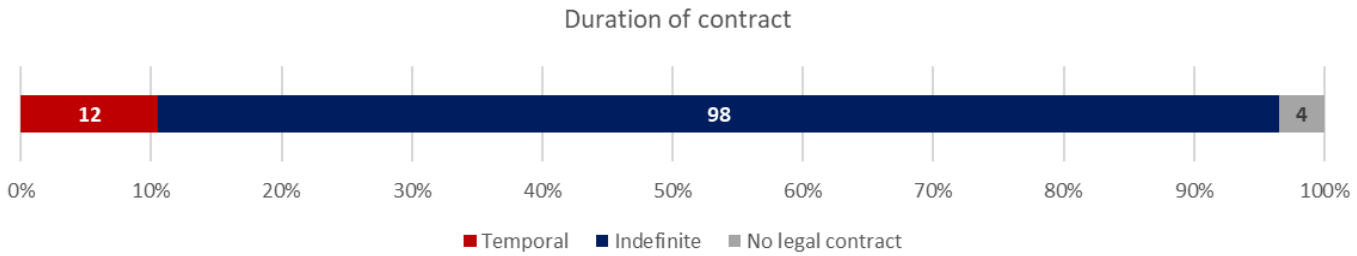
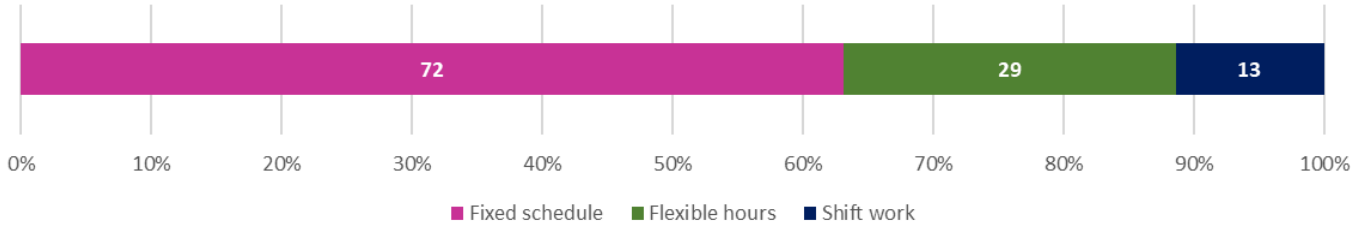


Figure 284. *Type of schedule or work shift*



Participants reported limited awareness of and access to employer-provided benefits (Mean = 3.01 out of 9; SD = 1.69). The benefits most commonly recognized were paid vacation (93%), sick leave (86.8%), and private health insurance (30.7%). However, the actual use of benefits was lower (Mean = 1.03 out of 9; SD = 1.32), with paid vacation being the most frequently used (35.1%). On the other hand, awareness of fuel reimbursement schemes was low (20.2%), and actual use was even lower (7.9%), which is particularly relevant given that 35.1% of participants relied on their own vehicles for commuting.

Participants' wages varied slightly between sectors. Home care workers earned an average of €2,445.87 per month (SD = €666.04), whereas those working in institutional care settings earned €2,679.93 on average (SD = €278.49). It is worth noting that some participants from target C worked in the home care sector, which may have contributed to increasing the average wage in that sector.

Access to lifting aids or mobility equipment was reported by 64% of participants, indicating that roughly one-third worked without such tools, which may pose a risk for musculoskeletal injuries. On average, care workers reported working 37.36 hours per week (SD = 13.35).

Figure 285. *Knowledge and use of workplace benefits and/or rewards*

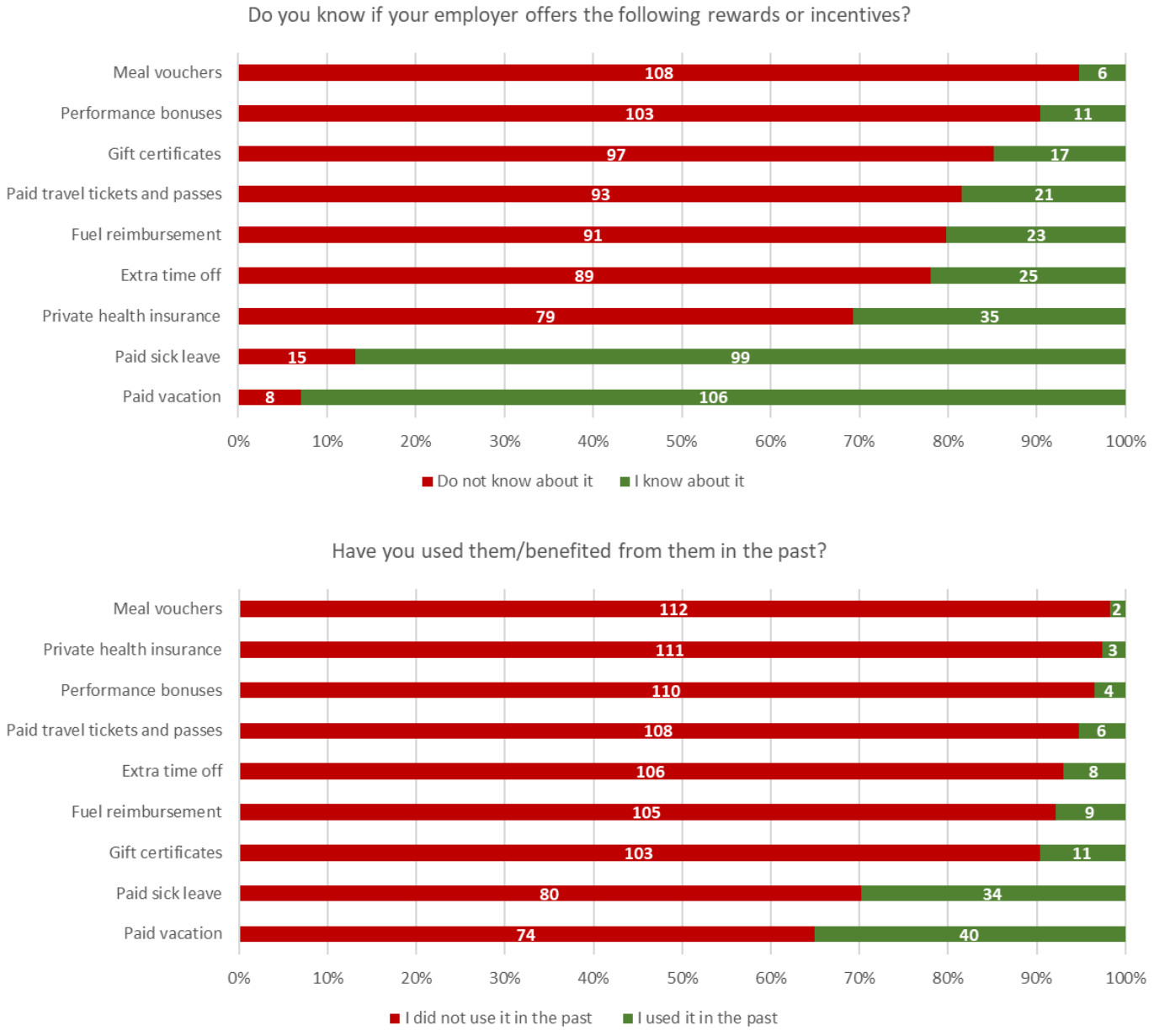


Figure 286. *Access to lifting aids or equipment*

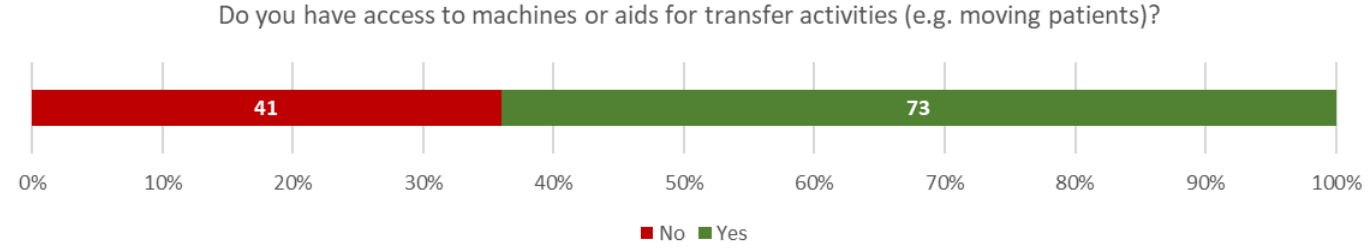
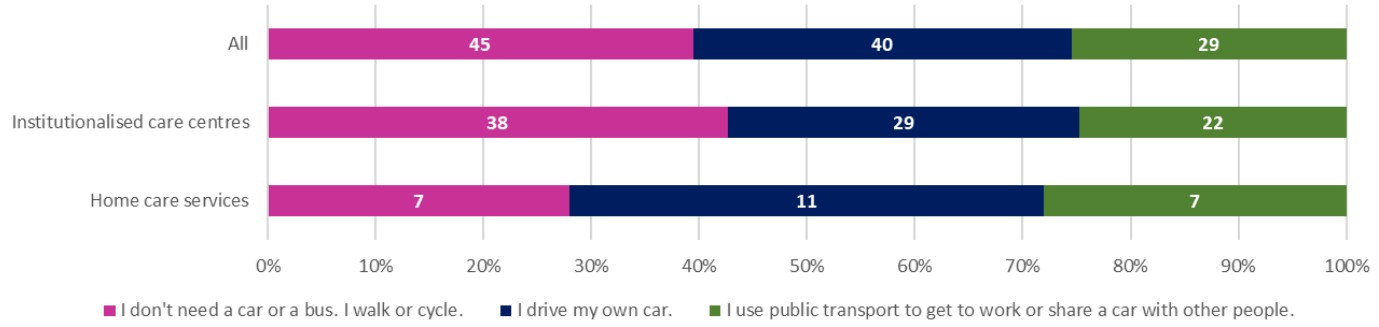


Figure 287. *Transport or commuting to work*



Among all participants, 21.9% worked in home care, while 78.1% were employed in institutional settings. Among home care workers, 83.3% were "live-out" carers, while 16.7% were "live-in" carers. Regarding continuity of care, half of participants had been providing care to the same care receiver for more than one year, whereas 25% had been working with a care receiver for less than three months.

Among the 4 participants who identified as live-in home care workers, only one reported the number of days per week spent caring for the care receiver at their residence, which was seven days. With regard to living conditions, none reported experiencing extreme indoor temperatures (hot or cold). However, one participant indicated not having a separate room, and two participants (50%) reported lacking a separate closet.

Figure 288. *Place of work*

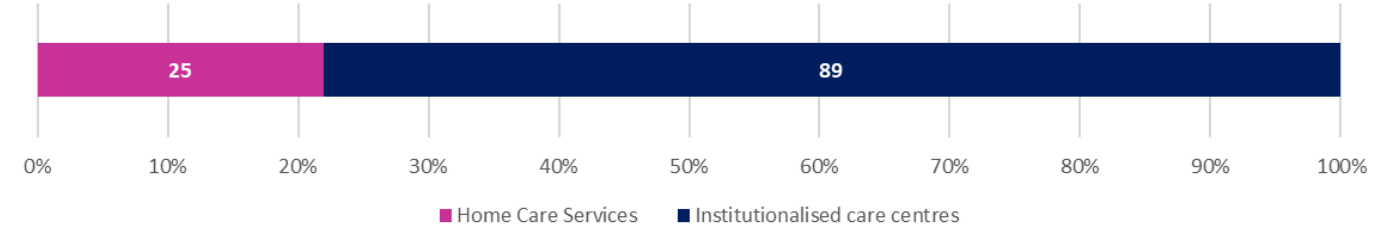


Figure 289. *Modality of home care work (HCWs)*

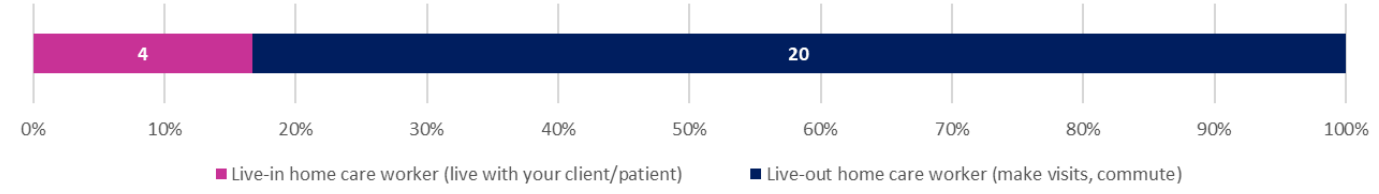


Figure 290. *Continuity of home care work (HCWs)*

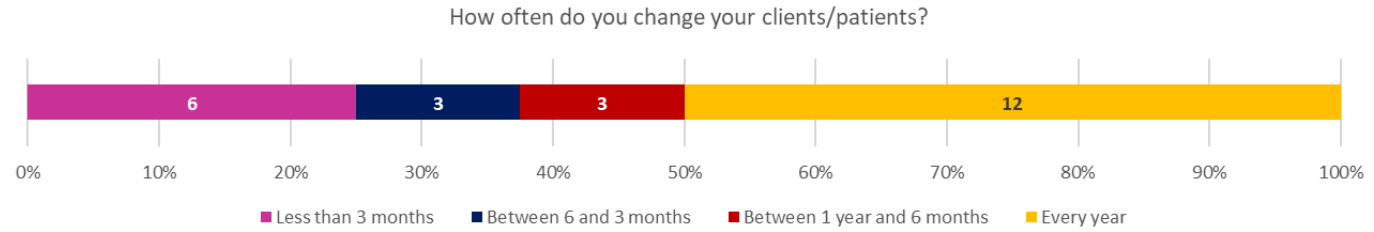
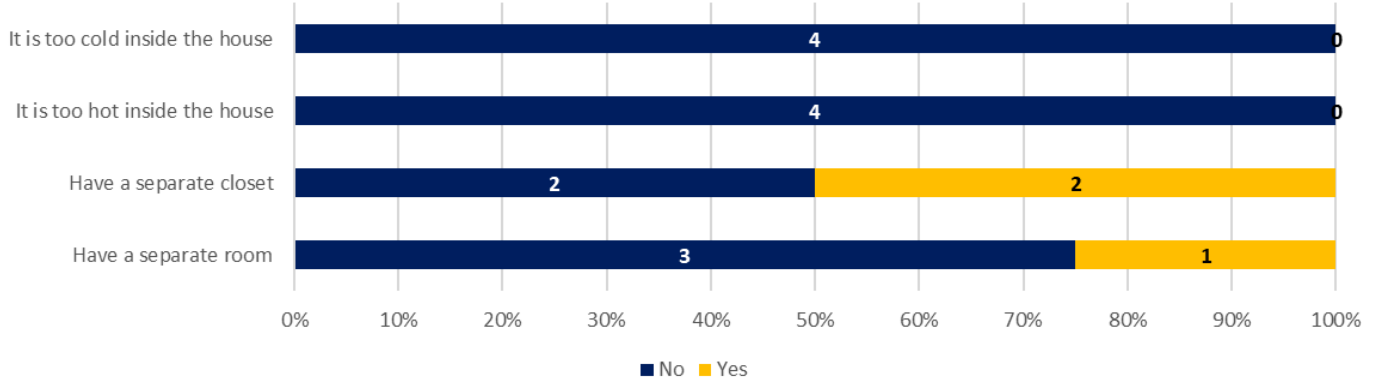


Figure 291. *Living conditions of live-in HCWs*



A total of 11 participants (9.6%) were migrants, with a mean duration of residence in Sweden of 394.18 months (SD = 132.8), that is, approximately 32 years on average. Of these, 1.8% did not hold a legal work permit. Language was generally not reported as a barrier, likely due to the long duration of residence of most migrant participants.

