The values and qualities of being a good helper: A qualitative study of adult foster home caregivers for persons with serious mental illness

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Abstract

Background—Canadian foster homes for adults with serious mental illness are operated by non-professional caregivers, usually women, whose mandate is to support residents and reintegrate them into the community. While mental health professionals recognize that adult foster homes are an important service for this population, there is little understanding of how caregivers impact on the lives of their residents.

Aims and objectives—This article draws on the findings of a larger study which examined both caregiver and resident perspectives on the helping relationship in adult foster homes. Caregiver perspectives on the values and qualities required to help people living in foster homes are reported.

Design and methods—With no pre-set theoretical framework, this qualitative study employed an inductive approach within a naturalistic paradigm. Semi-structured interviews were conducted with 20 caregivers. Data analysis was an ongoing, 2-year process, involving the identification of categories and themes through several distinct stages.

Setting—The study included Montreal adult foster homes ($n