Figure 292. *Immigration status*

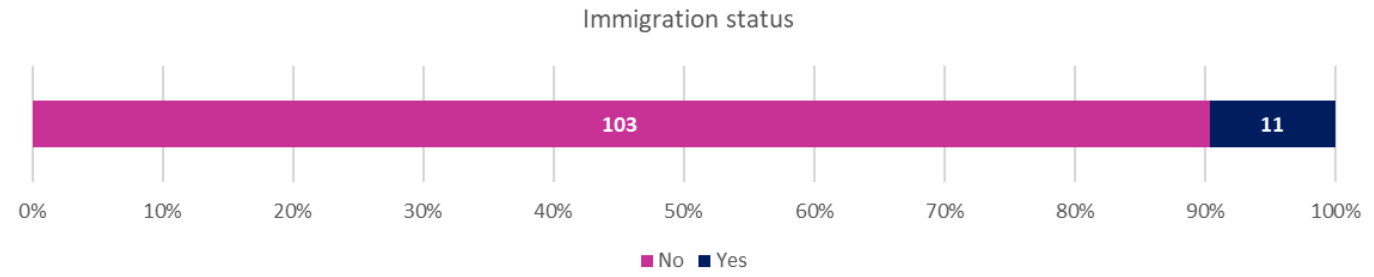


Figure 293. *Possession of work permit (migrant care workers)*

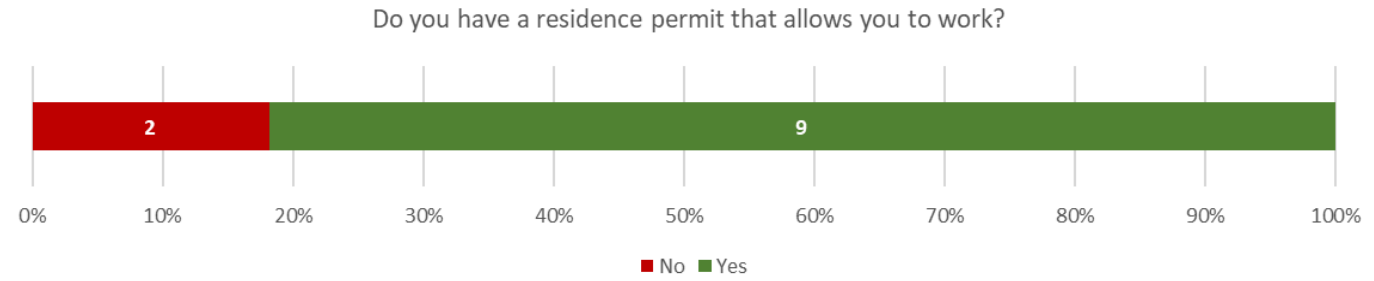
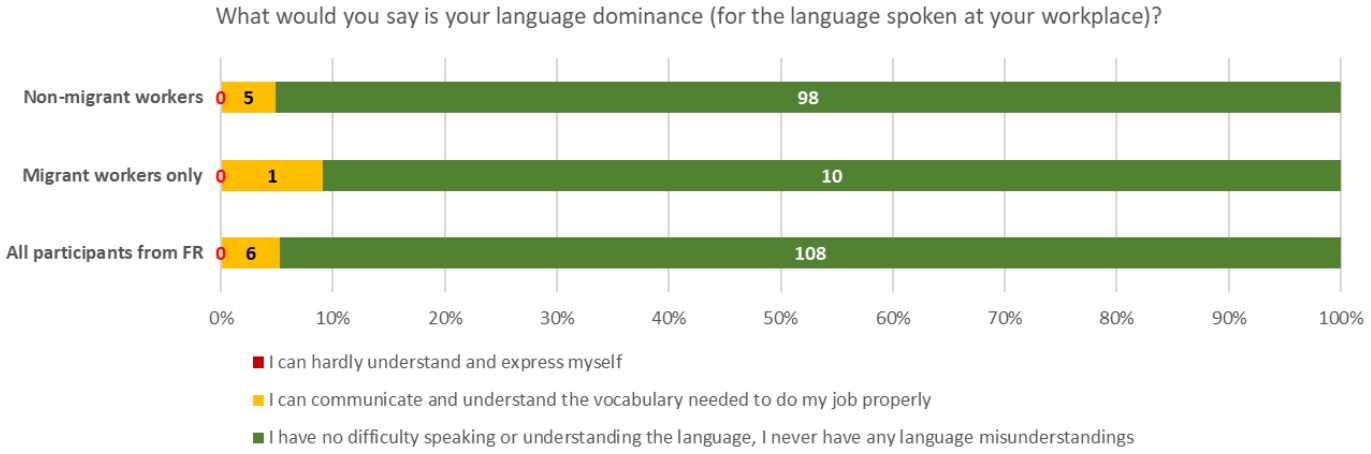


Figure 294. *Language dominance at the workplace*



In summary, the Swedish findings point to a generally stable and experienced care workforce, but also highlight areas requiring further attention. Most workers were formally employed on permanent, full-time contracts in the public or non-profit sector, and many reported long careers in care, suggesting a solid and professionalized workforce. At the same time, gaps in workplace support were evident: awareness and use of employer-provided benefits was limited, a minority of workers reported being without access to lifting aids or mobility equipment, and more than a third relied on personal vehicles for commuting, reflecting potential safety and economic vulnerabilities. Although supervision was common and most worked in teams, a notable minority worked alone, which may increase workload pressures and risks to professional well-being. Finally, while the workforce was predominantly Swedish, the small group of migrant workers had typically lived in the country for decades, which helped ensure that language did not represent a barrier and supported their integration into the sector.

11.2. Findings on Prevalence: Comparing Well-Being, Risks and Protective Factors Across Targets

11.2.1. Well-Being Results

In this section, the outcomes of work are examined, considering both its positive and negative dimensions. The positive dimension is captured through indicators of psychological well-being or flourishing, while the negative dimension focuses on burnout and perceived strain. In addition, the impact of work on personal life is explored, concluding with a report on employees' expressed desire to leave their job if given the opportunity.

Table 37. *Main results of Wellbeing*

Outcome	Target	Mean	S.D.	N
Burnout (Disengagement and Exhaustion)	Target A	2.19	0.32	10
	Target B	2.45	0.55	38
	Target C	2.22	0.41	66
	Mean	**2.29**	**0.47**	**114**
Perceived Exertion	Target A	5.40	3.31	10
	Target B	5.05	2.59	38
	Target C	4.11	2.46	66
	Mean	**4.54**	**2.61**	**114**
Turnover intentions	Target A	1.83	0.69	10
	Target B	2.43	1.38	38
	Target C	2.09	1.14	66
	Mean	**2.18**	**1.20**	**114**
Work-Private Life Conflict	Target A	2.40	0.62	10
	Target B	2.37	0.92	38
	Target C	2.36	0.81	66
	Mean	**2.37**	**0.83**	**114**
Work-Private Life Enrichment	Target A	3.52	0.47	10
	Target B	3.07	0.86	38
	Target C	3.54	0.65	66
	Mean	**3.38**	**0.75**	**114**
Happiness	Target A	7.30	1.83	10
	Target B	6.42	2.30	38
	Target C	7.23	1.54	66
	Mean	**6.96**	**1.87**	**114**
Flourishing	Target A	5.73	0.96	10
	Target B	5.17	1.04	38
	Target C	5.66	0.90	66
	Mean	**5.50**	**0.98**	**114**

Note: Target A: Home health aides; Target B: Basic care workers; Target C: Professional care workers.

Negative Indicators: Where Workers Are Struggling

Burnout Results. Burnout is a job-related syndrome that has been defined as a state of physical, emotional and mental exhaustion that results from prolonged exposure to chronic workplace stress that has not been successfully managed. This variable was assessed with the Oldenburg Burnout Inventory OLBI (Demerouti, et al. (2010). Two scales: disengagement (8 items) and psychological exhaustion (8 items). The responses ranged from 1 (strongly disagree) to 4 (strongly agree).

On average, care workers in Sweden reported moderate levels of burnout (M = 2.29, SD = 0.47) on a 1–4 scale, suggesting that feelings of exhaustion and disengagement were present but not pervasive. No significant differences were observed between home health aides, basic care workers and professional care workers, suggesting that these physically demanding tasks are experienced similarly across all care settings and levels of professional qualification.

Physical Exertion Results. This construct refers to the perceived level of physical effort required from care workers during their working hours. In other words, it quantifies the degree of exertion that care workers perceive themselves to be experiencing in relation to the physical demands of their work. This variable was measured using the Borg Rating of Perceived Exertion Scale (RPE) (1970). The scale ranges from 1 (no exertion) to 11 (maximal exertion).

The mean level of perceived physical exertion was moderate (M = 4.54, SD = 2.61) on the 1–11 Borg scale. No significant differences were observed between home health aides, basic care workers and professional care workers, suggesting that these physically demanding tasks are experienced similarly across all care settings and levels of professional qualification.

Turnover Intentions Results. This variable examined the intention or desire of care workers to leave or abandon their role within the care profession. It was measured using the Intention to Quit Questionnaire (ITQ), which was developed by Rahnfeld et al. (2016) and adapted from Price (1997). The ITQ comprises three items (example item 'despite the obligations I have made to my employer, I want to quit my job as soon as possible') that assess workers' intentions to quit their care job. Participants were asked to indicate the frequency of their intention to quit on a five-point Likert scale, with responses ranging from 1 (almost never) to 5 (almost always).

Turnover intentions were generally low to moderate (M = 2.18, SD = 1.20) on the 1–5 scale, indicating that workers occasionally expressed a desire to leave their job. No significant differences were observed between home health aides, basic care workers and professional care workers, suggesting that these physically demanding tasks are experienced similarly across all care settings and levels of professional qualification.

Work-Private Life Conflict Results. This construct represents a form of inter-role conflict, characterised by a clash between the risk factors of one's professional role and those of their personal or familial responsibilities. The scale from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version, comprising five items (e.g., 'Do you feel that your work drains so much of your energy that it has a negative effect on your private life?'), was employed to measure the variable. The responses ranged from 1 (never) to 5 (always).

Average scores of work-private life conflict were moderate (M = 2.37, SD = 0.83) on the 1–5 scale, reflecting occasional clashes between work and personal roles. No significant differences were observed between home health aides, basic care workers and professional care workers.

Positive Indicators: Signs of Strength

Work-Private Life Enrichment Results. This variable pertains to a process at the work-private life intersection, in which experience or involvement in one role enhances the quality or performance in the other role. The six-item scale Work-family enrichment, as originally proposed by Carlson et al. (2006) and subsequently abbreviated by Kacmar et al. (2014), was employed to assess the variable in question. Participants were invited to indicate their level of agreement with each item on a five-point Likert scale, with responses ranging from 1 (strongly disagree) to 5 (strongly agree).

Care workers reported a moderate-high level of work-private life enrichment (M = 3.38, SD = 0.75) on a 1–5 scale, suggesting that involvement in work frequently enhanced aspects of their private lives. No significant differences emerged across groups.

Happiness results. This construct was designed to assess care workers' general levels of happiness and their attitudes towards their own lives. The variable was assessed using a single item: ‘taken everything together, how happy are you with your life?’. Participants were instructed to indicate their level of satisfaction on a scale from 0 (totally unhappy) to 10 (extremely happy).

General happiness levels among care workers in Sweden were moderately high (M = 6.96, SD = 1.87) on a 0–10 scale, indicating that, overall, workers expressed relatively positive evaluations of their lives. These perceptions were consistent across groups.

Flourishing results. The concept of flourishing can be defined as the combination of subjective and psychological well-being, in which the individual is in a positive emotional state, experiencing feelings of engagement, meaning (or purpose), having personal resources and positive interpersonal relationships. It is measured using a scale comprising eight statements (example items are ‘I am optimistic about my future’ and ’I lead a purposeful and meaningful life’) (Diener et al., 2009), with respondents indicating their level of agreement on a scale from 1 (strongly disagree) to 7 (strongly agree).

Flourishing was high (M = 5.50, SD = 0.98) on the 1–7 scale, suggesting that care workers perceived themselves as experiencing meaning, engagement, and positive resources, albeit not at the highest levels. No significant group differences were observed.

11.2.2. Risk Factors among Care Workers

Drawing on the Job Demands–Resources (JD-R) theory (Bakker & Demerouti, 2011), which serves as the theoretical framework for this research, this section examines key findings related to job demands or risk factors as perceived by care workers.

Table 38. *Job, emotional and relational risk factors*

Risk factors	Target	Mean	S.D.	N
Physical Demands	Target A	3.90	1.29	10
	Target B	3.74	1.39	38
	Target C	2.39	1.30	66
	Mean	**2.97**	**1.48**	**114**
Quantitative Demands	Target A	2.03	0.51	10
	Target B	2.64	0.89	38
	Target C	2.71	0.73	66
	Mean	**2.63**	**0.79**	**114**
Work Pace	Target A	2.37	0.81	10
	Target B	3.25	0.97	38
	Target C	3.21	0.78	66
	Mean	**3.15**	**0.87**	**114**
Tasks Beyond Care Workers' duties	Target A	2.30	1.42	10
	Target B	2.76	1.34	38
	Target C	2.42	1.29	66
	Mean	**2.53**	**1.32**	**114**
Emotional Demands	Target A	3.23	0.72	10
	Target B	3.57	0.97	38
	Target C	3.41	0.78	66
	Mean	**3.45**	**0.84**	**114**
Demands for Hiding Emotions	Target A	4.13	0.46	10
	Target B	4.22	0.69	38
	Target C	3.88	0.69	66
	Mean	**4.02**	**0.68**	**114**
Exposure to Workplace Violence	Target A	1.50	0.71	10
	Target B	1.84	0.97	38
	Target C	1.30	0.50	66
	Mean	**1.50**	**0.74**	**114**
Exposure to Discrimination	Target A	0.20	0.63	10
	Target B	0.32	0.93	38
	Target C	0.20	0.71	66
	Mean	**0.24**	**0.78**	**114**
Intragroup Conflict	Target A	2.44	0.74	10
	Target B	2.43	0.99	38
	Target C	2.18	0.68	66
	Mean	**2.29**	**0.81**	**114**

Continuation Table 38.

Demand	Target	Mean	S.D.	N
Workplace Incivility	Target A	1.80	0.67	10
	Target B	2.13	0.98	38
	Target C	1.91	0.62	66
	Mean	**1.98**	**0.76**	**114**

Job-related Risk Factors

Physical Demands. This variable pertains to the frequency of physical activity that care workers are required to perform in order to fulfil the duties inherent to their role. These activities may include, but are not limited to, walking, lifting, carrying, reaching, pushing and pulling. Participants were asked to respond on a 5-point Likert scale, from 1 (never) to 5 (everyday).

On average, care workers reported a moderate level of physical demands (M = 2.97, SD = 1.48) on a 1–5 scale, indicating that tasks such as lifting, transferring, or supporting care receivers are a regular aspect of their daily work. Significant differences were observed between occupational groups: professional care workers reported lower levels of physical demands compared to home health aides and basic care workers.

Figure 294. *Cross-target intragroup physical demands comparative results*

Quantitative Demands. Defined as the psychological demands that arise from the amount of work that must be completed within a given timeframe. These demands are typically high when the volume of work exceeds the capacity to complete it within the specified period. Four items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were employed to assess the job demand in question. An illustrative item is "Is your workload unevenly distributed so it piles up?". The respondents were asked to respond on a 5-point Likert scale, from 1 (never) to 5 (always).

The mean level of quantitative demands was moderate (M = 2.63, SD = 0.79) on a 1–5 scale, suggesting that the volume of work was generally manageable, although still a source of pressure. Significant differences were observed between occupational groups: home health aides reported significantly lower quantitative demands compared to basic care workers and professional care workers. This pattern suggests that workload expectations tend to be greater among workers with higher formal qualifications in institutional settings.

Figure 295. *Cross-target intragroup quantitative demands comparative results*

Work Pace Demands. The term is defined as the psychological demand associated with the intensity of the work. To assess this job demand, three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were used. An illustrative item is, "Do you work at a high pace throughout the day?" Respondents were asked to indicate their level of agreement with the item on a 5-point Likert scale, from 1 (never) to 5 (always).

Care workers reported a moderate level of work pace demands (M = 3.15, SD = 0.87) on a 1–5 scale, suggesting that many workers experienced their job as requiring sustained intensity and speed. Significant differences were observed between occupational groups: home health aides reported lower work pace demands compared to basic care workers and professional care workers. These findings indicate that tasks performed by more qualified care workers are more likely to be characterised by a faster pace and intensity.

Figure 296. *Cross-target work pace demands comparative results*

Tasks Beyond Care Workers' Duties. The variable assessed the frequency of instances over the past year in which care workers were required to perform tasks that were not included in their job description or the care receivers' care plan (question taken from Karlsson et. al. (2020) study, in which 47% of home care aides agreed or strongly agreed with the statement. In our study, the response options were adapted to be coherent with the rest of the survey. They were instructed to indicate their response on a 5-point Likert scale, ranging from 1 (never or almost never) to 5 (a lot of the time).

On average, workers reported a moderate frequency of being asked to perform tasks outside their formal care duties (M = 2.53, SD = 1.32) on a 1–5 scale. This suggests that such requests are not uncommon, though not constant. No significant differences were observed between occupational groups, indicating that the experience of role extension is relatively consistent across care settings.

Emotional Risk Factors

Emotional Demands. The construct pertains to the psychological demands that arise from the interpersonal relationships involved in the work, which require care workers to engage in emotionally charged situations. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were employed to assess the aforementioned job demand. An illustrative item is "Do you have to deal with other people's personal problems as part of your work?" The respondents were requested to respond on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

Emotional demands were moderately high (M = 3.45, SD = 0.84) on a 1–5 scale, indicating that workers frequently faced emotionally challenging situations as part of their daily role. No significant differences were found between occupational groups, showing that this relational burden is shared across home health aides, basic care workers, and professional care workers.

Demands for Hiding Emotions. The variable in question alludes to the psychological demand associated with the necessity of maintaining a neutral demeanour in the face of unpredictable behaviour exhibited by care receivers, colleagues, superiors, family members, and other individuals within the professional setting. Four items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this job demand. An illustrative item is, "Are you required to be kind and open towards everyone – regardless of how they behave towards you?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The mean level of demands for hiding emotions was high (M = 4.02, SD = 0.68) on a 1–5 scale, suggesting that workers often felt the need to suppress their emotional responses and maintain a neutral demeanour in interactions with care receivers, families, or colleagues. No significant differences emerged between occupational groups, indicating that this need for emotional regulation is a common feature of care work across all levels of professional qualification and setting.

Relational Risk Factors

Exposure to Workplace Violence. The variable in question was designed to assess the frequency of instances in which care workers were exposed to violent behaviours or attitudes directed towards them in the workplace. Specifically, respondents were asked to respond to one question - In the last year, how often have you been exposed at work to violence from patients and/or their family members?. The respondents were required to indicate their level of agreement with the statement on a five-point Likert scale, with 1 representing "never" and 5 representing "everyday".

The average score for exposure to workplace violence was low (M = 1.50, SD = 0.74) on a 1–5 scale, suggesting that incidents of aggression or hostility from care receivers or their families occurred occasionally but were not frequent. Significant differences were observed between groups: professional care workers reported the lowest exposure, home health aides were in the middle, and basic care workers reported the highest exposure.

Figure 297. *Cross-target workplace violence comparative results*

Exposure to Discrimination. This variable assessed the frequency with which care workers had experienced discriminatory behaviour or attitudes that made them feel vulnerable because of their gender, ethnicity or colour in the past year. This was measured on a 4-point scale (0 - never; 1 - once; 2 - two or three times; and 3 - four or more times). The question was adapted from the Experiences of Discrimination Scale (EOD) developed by Williams et al. (1997).

A small number of care workers in Sweden (10 out of 114 or 8.8%) reported experiencing discrimination in the past year. Of these, three reported experiencing it two or three times and seven reported experiencing it four or more times. The most commonly perceived reasons for this discrimination were related to nationality, gender and age.

Figure 298. *Exposure to discrimination variable results*

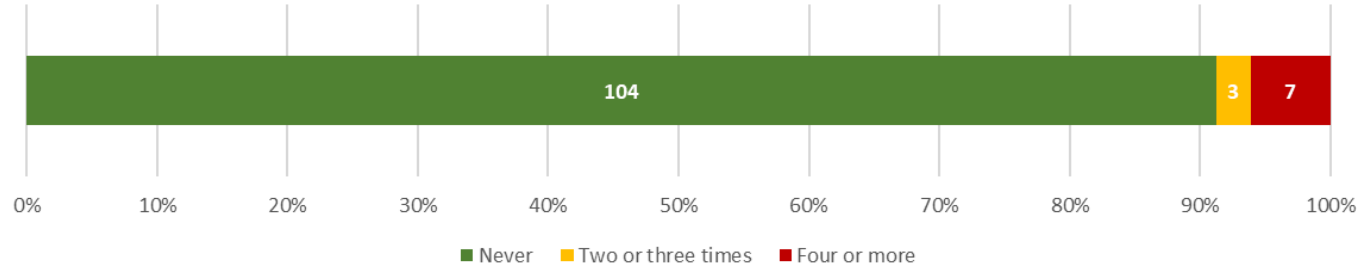
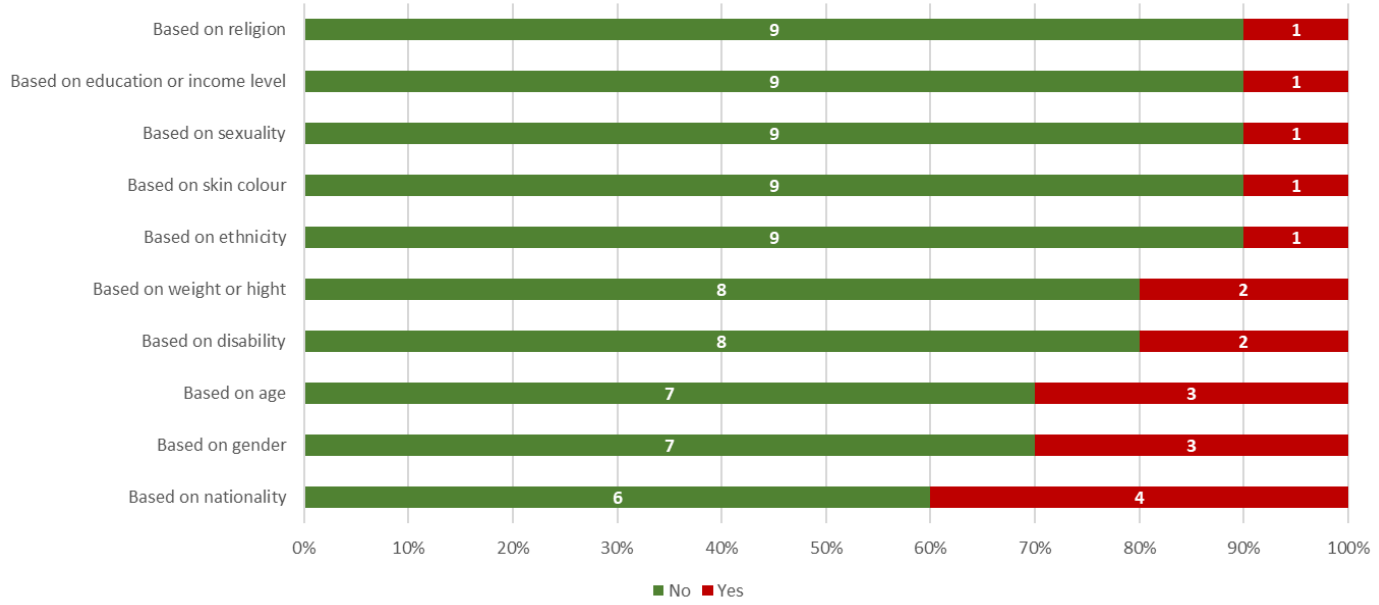


Figure 299. *Perceived motive of discrimination of those who experienced it*



Exposure to discrimination was very low (M = 0.24, SD = 0.78) on a 0–3 scale, with the majority of workers reporting no experiences of discriminatory behaviour. No significant differences were observed between occupational groups. However, this result should be interpreted with caution, as low levels of reporting do not necessarily imply the absence of discrimination.

Intragroup Conflict. The construct refers to the frequency with which carers experience conflict within a team, with the care receiver, their family members or other people at work, where members clash over work procedures or due to personality clashes. The 8-item scale was adapted from Jehn (1995). Participants were asked to respond on a 5-point Likert scale from 1 (none) to 5 (a lot).

The mean score for intragroup conflict was moderate (M = 2.29, SD = 0.81) on a 1–5 scale, reflecting occasional tensions or disagreements with colleagues, care receivers, or family members. No significant differences were found between occupational groups, suggesting that interpersonal conflict at work was experienced in a similar way across different roles.

Workplace Incivility. The variable is defined as low-intensity deviant behaviour (by care receivers, family members, colleagues, etc.) with ambiguous intent to harm the target (the care worker), in violation of workplace norms of mutual respect. The 4-item scale shortened by Matthews & Ritter (2016) from Cortina et al. (2013) was used to assess this construct. An example item is "In the past year, have you been in a situation where people you interact with at work made jokes at your expense?" Participants were asked to respond on a 5-point Likert scale ranging from 1 (never) to 5 (always).

Care workers reported a low-to-moderate level of workplace incivility (M = 1.98, SD = 0.76) on a 1–5 scale, indicating that occasional instances of disrespectful or inappropriate behaviour were present in their work environment. No significant differences were observed between occupational groups.

11.2.3. Protective Factors in the Care Sector

This section focuses on the resources available to care workers to help them cope with the demands of their work. As in the previous section, both overall results and comparisons between different target groups are presented.

Table 39. *Job, emotional and relational protective factors*

Protective factors	Target	Mean	S.D.	N
Possibilities for Development	Target A	3.80	0.57	10
	Target B	3.61	0.70	38
	Target C	3.94	0.75	66
	Mean	**3.82**	**0.73**	**114**
Variation of Work	Target A	2.65	0.63	10
	Target B	2.88	0.76	38
	Target C	3.22	0.75	66
	Mean	**3.06**	**0.76**	**114**
Control over Working Time	Target A	2.82	0.63	10
	Target B	2.81	0.73	38
	Target C	3.53	0.75	66
	Mean	**3.23**	**0.81**	**114**
Predictability	Target A	4.00	0.94	10
	Target B	3.45	0.88	38
	Target C	3.64	0.88	66
	Mean	**3.61**	**0.89**	**114**
Autonomy	Target A	2.47	0.61	10
	Target B	2.50	0.92	38
	Target C	3.11	0.63	66
	Mean	**2.85**	**0.79**	**114**
Meaning of Work	Target A	4.55	0.50	10
	Target B	4.22	0.78	38
	Target C	4.44	0.65	66
	Mean	**4.38**	**0.69**	**114**
Recognition	Target A	4.20	0.88	10
	Target B	3.75	1.09	38
	Target C	4.19	0.66	66
	Mean	**4.05**	**0.86**	**114**
Emotional Social Support	Target A	3.73	0.70	10
	Target B	3.21	1.04	38
	Target C	3.62	0.72	66
	Mean	**3.49**	**0.86**	**114**
Instrumental Social Support	Target A	3.45	0.71	10
	Target B	2.97	0.84	38
	Target C	3.27	0.86	66
	Mean	**3.18**	**0.85**	**114**

Job-related Protective Factors

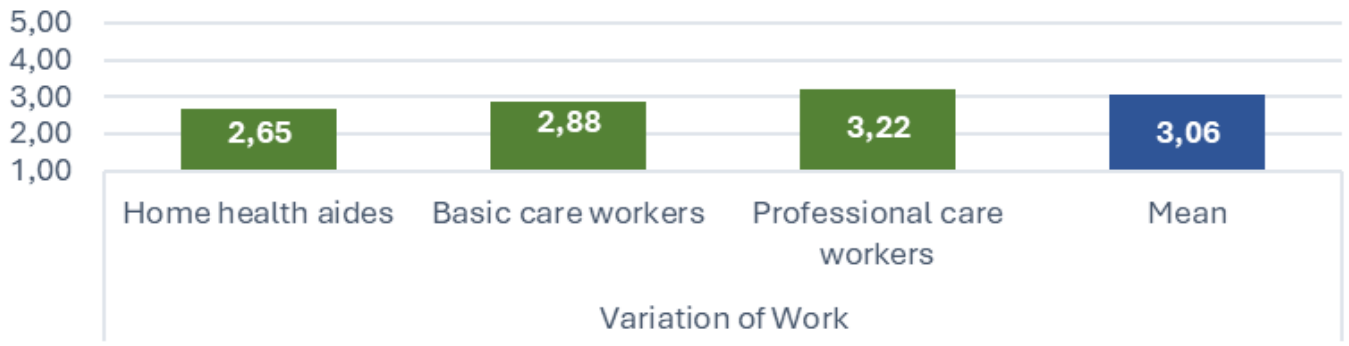
Possibilities for Development. The variable in question refers to the extent to which job performance provides opportunities for care workers to put their knowledge, skills and experience into practice and to acquire new knowledge, skills and experience. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. An illustrative item is "Do you have the possibility of learning new things through your work?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

Care workers from Sweden reported moderately high opportunities for professional development (M = 3.82, SD = 0.73) on a 1–5 scale, suggesting that most participants felt they frequently had the chance to apply their knowledge and learn new skills in the workplace. No significant differences were found between occupational groups, indicating that the perception of development opportunities was consistent across home health aides, basic care workers and professional care workers.

Variation of Work. The construct refers to whether care work tasks are repetitive or, on the contrary, diverse or varied. Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. An illustrative item is "Do you have to do the same thing over and over again?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

The mean score for task variety was moderate (M = 3.06, SD = 0.76) on a 1–5 scale, indicating that while some workers experienced repetitive work, others had more diverse daily tasks. Significant differences were observed: home health aides reported the lowest variation, basic care workers scored higher, and professional care workers reported the greatest variety. This pattern suggests that the diversity of tasks increases with higher levels of professional qualification.

Figure 300. *Cross-target variation of work comparative results*



Control over Working Time. The construct refers to care workers'' control over their working time in aspects such as starting and ending the working day, when to take breaks, days off, holidays, and control over whether, when and how much overtime to work. 5 items from the long version of the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) were selected to assess this resource. An illustrative item is "Can you decide when to take a break?". Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale ranging from 1 (never) to 5 (always).

On average, care workers reported a moderate degree of control over their working time (M = 3.23, SD = 0.81) on a 1–5 scale, indicating that they had some influence over their schedules, including start and end times, breaks and time off. Significant differences were found between groups: professional care workers reported greater control compared to home health aides and basic care workers. This suggests that decision latitude over work schedules is more common among those with highest qualifications.

Figure 301. *Cross-target control over working time comparative results*

Predictability. Work is predictable if the worker has adequate, sufficient and timely information to be able to perform the job correctly and to adapt to changes (future restructuring, new technologies, new tasks, new methods and the like). Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected for the assessment of this resource. One illustrative item is, "Do you receive all the information you need in order to do your work well?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The mean score for predictability was moderate (M = 3.61, SD = 0.89) on a 1–5 scale, suggesting that workers generally felt adequately informed about their tasks and potential changes in the workplace. No significant group differences were observed, indicating a broadly shared experience across occupational roles.

Autonomy. The construct refers to the degree of influence or decision latitude that the care worker has in the day-to-day activities, particularly in relation to the tasks to be carried out and the manner in which they are to be carried out. The three-item scale from Bakker and Bal

(2010), adapted from Karasek et al. (1985), was used to quantify this resource. An illustrative item is "I have a lot of freedom in the execution of my work". The responses ranged from 1 (strongly disagree) to 4 (strongly agree).

Care workers reported moderate levels of autonomy (M = 2.85, SD = 0.79) on a 1–5 scale, reflecting some degree of freedom in how they carried out their daily tasks, but also constraints. Significant group differences were observed: professional care workers reported higher autonomy compared to home health aides and basic care workers. This suggests that professional care workers had greater discretion over task execution than less qualified groups.

Figure 302. *Cross-target autonomy comparative results*

Emotional Protective Factors

Meaning of Work. The variable is defined as the relationship that work has to values other than those associated with having a job and earning an income. These include the utility, importance or social value, or learning involved. Two items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected for the assessment of this resource. One illustrative item is, "Are you required to be kind and open towards everyone – regardless of how they behave towards you?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

The perceived meaning of work was high (M = 4.38, SD = 0.69) on a 1–5 scale, indicating that care workers strongly valued their work for its personal and social importance. No significant differences were found between groups, suggesting that the sense of meaningfulness was consistently experienced across all occupational roles.

Relational Protective Factors

Recognition. The term denotes the appreciation, respect and fair treatment afforded to care workers by their supervisors in the workplace. Three items from the Copenhagen Psychosocial Questionnaire (COPSOQ-ISTAS21-III) long version were selected to assess this resource. One illustrative item is, "Is your work recognised and appreciated by the management/supervisor?" Respondents were instructed to indicate their level of agreement with the item on a 5-point Likert scale, ranging from 1 (never) to 5 (always).

Care workers reported moderately high levels of recognition from supervisors (M = 4.05, SD = 0.86) on a 1–5 scale, indicating that they generally felt appreciated and treated fairly. No significant group differences were observed, suggesting that perceptions of recognition were similar across occupational categories.

Social Support. The variable can be defined as the degree to which care workers receive emotional and instrumental (help with job tasks) support from the individuals with whom they interact at their place of work. The 8-item scale was adapted from that used by Peeters et al. (1995) for the purpose of measuring this resource. An example item is, "The people you interact with at work showed that they appreciated the way you do your work". The responses were measured on a scale ranging from 1 (not at all) to 5 (a lot).

The mean score for emotional social support was moderate (M = 3.49, SD = 0.86) on a 1–5 scale, suggesting that workers felt reasonably supported with encouragement, empathy and understanding from people in their work environment. No significant differences were found between groups.

Instrumental social support was somewhat lower (M = 3.18, SD = 0.85) on a 1–5 scale, suggesting that practical help with work tasks was less consistently available than emotional support. No significant differences emerged between occupational groups, indicating that this resource was experienced similarly across roles.

11.2.4. Summary: Main Differences Across Targets in Sweden

Table 40. *Summary of prevalence results in Poland*

Dimension		Variable	Overall level	Cross-target differences
Well-being indicators	***Negative well-being indicators***	Burnout (Disengagement and Exhaustion)	Moderate	No differences
		Physical Exertion	Moderate	No differences
		Turnover Intentions	Low-Moderate	No differences
		Work–Private Life Conflict	Moderate	No differences
	Positive well-being indicators	Work–Private Life Enrichment	Moderate-High	No differences
		Happiness	Moderate-High	No differences
		Flourishing	High	No differences
Risk factors	***Job-related risk factors***	Physical Demands	Moderate	C < A, B
		Quantitative Demands	Moderate	A < B, C
		Work Pace Demands	Moderate	A < B, C
		Tasks Beyond Job Duties	Moderate	No differences
	Emotional risk factors	Emotional Demands	Moderate-High	No differences
		Demands for Hiding Emotions	High	No differences
	Relational risk factors	Exposure to Workplace Violence	Low	C < A < B
		Exposure to Discrimination	Low	No differences
		Intragroup Conflict	Moderate	No differences
		Workplace Incivility	Low-Moderate	No differences
Protective factors	***Job protective factors***	Possibilities for Development	High	No differences
		Variation of Work	Moderate	A < B < C
		Control Over Time	Moderate	A, B < C
		Predictability	Moderate	No differences
		Autonomy	Moderate	A, B < C
	Emotional protective factors	Meaning of Work	High	No differences
	Relational protective factors	Recognition	High	No differences
		Emotional Support	Moderate-High	No differences
		Instrumental Support	Moderate	No differences

Note: Consider the sample sizes for each group (10 home health aides - A; 38 basic care workers - B; and 66 professional care workers - C)

The findings from the Swedish sample reveal a workforce that balances meaningful and positive aspects of care work with ongoing challenges related to physical and emotional demands. On average, care workers reported moderate levels of burnout, physical exertion, and turnover intentions, suggesting that while strain is present, it is not overwhelming. Work–private life conflict was moderate, but many workers also experienced enrichment between their professional and personal lives, and overall happiness and flourishing scores were relatively high. These results point to a workforce that, despite demands, finds personal meaning and well-being in their role.

Risk factors were evident in both physical and emotional dimensions. Care workers reported moderate levels of physical and quantitative demands, with higher demands for pace and workload intensity among more qualified groups, especially in institutional settings. Emotional demands were moderately high, and workers frequently felt the need to hide their emotions in order to remain professional in challenging situations. While exposure to workplace violence and discrimination was generally low, a small group of workers reported repeated experiences of discrimination, most often related to nationality, gender, or age.

Protective factors offered important resources. Most participants reported good opportunities for professional development, a moderate degree of autonomy and control over their working time, and reasonably high recognition from supervisors. Emotional support in the workplace was widely reported, though instrumental support was less consistent, highlighting gaps in practical help. Importantly, workers described their roles as highly meaningful, reinforcing the sense that their work carries strong personal and social value.

In summary, Swedish care workers demonstrate resilience, stability, and a strong sense of purpose in their roles. However, the coexistence of high emotional demands, frequent pressure to suppress emotions, and only moderate levels of practical workplace support points to a mismatch between the demands placed on workers and the resources available to them. Strengthening practical support mechanisms, reducing emotional strain, and addressing inequalities in workload intensity across occupational groups will be key to sustaining well-being and retention in the Swedish care sector.

Chapter 12. Qualitative Data Set: Making Sense of the Findings Through Workers' Voices

In January 2025, a series of semi-structured interviews were conducted with representatives from Kommunal, Vårdförbundet, SALAR, and Vårdföretagarna. These interviews provided essential empirical insights into the current configuration of the Swedish long-term care sector, capturing perspectives from both public and private actors as well as from professional and trade union organizations. The knowledge generated through these interactions has been integral to shaping the analytical framework and conclusions of this report.

The well-being of the formal eldercare workforce constitutes a critical issue within a system characterized by persistent structural pressures. Sweden's eldercare is organized primarily according to a social care model, providing housing and round-the-clock support for older adults. This model depends heavily on assistant nurses (undersköterskor) and care aides (vårdbiträden). Demographic projections indicate that the population aged 80 and over will increase by approximately 31% between 2021 and 2026, generating demand for an estimated 111,000 additional care workers by 2031. In this context, the introduction of licensure for assistant nurses on 1 July 2023 represents a significant policy measure intended to elevate the status and professional recognition of this occupational group.

Despite these developments, working conditions in the sector remain characterized by chronic stress, resource scarcity, and structural vulnerability. Long-standing underfunding and insufficient staffing levels have created sustained operational pressures that compromise the sustainability of care provision. Time constraints and high workloads translate into elevated physical and psychological demands, reflected in sickness absenteeism rates approximately 40% higher than the national labor market average for comparable occupations.

The introduction of managerial reforms inspired by New Public Management has further exacerbated these challenges by constraining professional autonomy and altering organizational dynamics. Empirical studies indicate that care workers employed in outsourced settings experience significantly higher emotional demands than those in publicly managed facilities. Precarious employment conditions are also widespread: around 20% of care workers in residential settings are employed on insecure contracts—such as zero-hour agreements—with this proportion notably higher in municipalities characterized by extensive marketization. Such employment insecurity contributes to sickness presenteeism, as workers often cannot afford income loss. At the policy level, organizational priorities tend to emphasize user empowerment, regulatory compliance, and staff competency requirements, while systematically neglecting the structural empowerment and well-being of the workforce. This misalignment between political ambitions and resource allocation undermines job

quality and contributes to high turnover intentions, with approximately one in four care workers frequently or consistently considering leaving their position.

The psychosocial work environment in residential care settings is further strained by persistent recruitment difficulties and insufficient organizational support. This combination of high job demands and limited resources generates elevated stress levels and weakens workforce retention. Comparative evidence suggests that nonprofit care providers generally achieve better outcomes in terms of employee well-being and lower turnover intentions than for-profit providers. Similarly, outsourcing of public services has been associated with deteriorating working conditions and lower wage levels. These cumulative pressures heighten the risk of occupational burnout, understood as the progressive depletion of physical, emotional, and cognitive resources resulting from sustained job strain.

An analysis of procurement and contracting frameworks (LOU/LOV) underscores the structural nature of these challenges. Policy documents overwhelmingly emphasize user-oriented objectives and regulatory compliance, with minimal attention to job resources and workforce empowerment. This lack of structural support impedes care workers' capacity to deliver high-quality, relationship-centered care and creates a persistent gap between policy ambitions and practical realities.

Finally, the continued marketization of eldercare in Sweden has led to the predominance of publicly traded, for-profit providers, primarily financed through commercial loans. This market-driven orientation and the pursuit of profit margins raise enduring concerns about their implications for staffing levels and overall care quality. The interplay between demographic pressures, market mechanisms, and systemic underinvestment constitutes a critical structural challenge for the sustainability and quality of the Swedish eldercare system.

CONCLUDING REFLECTIONS: Common Ground Across European Care Contexts

Care workers across Europe share a strong sense of purpose. Most describe their work as socially valuable and personally meaningful — a source of motivation that helps them cope with daily demands. Yet this same commitment often comes with emotional costs. They regularly face situations of illness, dependency, or end-of-life care, which require constant emotional regulation and the ability to remain composed.

Physical strain is equally present. Whether working in homes or institutions, many tasks involve lifting, assisting with mobility, and maintaining a demanding pace. These pressures contribute to widespread exhaustion, although many workers remain in their jobs out of dedication rather than favorable conditions.

Work-life balance is another persistent concern. Rigid schedules, staff shortages, and limited recovery time heighten fatigue. Still, relationships at work — especially emotional support from colleagues and recognition from supervisors — act as key buffers, even when practical help is scarce.

Altogether, the findings portray a vital yet undervalued workforce. Care workers uphold essential social systems through empathy, endurance, and moral commitment, but their well-being depends on fair conditions, proper training, and supportive management. While each country's context adds nuances, the emotional and physical toll of care work is a shared reality across borders. Strengthening protective factors such as recognition, autonomy, and opportunities for growth will not only enhance workers' health but also the sustainability of long-term care as a whole.

ANNEX – Depiction of Risk and Protective Factors by Country

Table 1. *France – Depiction of Risk and Protective Factors*

			Definition	Illustrative quotes
Risk Factors	Job-related	**Cognitive demands**	Care work entails a significant cognitive load, marked by constant reflection, self-monitoring, and autonomous decision-making. Workers describe living under continuous self-questioning, wondering whether they have handled situations correctly or fulfilled their responsibilities as expected.	*"We ask ourselves questions: Has the situation been well managed? Did we take our responsibilities properly? Sometimes we'd like a doctor to reassure us, but that's not always possible"* (FG8 FR Target C).
		Emotional demands	Relational care work is complex and professionals are required to regulate their own emotions, respond sensitively to others, and cope with the cumulative effects of deep personal involvement. These demands—from emotional display to sustained engagement— have a significant impact on mental health and professional endurance.	*"They're like sponges. When you have personal worries, even if you try to hide them behind a smile, they see it."* (FG3 FR Target B).
		Exposure to suffering and death	Care workers are routinely exposed to the deterioration, suffering, and death of residents, with whom they often develop emotional bonds.	*"There are complicated days... deaths... and I used to come home and cry. I couldn't sleep at night"* (FG1 FR Target B)
		Exposure to violence	Care workers are exposed to aggressive behaviour from patients or residents, often linked to postoperative effects, medications, or neuropsychiatric conditions. These incidents are not always labeled as violence but are experienced as stressful and emotionally draining.	*"In situations of aggressive behaviour, I think it's more difficult. I try to maintain my inner calm so as not to aggravate the situation. I'm careful never to find myself alone, but if I can be with a colleague I don't hesitate to contact her. Fortunately, in morning meetings you know when the others are coming round, so being in pairs can help avoid the escalation of aggression."* (FG 6 FR Target A).

			Definition	Illustrative quotes
		Pace of work	Work pace varies depending on the care setting. The speed imposes constant pressure, limits room for maneuver, and can increase physical and emotional strain.	*"We stay as long as we have to, and if I have to stay more than a quarter of an hour, I'll stay more than a quarter of an hour, and I don't want to be told anything because there are people who need more, and maybe that's reassuring for them."* (FG1 FR Target B).
		Perceived exploitation	Exploitation goes beyond physical exhaustion: it involves legal vulnerability, degrading treatment, and sustained psychological strain. Workers report exploitation classified in a wide range of experiences: Abusive recruitment and informal intermediaries, overwork and insufficient resources for quality care, lack of respect for rest time and legal vulnerability and impunity for abuse.	*"For me, it's important to be useful without feeling exploited. It's sometimes hard to see how the elderly are treated, and I don't want to be part of that. I think we should accompany people with dignity, especially at the end of their lives."* (FG 3 FR Target B).
		Physical demands	They are a central concern for care workers in institutional settings, where daily tasks often involve intense bodily effort and repeated strain. All of this leads to high levels of physical strain, and normalisation of bodily pain, all of which seriously impact workers' health and well-being.	*"I forgot, the biggest problem in my team is posture and back pain. Carrying the elderly. It's a question of posture that you have to learn, but it can take its toll on your bodybuilding."* (FG 4 FR Target A).
		Role ambiguity	Discrepancies between what is stated in contracts and the actual conditions of the job. Unclear information about patients' needs, care expectations, and work conditions gives rise to role ambiguity, which complicates daily tasks and weakens the boundaries of professional responsibility.	*"We don't always have the necessary information on the patients' pathologies or precise expectations" (FG6 FR Target A); "It's about not finding yourself alone with complex problems"* (FG6 FR Target A).
		Safety hazards	Biological risks faced by care workers which they feel as inherent danger to their profession and not recognised by institutions or society.	*"It's also true that the work environment at home is often less secure. You can find yourself in places where you don't feel comfortable, which can increase stress. Personal safety must also be a priority. It's essential that we are protected in our work, so that we can concentrate on what really matters."* (FG 8 FR Target C).

			Definition	Illustrative quotes
		Schedule	Organisation is a key factor affecting both well-being and work-life balance in institutional care. Some models are perceived positively, offering more days off and better recovery.	*"On the positive side, I work days now, whereas I used to work nights, which has improved my social life. I work three days and have four days off, so it's a good balance."* (FG5 FR Target C).
		Task beyond duties	Care staff are required to take on responsibilities outside their role, often as a result of organisational dynamics or the absence of specific personnel, leading to a steady extension of their duties.	*"Managers don't always give us enough recognition for our work. We do a lot, sometimes even outside the scope of our duties, such as handing out medication when that's not our role. This lack of support creates tension between the carers and management."* (FG 3 FR Target B).
		Time pressure	Work organisation, based on official staffing ratios perceived as unrealistic, forces constant prioritisation, affecting both the quality of care and the physical and emotional health of the workforce. This leads to accelerated work rhythms deriving in exhausting shifts and hinder the ability to provide personalised care.	*"We don't have enough staff and we end up working like a factory. Because we have to move fast, we don't take the time. A quick toilet is not our job. We're there to take our time with the resident"* (FG1 FR Target B).
		Travel demands	Participants describe it as a source of daily strain, shaped by inefficient planning, unpaid time, and the physical and logistical challenges of constant commuting. It impacts physical well-being but also encroaches on workers' personal time and overall quality of life.	*"Last-minute changes to schedules. Problems related to the organisation of work, such as travel between interventions, can also be a source of fatigue"* (FG6 FR Target A).
		Workload	Recurrent concern across discussions, closely linked to staff shortages and the multiplication of responsibilities. Participants describe how both care and administrative duties accumulate, generating a sense of permanent urgency and insufficient support.	*"For example, last Saturday there were only three care assistants instead of five. We had to reorganise our day and deal with the pressure"* (FG6 FR Target A).
	Relational	**Conflict with coworkers**	The most frequent conflicts are related to the unequal distribution of shifts, rest periods, or holidays, which results in	*"For me, the hardest thing is when there are replacements, they often arrive without knowing the work, and that disorganises the whole team. We have to explain things to*

			Definition	Illustrative quotes
			certain workers—especially those with part-time contracts—bearing a greater share of responsibility.	*them while carrying on with our own work, which is complicated. We all talk about the lack of time, and that's exactly it: we don't have the time to train the replacements properly."* (FG 3 FR Target B).
		Conflicts with relatives	Conflicts take various forms, which can be grouped into excessive demands, procedural misunderstandings, and relational tensions marked by lack of understanding. These situations add significant strain to the daily work of care staff, who must balance direct caregiving with the emotional management of family interactions.	*"And that's the difficulty, not necessarily in terms of the job. Then it's more with the families, the conflicts with the families that we can encounter. The family wants to say things, whereas it's up to the person themselves to tell us what they want. That's the hardest part, but there you go."* (FG 4 FR Target A).
		Relatives' expectations	These expectations are not always clearly communicated and are often unrealistic or difficult to meet within the context of collective care.TThey also impact the adaptation process to the centre. In discussion it is said that is more difficult for the family to adjust than for the residents themselves, which adds another layer of emotional complexity to the staff's work. Unrealistic beliefs about the potential for improvement also appear.	*"The challenges I face even include having to manage the expectations of patients and families to some extent, which is very complicated at times."* (FG 7 FR Target A y C).
	Personal	**Overcommitment**	Constant dedication, motivated by the desire to do a good job and provide quality care, but also by structural and ethical pressures that make it difficult to separate professional responsibilities from personal life. This overcommitment manifests itself in different ways—ranging from being permanently available to assuming a strong sense of responsibility at work.	*"We always try to do our best, even if we know that perfection is not always possible. We have a lot of resources at our disposal, but it's important to know how to use them effectively and to remain open to exchanges with other professionals"* (FG8 FR Target C).
Protective Factors	Job related	**Autonomy**	Emerges as a valuable resource referring to the freedom to make decisions and organise their work. This sense of control over the daily routine allows for greater flexibility and personal initiative, which contributes to job satisfaction. It is also	*"The positive side that I like is the autonomy you have when you're working at home. You can make decisions and put things in place"* (FG7 FR Target A and C).

			Definition	Illustrative quotes
			associated with the absence of constant supervision or team pressure and enables a degree of creativity and variation in care delivery.	
		On-the-job learning	Enables care workers to develop practical knowledge and coping strategies in a highly demanding environment. This learning occurs through both formal training and learning by doing, though workers highlight notable differences in usefulness, accessibility, and impact between these two forms.	*"Even though we have training, we still have difficulties with certain groups of people. How do you deal with people who have Alzheimer's or Parkinson's at a very advanced stage?"* (FG7 FR Target A).
		Time off	The effective respect for rest time and days off is an essential resource for preserving the physical and emotional health of home care workers.	*"Then we need our days off, to really rest we really need to... We can't afford to go out partying and all that on our days off. It's impossible because mentally, for us it's not physical it's mental, when you come out of it you're drained and when I say drained it's drained of tears, drained of brain. It's drained everywhere."* (FG 1 FR Target B).
		Workplace ergonomics and assistive devices	A key resource for preventing physical injuries and ensuring job sustainability. It includes three main dimensions: the availability of lifting equipment (such as hoists or adjustable beds), the presence of other supportive materials that help adapt the physical environment to the needs of both staff and care receivers, and the physical and functional design of the job itself.	*"On the other hand, during the day, situations where we have to lift patients because we don't have the right equipment, that's another story. Especially when there's a shortage of staff."* (FG 3 FR Target B).
	Relational	**Coworkers' cohesion**	An important element for coping with work-related challenges. Although they are advised in meetings to go through management in complex situations, it is explained that there are many situations that rely mainly on peer solidarity.	*"I think that team cohesion is the key to overcoming difficulties. [...] When we come across a problem with a care receiver, we usually call each other to find solutions"* (FG6 FR Target A).
		Coworkers' support	Functions as a vital resource that when present, it strengthens the work, improves the quality of care, and emotionally sustains the workers. Creating opportunities for connection, encouraging inter-shift communication, and formally recognizing the value of	*"It's true that we have a very close-knit team. We've known each other for quite a long time [...] It's our main resource. [...] It's this solidarity that makes the job more bearable, especially when the days are tough."* (FG8 FR Target C).

			Definition	Illustrative quotes
			peer support are necessary steps to reinforce this essential source of care, which currently relies heavily on individual initiative.	
		Emotional bonds	Emotional connections born in the daily care activity through the closeness and exposure to care receivers' intimate lives. While these connections often provide meaning, motivation, and a sense of belonging, they also expose caregivers to emotional strain and blurred boundaries.	*"I cry, then it gets better."* (FG4 FR Target A).
		Interteams coordination	Interteam coordination refers to the alignment and synchronization of actions, communication, and resources across different teams working toward shared goals. It distinguishes four key mechanisms: mutual adjustment, direct supervision, standardisation, and higher-order mutual adjustment. In discussion, a lack of interteams coordination is reported.	*"They change our timetable in the evening for the following day" (FG6 FR Target A). "Sometimes you're misinformed with the application, that's just what needs to be reviewed" (*FG4 FR Target A).
		Recognition by the care receiver	While not universal—some care receivers dismiss the value of the care provided—many others express gratitude through words, gestures, or emotional connection. Workers describe feeling deeply moved when care receivers remember them after absences, express joy upon their arrival, or offer subtle signs of appreciation even without speaking.	*"When we receive sincere thanks from care receivers or their families, that offsets the negative aspects."* (FG6 FR Target A).
		Relatives´ support	It has a relevant impact on the work experience of home care workers, both positively and negatively. The testimonies show that the relationship with family members can either ease or complicate the caregiver's work, depending on the level of availability, recognition, and communication established with them.	*"It's true that patients' families can also be a valuable resource. When the family is present, we don't hesitate to ask for their help, whether it's to fetch medicines or to look after the patient when we can't be there. Some families are really reliable, and it's a relief to know you can count on them."* (FG 8 FR Target C).

			Definition	Illustrative quotes
		Relatives´recognition	Emerges as a significant emotional factor in the experience of home care workers. While not a formal part of the employment relationship, this recognition—or lack of it—can strongly influence workers' emotional well-being, motivation, and sense of fairness in their daily tasks.	*"When we receive sincere thanks from service users or their families, that offsets the negative aspects. The support and recognition we receive helps us to stay motivated and to continue providing quality care despite the difficulties."* (FG 6 FR Target A).
	Personal	**Boundaries management**	Constant negotiation whether related to tasks, emotions, or time, these boundaries are often tested by care receiver expectations, emotional proximity, or inconsistent practices among colleagues. While some workers succeed in asserting clear limits, others express difficulty in doing so, revealing the tensions and ambiguities that shape daily caregiving experiences.	*"I love my work and it doesn't spill over into my personal life too much... but maybe if my children were younger it would be more complicated."* (FG7 FR Target A and C).
		Cognitive appraisal	A meaningful personal strategy to cope with the emotional impact of death and loss in institutional settings. In dialogue it appears as a way to reframe the experience by focusing on the resident's suffering and advanced age.	*"I concentrate on the positive aspects of the job. When I finish a difficult day, I take the time to think about the successes, however small, in the job or otherwise, it's not a big deal. But what I don't have is a supportive space where we can find solutions together."* (FG 7 FR Target A y C).
		Coping strategies	Managing the emotional and practical demands of their job. Participants mention different ways of coping with stressful situations, ranging from avoidance to emotional expression, distancing, or the use of humour.	*"Over time I've learnt to put things into perspective, to stand back"* (FG2 FR Target A).
		Disconnection	Far from automatic—it often requires conscious strategies, emotional effort, and other personal resources. The inability to disconnect not only prolongs work-related stress but also intrudes on rest time and personal well-being.	*"I've seen nights when I couldn't fall asleep because I was thinking about what I had to do for the care receiver the next day" (FG2 ES Target A). "My work follows me home and even at night... I ask myself: did I do it right?"* (FG4 FR Target A).
		Emotional self-regulation	Implies the capacity — acquired through experience — to remain engaged without becoming overwhelmed, especially when working in close contact with fragility, suffering, or loss.	You have to have nerves of steel" (FG1 FR Target B).

		Definition	Illustrative quotes
	Empathy	Resource that helps sustain workers' motivation and meaning in their caregiving roles. Several participants describe feeling emotionally moved by the loneliness, abandonment or vulnerability of the people they support.	*"There are times when you manage to put a smile back on someone's face, and that's really nice"* (FG8 FR Target C)
	Meaning of work	Far from being perceived as a purely functional or routine occupation, care work is described as emotionally significant and personally meaningful, rooted in human connection, reciprocity, and the opportunity to make a positive difference in others' lives.	*"It's a rewarding job, because you go home feeling that you've done something useful."* (FG8 FR Target C).
	Motivation	Motivation spans a broad spectrum, from intrinsic motivation to amotivation. The testimonies analysed show that the reasons for remaining in the care profession combine personal enjoyment, commitment to the task, recognition of its social value, and, in some cases, resignation or a sense of lost purpose.	*"The good thing is that I've always loved this job, so it's a real pleasure"* (FG1 FR Target B).
	Proactive behaviour	Self-initiated, anticipatory actions through which individuals aim to bring about change in themselves or in their environment. Participants described how they organised their tasks, regulated their emotions, and relied on personal experience to respond effectively to challenges in daily care work.	*"I try to remain flexible and anticipate the unexpected. I plan my days according to priorities..."* (FG7 FR Target A and C)
	Professional vocation	Appears in the testimonies as a personal inclination toward caregiving. It is described as a meaningful disposition that helps workers stay committed to their tasks, especially in emotionally and physically demanding situations.	*"Firstly, the positive points of my work. It's meaningful, it makes sense to me. This is exactly the field in which I saw myself developing. For the record, I was a family carer for my son for 13 years; since then I've delegated, so I don't have him at home any more."* (FG 4 FR Target A).
	Recovery strategies	Essential coping with the demands of home care work. These strategies focus on personal well-being and include self-care, physical activity, music, and social outings as ways to recharge and regain emotional balance.	*I take time out for myself. This allows me to recharge my batteries and come back to work with more energy. I think that's essential if you want to last in this profession"* (FG2 FR Target A).

Table 2. *Italy – Depiction of Risk and Protective Factors*

			Definition	Illustrative quotes
Risk Factors	Job related	Emotional demands	Relational care work is complex and professionals are required to regulate their own emotions, respond sensitively to others, and cope with the cumulative effects of deep personal involvement. These demands—from emotional display to sustained engagement— have a significant impact on mental health and professional endurance.	*"I have learned to detach myself, in the sense that when I'm at work, I listen to them and I take care of many things with regard to patients, but once at home I manage to leave everything at the dialysis unit…".* (FG 1 IT Target B).
		Exposure to suffering and death	Care workers are routinely exposed to the deterioration, suffering, and death of residents, with whom they often develop emotional bonds.	*"yes, then perhaps on an emotional level it depends, sometimes it does affect me, but simply because I'm in an emergency department, we often have to deal with small children, and so perhaps on an emotional level it touches me a little, it affect me because I experienced it firsthand recently, when a very small child unfortunately passed away, but before that I heard that some colleagues had also done some sessions with the psychologist."* (FG 1 IT Target B).
		Exposure to violence	Care workers are exposed to aggressive behaviour from patients or residents, often linked to postoperative effects, medications, or neuropsychiatric conditions. These incidents are not always labeled as violence but are experienced as stressful and emotionally draining.	*"It's more than two months. At times she gets pissed off, starts yelling, screaming, going out in the street…she says: 'I'll call for help! I'm going outside to call for help!' When I come back, at four o'clock, she comes near me and says: 'Aliona, I have to say sorry', I say: 'why?'… 'Eh I made a mistake today…' She calms down after a time, but at that time it is very very difficult."* (FG 3 IT Target A).
		Exposure to discrimination	Some migrant care workers report experiences of discrimination and racism linked to their foreign origin, often expressed by care receivers or their families. These situations include derogatory remarks and rejection, which directly affect the emotional well-being of the workers and reinforce feelings of exclusion.	*"They are arrogant! Then the fact that you are a foreigner, (unintelligible) Africa, things a bit like that…a bit of racism…a bit of a lot of things….but you get used to it, over the years you get used to it…you live your life."* (FG 3 IT Target A).

			Definition	Illustrative quotes
		Pace of work	Work pace varies depending on the care setting. The speed imposes constant pressure, limits room for maneuver, and can increase physical and emotional strain.	*"In the emergency department, so the workload is different because it's all faster, much faster… being an emergency department we happen to deal with people who, how can I put it?"* (FG 1 IT Target B).
		Perceived exploitation	Exploitation goes beyond physical exhaustion: it involves legal vulnerability, degrading treatment, and sustained psychological strain. Workers report exploitation classified in a wide range of experiences: Abusive recruitment and informal intermediaries, overwork and insufficient resources for quality care, lack of respect for rest time and legal vulnerability and impunity for abuse.	*"But we carers are (unintelligible) 85 per cent are very disappointed with their work. We are really exploited! They are not taken into consideration…because even sleeping, you wake up crying."* (FG 3 IT Target A).
		Physical demands	They are a central concern for care workers in institutional settings, where daily tasks often involve intense bodily effort and repeated strain. All of this leads to high levels of physical strain, and normalisation of bodily pain, all of which seriously impact workers' health and well-being.	*"If we are in two it is different, if you can use machinery in a person who weighs 80 kg you cannot do it, you always have to be in two, you can do it yes but it is at your risk".* (FG 4 IT Target B).
		Role ambiguity	Discrepancies between what is stated in contracts and the actual conditions of the job. Unclear information about patients' needs, care expectations, and work conditions gives rise to role ambiguity, which complicates daily tasks and weakens the boundaries of professional responsibility.	*"I would also like to stress that there has been a lot of talk about the fact that sometimes in the contract they put people who are self-sufficient, that they are not so sincere, it really is when you get to work you find people who are not self-sufficient, if they find a way to put it another way. But on this really speaking, if you let the family know right away that what's written in the contract is no good, they will surely agree beforehand."* (FG 5 IT Target A).
		Schedule	Organisation is a key factor affecting both well-being and work-life balance in institutional care. Some models are perceived positively, offering more days off and better recovery.	*"I worked 24 hours a day, when I say 24 hours a day it means that to be called at night maybe 4 or 5 times a night, that you have to get up because he pooped himself, because he vomited, because he cannot sleep, because there is always … It was a hallucinating thing…"* (FG 5 IT Target A).

			Definition	Illustrative quotes
		Task beyond duties	Care staff are required to take on responsibilities outside their role, often as a result of organisational dynamics or the absence of specific personnel, leading to a steady extension of their duties.	*"Come very reactive with the reality of the staff, of the personnel, as has already been said, we are often asked to do much more than what we are responsible for, and it is easy to get angry because then they suffer, perhaps they do not have the answers they would like to have..."* (FG 6 IT Target C).
		Time pressure	Work organisation, based on official staffing ratios perceived as unrealistic, forces constant prioritisation, affecting both the quality of care and the physical and emotional health of the workforce. This leads to accelerated work rhythms deriving in exhausting shifts and hinder the ability to provide personalised care.	*"Because the speed of the work you are forced to go to also leads you to waste more material, sometimes I say a triviality".* (FG 1 IT Target B).
		Travel demands	Participants describe it as a source of daily strain, shaped by inefficient planning, unpaid time, and the physical and logistical challenges of constant commuting. It impacts physical well-being but also encroaches on workers' personal time and overall quality of life.	*"I'm not very close to home, but I'm lucky enough to drive, I have my licence and in fifteen to twenty minutes I'm there at work. By car eh!"* (FG 3 IT Target A).
		Workload	Recurrent concern across discussions, closely linked to staff shortages and the multiplication of responsibilities. Participants describe how both care and administrative duties accumulate, generating a sense of permanent urgency and insufficient support.	*"We have access to 50/60 people per day, we are few, we are 6 or 7 per shift and we have to manage yellow, red, surgical, triage and medical cases.."* (FG 1 IT Target B).
	Relational	**Conflict with care receiver**	They take three main forms: role conflict, task-related, and emotional. These situations affect not only the organisation of work but also emotional well-being and the perception of fairness in the workplace.	*"The problem is her! She is very very delicate. You have to be careful: when I speak, what I speak, when you have to be quiet you have to be quiet, leave her a little bit quiet then start again...because she has...four injections: three injections for insulin and one in the evening that also many many (unintelligible)...sometimes she doesn't want to take them, she gets up insulin you become aggressive...and it's*

			Definition	Illustrative quotes
				my first time. The truth is that this is my first time working like this." (FG 3 IT Target A).
		Conflicts with relatives	Conflicts take various forms, which can be grouped into excessive demands, procedural misunderstandings, and relational tensions marked by lack of understanding. These situations add significant strain to the daily work of care staff, who must balance direct caregiving with the emotional management of family interactions.	*"...you get used to it, over the years you get used to it...you live your life. You do yours anyway (unintelligible)...I do mine, properly and if the family doesn't like me or treats me badly, I respond! If they don't like mine, I answer... Why don't I shut up! Because it's been many years that I've been silent... I don't understand after those years: we are carers, but we are not slaves!"* (FG 3 IT Target A).
		Relatives' expectations	These expectations are not always clearly communicated and are often unrealistic or difficult to meet within the context of collective care.TThey also impact the adaptation process to the centre. In discussion it is said that is more difficult for the family to adjust than for the residents themselves, which adds another layer of emotional complexity to the staff's work. Unrealistic beliefs about the potential for improvement also appear.	*"... and then perhaps I find some difficulty in dealing with certain patients' relatives when they don't have a clear idea of the hospice's objective, because very often, too often, it happens that either the main objective of the hospice is not explained well, which is the taking into care, that is the improvement of the person's quality of life, or I don't know, the relatives have very high expectations or react very badly to the patient's condition."* (FG 1 IT Target B).
	Personal	**Foreign language**	The language barrier is a significant challenge for many migrant care workers, especially at the beginning of their employment.	*"For me it was when I arrived that I didn't know a single word of Italian. This was a door in the face for me"* (FG5 IT Target A).
		Overcommitment	Constant dedication, motivated by the desire to do a good job and provide quality care, but also by structural and ethical pressures that make it difficult to separate professional responsibilities from personal life. This overcommitment manifests itself in different ways—ranging from being permanently available to assuming a strong sense of responsibility at work.	*"...but in any case, I don't think of it as a solution, my availability should not be the solution, because if I were able to impose myself and say no, I don't know how they do it, because it's a detachment. I cańt say no."* (FG 1 IT Target B).

			Definition	Illustrative quotes
Protective Factors	Job related	On-the-job learning	Enables care workers to develop practical knowledge and coping strategies in a highly demanding environment. This learning occurs through both formal training and learning by doing, though workers highlight notable differences in usefulness, accessibility, and impact between these two forms.	*"I came out of the university with skills, I put them into practice and I constantly need to update them because in just a few years I realised that I had learnt a lot more than I had seen or heard about or that they had explained to me, and this is somewhat underestimated".* (FG 6 IT Target C).
		Time off	The effective respect for rest time and days off is an essential resource for preserving the physical and emotional health of home care workers.	*"Tomorrow is Saturday, they'll give me half a day on Monday... for me there's no problem either Saturday or Monday".* (FG3 IT Target A).
		Workplace ergonomics and assistive devices	A key resource for preventing physical injuries and ensuring job sustainability. It includes three main dimensions: the availability of lifting equipment (such as hoists or adjustable beds), the presence of other supportive materials that help adapt the physical environment to the needs of both staff and care receivers, and the physical and functional design of the job itself.	*"If you have to use a lift, by rule you should be in pairs, but if you're alone, it's at your own risk".* (FG 4 IT Target B).
	Relational	Coworkers´support	Functions as a vital resource that when present, it strengthens the work, improves the quality of care, and emotionally sustains the workers. Creating opportunities for connection, encouraging inter-shift communication, and formally recognizing the value of peer support are necessary steps to reinforce this essential source of care, which currently relies heavily on individual initiative.	*"Some colleagues believe they have the more right than others to take time off at home and if they are denied for some reason [...] they simply call in sick [...] and being the only person who does part time I am always the one who has to cover the shift"* (FG1 IT Target B).
		Emotional bonds	Emotional connections born in the daily care activity through the closeness and exposure to care receivers' intimate lives. While these connections often provide meaning, motivation, and a sense of belonging, they also expose caregivers to emotional strain and blurred boundaries.	*"I don't have any difficulty here, as my colleague said before, I also feel like a family, and the children feel like I am a sister too, the lady says to me 'I have four children', she includes me as a daughter too"* (FG 5 IT Target A).

			Definition	Illustrative quotes
		Interteams coordination	Interteam coordination refers to the alignment and synchronization of actions, communication, and resources across different teams working toward shared goals. It distinguishes four key mechanisms: mutual adjustment, direct supervision, standardisation, and higher-order mutual adjustment. In discussion, a lack of interteams coordination is reported.	*"...The work with the guests we try to stay in communication with them but as my colleague said the biggest problem is this communication between us, because there is not..."* (FG 4 IT Target B).
		Recognition by the care receiver	While not universal—some care receivers dismiss the value of the care provided—many others express gratitude through words, gestures, or emotional connection. Workers describe feeling deeply moved when care receivers remember them after absences, express joy upon their arrival, or offer subtle signs of appreciation even without speaking.	*"...But there is always a return from many patients, so in this sense it is also satisfying to know that many of them recognise the great sacrifices we are making to guarantee more than complete and more than complete care."* (FG 6 IT Target C).
	Personal	**Boundaries management**	Constant negotiation whether related to tasks, emotions, or time, these boundaries are often tested by care receiver expectations, emotional proximity, or inconsistent practices among colleagues. While some workers succeed in asserting clear limits, others express difficulty in doing so, revealing the tensions and ambiguities that shape daily caregiving experiences.	*"She says to me: 'Did you go away to pull out the patient's probe and did you do the enema?' I said 'No, because my skills are up to you on the enema.'"* (FG2 IT Target B).
		Coping strategies	Managing the emotional and practical demands of their job. Participants mention different ways of coping with stressful situations, ranging from avoidance to emotional expression, distancing, or the use of humour.	*"At a certain point you create a shield... otherwise you can't live"* (FG6 IT Target C).
		Disconnection	Far from automatic—it often requires conscious strategies, emotional effort, and other personal resources. The inability to disconnect not only prolongs work-related stress but also intrudes on rest time and personal well-being.	*"You always take something from work home, whether you want to or not"* (FG1 IT Target B).

			Definition	Illustrative quotes
		Emotional self-regulation	Implies the capacity — acquired through experience — to remain engaged without becoming overwhelmed, especially when working in close contact with fragility, suffering, or loss.	*"You really have to be sure, don't panic, know what you have to do, because then it's a person's life at stake"* (FG4 IT Target B).
		Empathy	Resource that helps sustain workers' motivation and meaning in their caregiving roles. Several participants describe feeling emotionally moved by the loneliness, abandonment or vulnerability of the people they support.	*"You inevitably establish empathy, sympathy, or even antipathy... whether you want it or not."* (FG6 IT Target C).
		Meaning of work	Far from being perceived as a purely functional or routine occupation, care work is described as emotionally significant and personally meaningful, rooted in human connection, reciprocity, and the opportunity to make a positive difference in others' lives.	*"This work has given me so much, both in terms of intellectual wealth and wealth of life [...] it has really filled me."* (FG4 IT Target B).
		Motivation	Motivation spans a broad spectrum, from intrinsic motivation to amotivation. The testimonies analysed show that the reasons for remaining in the care profession combine personal enjoyment, commitment to the task, recognition of its social value, and, in some cases, resignation or a sense of lost purpose.	*"A job that has to be done with love"* (FG5 IT Target A).
		Proactive behaviour	Self-initiated, anticipatory actions through which individuals aim to bring about change in themselves or in their environment. Participants described how they organised their tasks, regulated their emotions, and relied on personal experience to respond effectively to challenges in daily care work.	*"I can't explain it well...but (unintelligible)...as a woman, as a mother, as a job I think I'm not...I always know how to manage. (unintelligible) manage the person's situation. I am fine like this, I have found my way and if (unintelligible) problem I solve it. I also first notify the family and then I do, afterwards we see...maybe for the experiences I have I don't know...but it is not that...for me it is not a problem. "* (FG 3 IT Target A).
		Professional vocation	Appears in the testimonies as a personal inclination toward caregiving. It is described as a meaningful disposition that helps	*"Frankly, towards my job, even if I have been doing it for many years, I am not tired of it [...] I work with the same*

			Definition	Illustrative quotes
			workers stay committed to their tasks, especially in emotionally and physically demanding situations.	*passion.*" (FG4 IT Target B).
		Recovery strategies	Essential coping with the demands of home care work. These strategies focus on personal well-being and include self-care, physical activity, music, and social outings as ways to recharge and regain emotional balance.	*"When I have my things, I say no to the head nurse without worrying, because I can't save everything myself"* (FG1 IT Target B); *"I also need time for myself, not just for others, I'm there too"* (FG4 IT Target B).

Table 3. *Germany – Depiction of Risk and Protective Factors*

			Definition	Illustrative quotes
Risk Factors	Job related	**Exposure to abuse**	Experiences of sexual, physical, and verbal abuse by care receivers, occurring in private settings without supervision. Some participants described situations where agencies or employers were aware of the abuse but allowed the employment relationship to continue.	*"It was still with sexual overtones...It's really awful. But this company knew it... This company knew everything... but acted as if it wasn't happening"* (FG2 DE Target A).
		Emotional demands	Relational care work is complex and professionals are required to regulate their own emotions, respond sensitively to others, and cope with the cumulative effects of deep personal involvement. These demands—from emotional display to sustained engagement— have a significant impact on mental health and professional endurance.	*"You have to keep your game face on and keep going. So, it's not always easy."* (FG5 DE Target C).
		Exposure to suffering and death	Care workers are routinely exposed to the deterioration, suffering, and death of residents, with whom they often develop emotional bonds.	*"There are also negative aspects, unfortunately. First of all, these events that she mentioned earlier, that's normal for us, that's everyday life there and it's extremely emotional. So you have to act as if it hasn't happened and carry on. But it's extremely difficult emotionally. Of course, they also have psychologists on the ward, but it's not always easy. You should actually see a psychologist every day. Patients are also under a lot of psychological stress after the transplant. This affects us because we are the working group that spends eight hours at the bedside."* (FG 5 DE Target C).
		Exposure to violence	Care workers are exposed to aggressive behaviour from patients or residents, often linked to postoperative effects, medications, or neuropsychiatric conditions. These incidents are not always labeled as violence but are experienced as stressful and emotionally draining.	*"They treat us very badly, a little bit like servants. Yes I was on the side of this DDR u or with a full on head and e.g. nurses were coming then sister sister still looking in there too girl jumped in. Still a month awful, though the words are demeaning. Demeaning behavior and that too when someone humiliates you. It is not pleasant."* (FG 2 DE Target A).

			Definition	Illustrative quotes
		Perceived exploitation	Exploitation goes beyond physical exhaustion: it involves legal vulnerability, degrading treatment, and sustained psychological strain. Workers report exploitation classified in a wide range of experiences: Abusive recruitment and informal intermediaries, overwork and insufficient resources for quality care, lack of respect for rest time and legal vulnerability and impunity for abuse.	*"A day off? None of them ever asked for that"* (FG2 DE Target A).
		Physical demands	They are a central concern for care workers in institutional settings, where daily tasks often involve intense bodily effort and repeated strain. All of this leads to high levels of physical strain, and normalisation of bodily pain, all of which seriously impact workers' health and well-being.	*"Back pain in intensive care is normal... I would describe all that as negative, it's physically, emotionally, and psychologically stressful"* (FG5 DE Target C).
		Role ambiguity	Discrepancies between what is stated in contracts and the actual conditions of the job. Unclear information about patients' needs, care expectations, and work conditions gives rise to role ambiguity, which complicates daily tasks and weakens the boundaries of professional responsibility.	*"I had a lady with depression and psychosis who refused any medications—it was mental torture... and the problem was also the lack of contact with the family"* (FG2 DE Target A).
		Safety hazards	Biological risks faced by care workers which they feel as inherent danger to their profession and not recognised by institutions or society.	*"I can care for patients every day or risk my life... but in the end, there's almost nothing left. I work the whole month just to be able to pay the rent, electricity, insurance..."* (FG3 DE Target B).
		Schedule	Organisation is a key factor affecting both well-being and work-life balance in institutional care. Some models are perceived positively, offering more days off and better recovery.	*"Basically, I think my work is positive and I no longer work directly in shifts, but twelve hours on call at weekends and on public holidays, that's okay. But I also enjoyed working shifts."* (FG 4 DE Target C).
		Task beyond duties	Care staff are required to take on responsibilities outside their role, often as a result of organisational dynamics or the absence	*"If the company doesn't stand behind you, there's serious criminal liability... even for things like compression stockings*

			Definition	Illustrative quotes
			of specific personnel, leading to a steady extension of their duties.	*or dressings"* (FG2 DE Target A).
		Time pressure	Work organisation, based on official staffing ratios perceived as unrealistic, forces constant prioritisation, affecting both the quality of care and the physical and emotional health of the workforce. This leads to accelerated work rhythms deriving in exhausting shifts and hinder the ability to provide personalised care.	*"This physical strain, this pushing beds and transferring patients under time pressure is also stressful. And yes, sometimes I have to fill in at short notice when I'm not on duty."* (FG 4 DE Target C).
		Workload	Recurrent concern across discussions, closely linked to staff shortages and the multiplication of responsibilities. Participants describe how both care and administrative duties accumulate, generating a sense of permanent urgency and insufficient support.	*"The workload can be light at the beginning, but it increases as the service progresses. And as I said, the challenge is always not only to look after the child, but also to look after the parents."* (FG 4 DE Target C).
	Relational	**Conflict with care receiver**	They take three main forms: role conflict, task-related, and emotional. These situations affect not only the organisation of work but also emotional well-being and the perception of fairness in the workplace.	*"On the negative side, I sometimes find that the tone from patients has become very demanding. Not always, but when it's noticeable, it's kind of negative that you have to discuss a lot and get a lot of incomprehension. That's a bit negative."* (FG 4 DE Target C).
		Conflict with coworkers	The most frequent conflicts are related to the unequal distribution of shifts, rest periods, or holidays, which results in certain workers—especially those with part-time contracts—bearing a greater share of responsibility.	*"So I have difficulties with colleagues when they want to take advantage of something. For example, I would have the case... brings a colleague or and then comes to me and says that the ... has to go into the machine because that's my job. And then, of course, when I say yes, what's going on? It sounds bad in German, my words, and they think it's bad. And then they go to other colleagues and there's a negative response."* (FG 3 DE Target B).
		Conflicts with relatives	Conflicts take various forms, which can be grouped into excessive demands, procedural misunderstandings, and	*"Sometimes there is a problem with cooperation with the family. Because just as there was a joke anecdote that*

			Definition	Illustrative quotes
			relational tensions marked by lack of understanding. These situations add significant strain to the daily work of care staff, who must balance direct caregiving with the emotional management of family interactions.	*Mommy has Alzheimer's, do not take Mommy seriously, but if Mommy says that the caregiver digs, buys, robs the family, who does she believe? Mommy."* (FG 2 DE Target A).
	Personal	**Foreign language**	The language barrier is a significant challenge for many migrant care workers, especially at the beginning of their employment.	*"I have this impression that if we don't know German well, we don't know German law well and we won't demand something... that's why you have to fight for your rights"* (FG2 DE Target A).
		Overcommitment	Constant dedication, motivated by the desire to do a good job and provide quality care, but also by structural and ethical pressures that make it difficult to separate professional responsibilities from personal life. This overcommitment manifests itself in different ways—ranging from being permanently available to assuming a strong sense of responsibility at work.	*"Plus my difficulty is that I find it really difficult when I have a patient who is ventilated, because you have a huge responsibility. Of course, on a normal ward you also have a human life, even several intensive ones, and there it's only three. But it's this responsibility that a patient is simply being ventilated on a machine and anything could happen at any second. It's hard to go wrong. I have to say in return."* (FG 3 DE Target B).
Protective Factors	Job related	**On-the-job learning**	Enables care workers to develop practical knowledge and coping strategies in a highly demanding environment. This learning occurs through both formal training and learning by doing, though workers highlight notable differences in usefulness, accessibility, and impact between these two forms.	*"Plus my difficulty is that I find it really difficult when I have a patient who is ventilated, because you have a huge responsibility. Of course, on a normal ward you also have a human life, even several intensive ones, and there it's only three. But it's this responsibility that a patient is simply being ventilated on a machine and anything could happen at any second. It's hard to go wrong. I have to say in return."* (FG 3 DE Target B).
		Time off	The effective respect for rest time and days off is an essential resource for preserving the physical and emotional health of home care workers.	*"One solution was shortening working hours. That's an important point: that you don't work 100%, but 80% and that you don't have so many shifts in a row. Because you immediately notice when you have seven shifts or five and then four days or three or two off."* (FG5 DE Target C).

			Definition	Illustrative quotes
	Relational	**Emotional bonds**	Emotional connections born in the daily care activity through the closeness and exposure to care receivers' intimate lives. While these connections often provide meaning, motivation, and a sense of belonging, they also expose caregivers to emotional strain and blurred boundaries.	*"People always say that patients are important. Yes, they are. Many of them are ill and we are there for them. But sometimes we also need help because our heads are on fire. There is so much emotion, so much frustration sometimes, because this feeling makes us powerless. You can't change anything. Sometimes you have to accept what happens. Yes, that does something to your psyche. You always have to smile, but you don't have to."* (FG 3 DE Target B).
		Recognition by the care receiver	While not universal—some care receivers dismiss the value of the care provided—many others express gratitude through words, gestures, or emotional connection. Workers describe feeling deeply moved when care receivers remember them after absences, express joy upon their arrival, or offer subtle signs of appreciation even without speaking.	*"Positive because every day, regardless of whether you are tired or not, you go home with a positive feeling. There's nothing better than feedback from patients. You can see that and you want it to be super nice again. So I've also become more open and that's positive."* (FG 3 DE Target B):
		Relatives´ support	It has a relevant impact on the work experience of home care workers, both positively and negatively. The testimonies show that the relationship with family members can either ease or complicate the caregiver's work, depending on the level of availability, recognition, and communication established with them.	*"Lack of pause, lack of time off, where the family causes problems with time off, They don't want to accept it, and the company makes them get along with their families. It's such a vicious circle. And yet the caregiver needs to reset a little, to rest."* (FG 1 DE Target A).
		Supervisor support	Central role in the organisation of home care, particularly when workers must navigate complex tasks, emotional demands, or conflictive situations.	*"Sometimes it happens that the coordinator is actually helpful, because as one lady came up with a short time before my departure in February, where it was cold, that I should wash the windows, an old tenement, high windows, then I for the coordinator's phone says that absolutely not a lady to your German coordinator. Thank God, the gentlemen were in agreement this time and she got it from the Polish coordinator and still from the German coordinator."* (FG 2 DE Target A).

			Definition	Illustrative quotes
	Personal	**Boundaries management**	Constant negotiation whether related to tasks, emotions, or time, these boundaries are often tested by care receiver expectations, emotional proximity, or inconsistent practices among colleagues. While some workers succeed in asserting clear limits, others express difficulty in doing so, revealing the tensions and ambiguities that shape daily caregiving experiences.	*"So I have everything on the ward. And I'm grateful for that. I've learnt to say no, but to say no in a way that doesn't come across as negative, because you don't always have to say yes, you don't have to take a thousand things. Because you think she'll get angry."* (FG 2 DE Target B).
		Empathy	Resource that helps sustain workers' motivation and meaning in their caregiving roles. Several participants describe feeling emotionally moved by the loneliness, abandonment or vulnerability of the people they support.	*"So as the colleague here said, mat builds relationships when the patients are with us for a long time and then they are discharged, because sometimes you get separated in the eyes. That's why you have to have this empathy."* (FG 3 DE Target B).
		Meaning of work	Far from being perceived as a purely functional or routine occupation, care work is described as emotionally significant and personally meaningful, rooted in human connection, reciprocity, and the opportunity to make a positive difference in others' lives.	*"I love my job as a pediatric nurse and children are something special. They are different from adults and back more than others can."* (FG 4 DE Target C).
		Motivation	Motivation spans a broad spectrum, from intrinsic motivation to amotivation. The testimonies analysed show that the reasons for remaining in the care profession combine personal enjoyment, commitment to the task, recognition of its social value, and, in some cases, resignation or a sense of lost purpose.	*"The positive thing about the job is that you get to know lots of people, lots of characters [...] There are also grateful patients"* (FG4 DE Target C).
		Proactive behaviour	Self-initiated, anticipatory actions through which individuals aim to bring about change in themselves or in their environment. Participants described how they organised their tasks, regulated their emotions, and relied on personal experience to respond effectively to challenges in daily care work.	*"And everything is postponed and then you have to adapt. It's something you don't expect and can come at any time. And if you're in this team on that day, you have to organize or do everything with your patient in such a way that you always have in the back of your mind that it could be the case that a real call could come."* (FG 5 DE Target C).

			Definition	Illustrative quotes
		Professional vocation	Appears in the testimonies as a personal inclination toward caregiving. It is described as a meaningful disposition that helps workers stay committed to their tasks, especially in emotionally and physically demanding situations.	*"I love my job as a pediatric nurse and children are something special. They are different from adults and back more than others can. "*(FG 4 DE Target C).
		Recovery strategies	Essential coping with the demands of home care work. These strategies focus on personal well-being and include self-care, physical activity, music, and social outings as ways to recharge and regain emotional balance.	*"So it's always important to find a balance when you're having a bad day, for example by going to the gym or doing some kind of therapy or finding an individual balance for yourself, for example with shopping or wellness or, or. There are also psychologists at work. Have a drink of water, get some fresh air."* (FG 3 DE Target B).
		Respect for legal regulations	Respect for labour and contractual regulations plays a central role in shaping the experiences of home care workers.	*"For four years I've been in different parts of Germany... and this was the first place where I had a day off"* (FG2 DE Target A).
		Task prioritization and time management	Efforts to protect time for core responsibilities, even in contexts where external demands compete for attention.	*"The organizational side is a part that also influences everyday life very well. Even if you're not at work, you have to make extremely good use of this time and do lots of things at the same time."* (FG 5 DE Target C).

Table 4. *Spain – Depiction of Risk and Protective Factors*

			Definition	Illustrative quotes
Risk Factors	Job related	Emotional demands	Relational care work is complex and professionals are required to regulate their own emotions, respond sensitively to others, and cope with the cumulative effects of deep personal involvement. These demands—from emotional display to sustained engagement— have a significant impact on mental health and professional endurance.	*"You end up taking all the crap they've been bottling up…".* (FG1 ES Target A). "what would I do without you?" (FG1 ES Target A)..
		Exposure to abuse	Experiences of sexual, physical, and verbal abuse by care receivers, occurring in private settings without supervision. Some participants described situations where agencies or employers were aware of the abuse but allowed the employment relationship to continue.	*"He took his clothes off and said: 'Come touch me'… I told him I'd call his children. 'No, no, I won't do it again,' he said"* (FG9 ES Target A).
		Exposure to suffering and death	Care workers are routinely exposed to the deterioration, suffering, and death of residents, with whom they often develop emotional bonds.	*"You can't forget… the person you've bathed, accompanied, and known in good health is dying. It's not possible to separate"* (FG1 ES Target A).
		Exposure to violence	Care workers are exposed to aggressive behaviour from patients or residents, often linked to postoperative effects, medications, or neuropsychiatric conditions. These incidents are not always labeled as violence but are experienced as stressful and emotionally draining.	*"Then the grandmother would chase me, she would chase me to hit me, she told me 'get out of here, I'm going to call the police'… I would hide and lock myself in the room, scared, because it was my first time, I hadn't worked with people with dementia before."* (FG9 ES Target A).
		Pace of work	Work pace varies depending on the care setting. The speed imposes constant pressure, limits room for maneuver, and can increase physical and emotional strain.	*"In home care, you might spend three hours with one person and then have to run with the next one"* (FG4 ES Target A).
		Perceived exploitation	Exploitation goes beyond physical exhaustion: it involves legal vulnerability, degrading treatment, and sustained psychological strain. Workers report exploitation classified in a wide range of experiences: Abusive recruitment and informal intermediaries,	*"He charged 1600€, gave us 600€, and didn't pay social security. He told us we were registered"* (FG9 ES Target A).

			Definition	Illustrative quotes
			overwork and insufficient resources for quality care, lack of respect for rest time and legal vulnerability and impunity for abuse.	
		Physical demands	They are a central concern for care workers in institutional settings, where daily tasks often involve intense bodily effort and repeated strain. All of this leads to high levels of physical strain, and normalisation of bodily pain, all of which seriously impact workers' health and well-being.	*"We have many sick leaves because of bone issues... cervical problems, lifting weight"* (FG8 ES Target B and C).
		Role ambiguity	Discrepancies between what is stated in contracts and the actual conditions of the job. Unclear information about patients' needs, care expectations, and work conditions gives rise to role ambiguity, which complicates daily tasks and weakens the boundaries of professional responsibility.	*"In the morning, after not sleeping or sleeping just a few hours, I'd feel dazed all day"* (FG5 ES Target A).
		Safety hazards	Biological risks faced by care workers which they feel as inherent danger to their profession and not recognised by institutions or society.	*"We are exposed to health hazards that no one even realizes; no one sees how dangerous this profession is. We were the ones facing the new virus, we were there, keeping things going."* (FG7 ES Target B y C).
		Schedule	Organisation is a key factor affecting both well-being and work-life balance in institutional care. Some models are perceived positively, offering more days off and better recovery.	*"I leave at 8 a.m. and get back at 7:30 p.m.... with lots of gaps in between"* (FG1 ES Target A).
		Task beyond duties	Care staff are required to take on responsibilities outside their role, often as a result of organisational dynamics or the absence of specific personnel, leading to a steady extension of their duties.	*"And we bear not only the burden of the work, but also the responsibility for the patient. As he says, sometimes the food runs out, and you have to call the children to tell them that this is missing, that the other thing is missing."* (FG 5 ES Target A).

			Definition	Illustrative quotes
		Time pressure	Work organisation, based on official staffing ratios perceived as unrealistic, forces constant prioritisation, affecting both the quality of care and the physical and emotional health of the workforce. This leads to accelerated work rhythms deriving in exhausting shifts and hinder the ability to provide personalised care.	*"Exhausting days, days when there isn't enough time, days when things happen that don't usually happen every day and it's a bit chaotic, but it's still manageable with the help of our other colleagues, who always support us."* (FG 8 ES Target B and C).
		Travel demands	Participants describe it as a source of daily strain, shaped by inefficient planning, unpaid time, and the physical and logistical challenges of constant commuting. It impacts physical well-being but also encroaches on workers' personal time and overall quality of life.	*"I've been walking around this town for fifteen years... and the hills are exhausting"* (FG1 ES Target A).
		Workload	Recurrent concern across discussions, closely linked to staff shortages and the multiplication of responsibilities. Participants describe how both care and administrative duties accumulate, generating a sense of permanent urgency and insufficient support.	*"They tell you: 'I need you to do this, you have to do it, I don't have anyone else,' and you get home at nine o'clock at night saying, I can't take it anymore"* (FG4 ES Target A).
	Relational	**Adverse family environment**	Strained and disorganised family context that directly affects both residents and staff. Their disengagement and conflict remains a source of problems.	*"The siblings don't speak to each other... each one has different ideas... and who's in the middle? Us. And grandfather."* (FG6 ES Target B and C).
		Conflict with coworkers	The most frequent conflicts are related to the unequal distribution of shifts, rest periods, or holidays, which results in certain workers—especially those with part-time contracts—bearing a greater share of responsibility.	*"A substitute arrives and does tasks that don't belong to her [...] and then there's trouble. She's doing tasks that I don't do"* (FG3 ES Target A).
		Conflicts with relatives	Conflicts take various forms, which can be grouped into excessive demands, procedural misunderstandings, and relational tensions marked by lack of understanding. These situations add significant strain to the daily work of care staff, who must balance direct caregiving with the emotional	*"I can't leave at the time I'm supposed to, but I have to be back at the exact time he says."* (FG5 ES Target A).

			Definition	Illustrative quotes
			management of family interactions.	
		Relatives' expectations	These expectations are not always clearly communicated and are often unrealistic or difficult to meet within the context of collective care.TThey also impact the adaptation process to the centre. In discussion it is said that is more difficult for the family to adjust than for the residents themselves, which adds another layer of emotional complexity to the staff's work. Unrealistic beliefs about the potential for improvement also appear.	*"Families, especially families. Families, because in the end we are all our fathers and mother's, and what he said before is that there are families who believe that their mother, uncle, grandfather, or cousin, or the relative they have here at the center, believe that they can have someone by their side 24 hours a day, and that's impossible."* (FG 7 ES Target B and C)
Protective Factors	**Job related**	**On-the-job learning**	Enables care workers to develop practical knowledge and coping strategies in a highly demanding environment. This learning occurs through both formal training and learning by doing, though workers highlight notable differences in usefulness, accessibility, and impact between these two forms.	*"That comes from experience. It's day-to-day. It's not teaching—it's practice, the person, and common sense"* (FG6 ES Target B and C).
		Time off	The effective respect for rest time and dys off is an essential resource for preserving the physical and emotional health of home care workers.	*"When you come back from a rest day, you feel like new"* (FG7 ES Target B and C).
		Workplace ergonomics and assistive devices	A key resource for preventing physical injuries and ensuring job sustainability. It includes three main dimensions: the availability of lifting equipment (such as hoists or adjustable beds), the presence of other supportive materials that help adapt the physical environment to the needs of both staff and care receivers, and the physical and functional design of the job itself.	*"He says that since she doesn't weigh much, a hoist isn't necessary [...], but a man's strength isn't the same as a woman's"* (FG3 ES Target A).
	Relational	**Coworkers´support**	Functions as a vital resource that when present, it strengthens the work, improves the quality of care, and emotionally sustains the workers. Creating opportunities for connection, encouraging inter-shift communication, and formally recognizing the value of peer support are necessary steps to reinforce this essential source of care, which currently relies heavily on individual	*"Informally, informally. For example, you run into her in the hallway and we start venting to each other, because there's no other way, no other way" (FG7 ES Target B and C); "When we can, we go out for beers"* (FG7 ES Target B and C).

			Definition	Illustrative quotes
			initiative.	
		Emotional bonds	Emotional connections born in the daily care activity through the closeness and exposure to care receivers' intimate lives. While these connections often provide meaning, motivation, and a sense of belonging, they also expose caregivers to emotional strain and blurred boundaries.	*"How do you not get attached to someone who tells you everything because they can't say it to their relatives?" asked one worker* (FG1 ES Target A).
		Interteams coordination	Interteam coordination refers to the alignment and synchronization of actions, communication, and resources across different teams working toward shared goals. It distinguishes four key mechanisms: mutual adjustment, direct supervision, standardisation, and higher-order mutual adjustment. In discussion, a lack of interteams coordination is reported.	*"Every day we read the notifications and the incident reports [...] That's the first thing we have to do. You come in the morning and read the notifications from the night and afternoon shifts."* (FG6 ES Target B and C).
		Recognition by the care receiver	While not universal—some care receivers dismiss the value of the care provided—many others express gratitude through words, gestures, or emotional connection. Workers describe feeling deeply moved when care receivers remember them after absences, express joy upon their arrival, or offer subtle signs of appreciation even without speaking.	*"They give you a hug, say a word of affection and you have already forgotten everything you carry inside"* (FG7 ES Target B and C).
		Relatives´ support	It has a relevant impact on the work experience of home care workers, both positively and negatively. The testimonies show that the relationship with family members can either ease or complicate the caregiver's work, depending on the level of availability, recognition, and communication established with them.	*"They never explained it to me. But they have a daughter who is a doctor. So I tell her, look, my glucose is like this and you told me it should be between such and such levels, what should I do? Then she tells me to do this or that. And she is available 24 hours a day. If I have to call her at 3 in the morning, she is ready."* (FG 9 ES Target A).
		Relatives´ recognition	Emerges as a significant emotional factor in the experience of home care workers. While not a formal part of the employment relationship, this recognition—or lack of it—can strongly	*"They understand the decline, they appreciate it. They say: I don't know how you can do this work, and we're so grateful."* (FG6 ES Target B and C).

			Definition	Illustrative quotes
			influence workers' emotional well-being, motivation, and sense of fairness in their daily tasks.	
	Personal	**Boundaries management**	Constant negotiation whether related to tasks, emotions, or time, these boundaries are often tested by care receiver expectations, emotional proximity, or inconsistent practices among colleagues. While some workers succeed in asserting clear limits, others express difficulty in doing so, revealing the tensions and ambiguities that shape daily caregiving experiences.	*"I clean the grandfather's bedroom, I wash him and do everything I have to do for him, because he's my care receiver. But if you have the sink full of dishes, I will wash one plate, one glass, one spoon—what I need to give him breakfast—and that's it."* (FG1 ES Target A).
		Cognitive appraisal	A meaningful personal strategy to cope with the emotional impact of death and loss in institutional settings. In dialogue it appears as a way to reframe the experience by focusing on the resident's suffering and advanced age.	*"He was very sick already… now he's at rest, he was ninety-something."* (FG6 ES Target B and C).
		Compassion	A personal value that shapes their responses to emotionally demanding situations. It normally becomes both a deeply rooted value and a source of emotional strain.	*"I was taught to respect my elders. In my culture, you don't scold someone older than you… even if they're wrong, you still owe them respect"* (FG5 ES Target A).
		Coping strategies	Managing the emotional and practical demands of their job. Participants mention different ways of coping with stressful situations, ranging from avoidance to emotional expression, distancing, or the use of humour.	*"Holding on, holding on, holding on"* (FG2 ES Target A).
		Disconnection	Far from automatic—it often requires conscious strategies, emotional effort, and other personal resources. The inability to disconnect not only prolongs work-related stress but also intrudes on rest time and personal well-being.	*"It's very difficult to disconnect. I would say impossible"* (FG7 ES Target B and C). *The night shift calls you, the afternoon shift calls you… it's impossible to rest"* (FG7 ES Target B and C).
		Emotional self-regulation	Implies the capacity — acquired through experience — to remain engaged without becoming overwhelmed, especially when working in close contact with fragility, suffering, or loss.	*"At some point, the older person will be gone—the one you laughed with, ate with, cared for like a father—and we go through that loss too"* (FG5 ES Target A).

			Definition	Illustrative quotes
		Empathy	Resource that helps sustain workers' motivation and meaning in their caregiving roles. Several participants describe feeling emotionally moved by the loneliness, abandonment or vulnerability of the people they support.	*"I'm not his blood, I'm just someone who takes care of him, but he has a son, a brother, and still no one visits him. That weighs on me, it makes me feel pity."* (FG5 ES Target A).
		Meaning of work	Far from being perceived as a purely functional or routine occupation, care work is described as emotionally significant and personally meaningful, rooted in human connection, reciprocity, and the opportunity to make a positive difference in others' lives.	*"We don't work with papers, we work with people."* (FG4 ES Target A).
		Motivation	Motivation spans a broad spectrum, from intrinsic motivation to amotivation. The testimonies analysed show that the reasons for remaining in the care profession combine personal enjoyment, commitment to the task, recognition of its social value, and, in some cases, resignation or a sense of lost purpose.	*"I love it. I enjoy my job very much, and the gratitude it gives me"* (FG1 ES Target A), or *"It's vocational. I love it. I truly love it"* (FG1 ES Target A).
		Proactive behaviour	Self-initiated, anticipatory actions through which individuals aim to bring about change in themselves or in their environment. Participants described how they organised their tasks, regulated their emotions, and relied on personal experience to respond effectively to challenges in daily care work.	*"I reorganised everything related to the psychologist's role so it fit with also being a director."* (FG8 ES Target B and C).
		Professional vocation	Appears in the testimonies as a personal inclination toward caregiving. It is described as a meaningful disposition that helps workers stay committed to their tasks, especially in emotionally and physically demanding situations.	*"Time flies here, and I wish the clock would stop."* (FG6 ES Target B and C).
		Recovery strategies	Essential coping with the demands of home care work. These strategies focus on personal well-being and include self-care, physical activity, music, and social outings as ways to recharge and regain emotional balance.	*"Sport helps me a bit, sport helps me de-stress"* (FG7 ES Target B and C).

			Definition	Illustrative quotes
		Respect for legal regulations	Respect for labour and contractual regulations plays a central role in shaping the experiences of home care workers.	*"If the contract says I leave at nine on Saturday, the family members know they have to be there at nine because I'm leaving"* (FG5 ES Target A).
		Task prioritization and time management	Efforts to protect time for core responsibilities, even in contexts where external demands compete for attention.	*"Your priority is the person you care for. Then everything else will come later."* (FG1 ES Target A).

Table 5. *Poland– Depiction of Risk and Protective Factors*

			Definition	Illustrative quotes
Risk Factors	Job related	**Emotional demands**	Relational care work is complex and professionals are required to regulate their own emotions, respond sensitively to others, and cope with the cumulative effects of deep personal involvement. These demands—from emotional display to sustained engagement— have a significant impact on mental health and professional endurance.	*"I think that if you work with a person and with a person in need, who is with us 24 hours a day and often deprived of his family, and for whom we are the family and we attend his birthday, name day and often we are the only members at his funeral, these emotions are so many that it is impossible to switch it off. That is one issue. The other issue. I think people who wouldn't have those emotions, wouldn't be. They're not going to be able to work here."* (FG 5 PL Target B and C).
		Exposure to suffering and death	Care workers are routinely exposed to the deterioration, suffering, and death of residents, with whom they often develop emotional bonds.	*"Like, like the person. You have to look at how he or she suffers, if a condition appears, if he or she passes away from life, for example, when it is irreversible."* (FG 2 PL Target B and C).
		Exposure to violence	Care workers are exposed to aggressive behaviour from patients or residents, often linked to postoperative effects, medications, or neuropsychiatric conditions. These incidents are not always labeled as violence but are experienced as stressful and emotionally draining.	*"Our employees are exposed to all sorts of behaviour... even violence... but it is difficult to call it violence, because these are often uncontrollable behaviours resulting from disease entities... Our employees are a little bit too little protected"* (FG5 PL Target B and C).
		Physical demands	They are a central concern for care workers in institutional settings, where daily tasks often involve intense bodily effort and repeated strain. All of this leads to high levels of physical strain, and normalisation of bodily pain, all of which seriously impact workers' health and well-being.	*"So that's why the girls don't want to agree. I think the work is difficult, it's also physical because these people have to be lifted, they have to be helped, so that should be rewarded accordingly."* (FG 4 PL Target B and C).
		Schedule	Organisation is a key factor affecting both well-being and work-life balance in institutional care. Some models are perceived positively, offering more days off and better recovery.	*"I work twelve hours at a time. That's the number of hours in a month divided into twelve, so today I'm at work, tomorrow I'm off, the day after tomorrow I go to work, and it's around the clock."* (FG 2 PL Target B and C).

			Definition	Illustrative quotes
		Task beyond duties	Care staff are required to take on responsibilities outside their role, often as a result of organisational dynamics or the absence of specific personnel, leading to a steady extension of their duties.	*"Well yes, you think about this job, then come over here and you say oh cool thing come up with that I'm the one that when something comes to mind while I'm at home, it's not some problem for me that coming out of this job is such a part of my life that we want it to be, not."* (FG4 PL Target B and C).
		Workload	Recurrent concern across discussions, closely linked to staff shortages and the multiplication of responsibilities. Participants describe how both care and administrative duties accumulate, generating a sense of permanent urgency and insufficient support.	*"If there are somatic people, yes with tendencies, this is also a burden, while I do not hide the fact that it burdens us, because these are difficult cases, these are cases that are, for example, compressed syndrome."*
	Relational	**Conflicts with relatives**	Conflicts take various forms, which can be grouped into excessive demands, procedural misunderstandings, and relational tensions marked by lack of understanding. These situations add significant strain to the daily work of care staff, who must balance direct caregiving with the emotional management of family interactions.	*"Sometimes it's very difficult to interact with the family because they don't understand that this is a place where we work. Acct is a care facility and not a treatment facility."* (FG 4 PL Target B and C).
		Relatives'expectations	These expectations are not always clearly communicated and are often unrealistic or difficult to meet within the context of collective care.TThey also impact the adaptation process to the centre. In discussion it is said that is more difficult for the family to adjust than for the residents themselves, which adds another layer of emotional complexity to the staff's work. Unrealistic beliefs about the potential for improvement also appear.	*"They confuse us very often with a hospital. They think that when they are here, we just start from heaven. Sometimes figuratively speaking we just organise activities for them here. They want everything."* (FG 4 PL Target B and C).
	Personal	**Overcommitment**	Constant dedication, motivated by the desire to do a good job and provide quality care, but also by structural and ethical pressures that make it difficult to separate professional responsibilities from personal life. This overcommitment manifests itself in different ways—ranging from being	*"Sure I'm warm, very responsible, but also such a specific, specific job, which is also probably very mentally taxing."* (FG 2 PL Target B and C).

			Definition	Illustrative quotes
			permanently available to assuming a strong sense of responsibility at work.	
Protective Factors	Job related	On-the-job learning	Enables care workers to develop practical knowledge and coping strategies in a highly demanding environment. This learning occurs through both formal training and learning by doing, though workers highlight notable differences in usefulness, accessibility, and impact between these two forms.	*"I guess the brain finds a way to deal with it on its own... over time, we learn how to deal with it and move on"* (FG2 PL Target B and C).
		Time off	The effective respect for rest time and days off is an essential resource for preserving the physical and emotional health of home care workers.	*"That's two weeks to yourself. That's when, you know, everybody it's once, twice, a year away. Not more. "* (FG 3 PL Target B and C).
	Relational	Coworkers´support	Functions as a vital resource that when present, it strengthens the work, improves the quality of care, and emotionally sustains the workers. Creating opportunities for connection, encouraging inter-shift communication, and formally recognizing the value of peer support are necessary steps to reinforce this essential source of care, which currently relies heavily on individual initiative.	*"I am also a [social worker]. Just like my colleagues. We deal together, we also exchange. We know each other's areas, because theoretically we are divided into floors, but in fact during our absences we orient ourselves to all the residents. We complement each other, support each other, help each other."* (FG 2 PL Target B and C)
		Emotional bonds	Emotional connections born in the daily care activity through the closeness and exposure to care receivers' intimate lives. While these connections often provide meaning, motivation, and a sense of belonging, they also expose caregivers to emotional strain and blurred boundaries.	*"Just after work, some activities, your passions, pursuing, interests. Generally yes, because out of it your errands, shopping, walking around the mall yourself, there is music, which after all can be therapy, activities generally various hobbies."* (FG 5 PL Target B and C).
		Interteams coordination	Interteam coordination refers to the alignment and synchronization of actions, communication, and resources across different teams working toward shared goals. It distinguishes four key mechanisms: mutual adjustment, direct supervision, standardisation, and higher-order mutual adjustment. In discussion, a lack of interteams coordination is	*"There is a lack of that person who is responsible and who will help us and tell us."* (FG4 PL Target B and C).

			Definition	Illustrative quotes
			reported.	
		Recognition by the care receiver	While not universal—some care receivers dismiss the value of the care provided—many others express gratitude through words, gestures, or emotional connection. Workers describe feeling deeply moved when care receivers remember them after absences, express joy upon their arrival, or offer subtle signs of appreciation even without speaking.	*"They give us that. thanks and that I will say it may be silly. Good morning, how are you? How are you? Smiles, content they're happy and that conversation that's just with them and for me that's a lot because for us to talk to them straight away that's a lot."* (FG4 PL Target B and C).
		Relatives´ support	It has a relevant impact on the work experience of home care workers, both positively and negatively. The testimonies show that the relationship with family members can either ease or complicate the caregiver's work, depending on the level of availability, recognition, and communication established with them.	*"There are some families who are fun to work with, who understand us and support us in this somewhat difficult work of ours."* (FG3 PL Target B and C).
		Relatives´recognition	Emerges as a significant emotional factor in the experience of home care workers. While not a formal part of the employment relationship, this recognition—or lack of it—can strongly influence workers' emotional well-being, motivation, and sense of fairness in their daily tasks.	*"They underestimate this work of ours and expect too much."* (FG3 PL Target B and C).
		Supervisor support	Central role in the organisation of home care, particularly when workers must navigate complex tasks, emotional demands, or conflictive situations.	*"Not yet. There hasn't been such a need. If there was, I'm sure the director would help us with that, because we also have to say that we have great support*" (FG4 PL Target B and C).
	Personal	**Boundaries management**	Constant negotiation whether related to tasks, emotions, or time, these boundaries are often tested by care receiver expectations, emotional proximity, or inconsistent practices among colleagues. While some workers succeed in asserting clear limits, others express difficulty in doing so, revealing the tensions and ambiguities that shape daily caregiving	*"I think another such thing is to set boundaries. This is also important in working between residents. I have such a method that I never go over to you, because even though we already have a charge younger than me, if you look significantly, they correct themselves and say Ladies, I*

			Definition	Illustrative quotes
			experiences.	*already or I don't try to go over, it's cordial, cool…"* (FG 2 PL Target B and C).
		Disconnection	Far from automatic—it often requires conscious strategies, emotional effort, and other personal resources. The inability to disconnect not only prolongs work-related stress but also intrudes on rest time and personal well-being.	*"After work, some activities, your passions, pursuing interests, shopping, walking around the mall yourself, there is music, which after all can be therapy, activities generally various hobbies."* (FG 4 PL Target B and C).
		Emotional self-regulation	Implies the capacity — acquired through experience — to remain engaged without becoming overwhelmed, especially when working in close contact with fragility, suffering, or loss.	*"But I think over time we learn, we learn, we learn how to deal with this one from here. And move on from there.The facts are that depending on the degree of emotional involvement with the resident is more difficult. And that sometimes this work is brought home. But also we have to delineate and we know that we have our own lives and we live our lives."* (FG 4 PL Target B and C).
		Empathy	Resource that helps sustain workers' motivation and meaning in their caregiving roles. Several participants describe feeling emotionally moved by the loneliness, abandonment or vulnerability of the people they support.	*"Of course, this empathy with these people is a specific profession. You need to have specific character traits and personalities to do such work. Not everyone is suitable for such work in my opinion, and not everyone could do such work."* (FG 2 PL Target B and C).
		Meaning of work	Far from being perceived as a purely functional or routine occupation, care work is described as emotionally significant and personally meaningful, rooted in human connection, reciprocity, and the opportunity to make a positive difference in others' lives.	*"The idea of doing something else does not arise."* (FG3 PL Target B and C).
		Motivation	Motivation spans a broad spectrum, from intrinsic motivation to amotivation. The testimonies analysed show that the reasons for remaining in the care profession combine personal enjoyment, commitment to the task, recognition of its social value, and, in some cases, resignation or a sense of lost purpose.	*"I think this disparity between how important the work is and […] the fact that the prestige of the social work profession is virtually none"* (FG5 PL Target B and C).

			Definition	Illustrative quotes
		Proactive behaviour	Self-initiated, anticipatory actions through which individuals aim to bring about change in themselves or in their environment. Participants described how they organised their tasks, regulated their emotions, and relied on personal experience to respond effectively to challenges in daily care work.	*"Well, because we have to make some decisions, well we can't also leave a person with some needs and we have to make some decisions, we have to do something. And I think that's the stress. I would also say it is a bit. However, it is nonetheless"* (FG 4 PL Target B and C).
		Professional vocation	Appears in the testimonies as a personal inclination toward caregiving. It is described as a meaningful disposition that helps workers stay committed to their tasks, especially in emotionally and physically demanding situations.	*"Since I was a child I wanted to be a nurse [...] I am happy because I also work with the elderly."* (FG3 PL Target B and C).
		Recovery strategies	Essential coping with the demands of home care work. These strategies focus on personal well-being and include self-care, physical activity, music, and social outings as ways to recharge and regain emotional balance.	*"Everyone has their own individual.Family. Or like to go to the forest for some walks. Going out for a walk for example."* (FG 4 PL Target B and C):

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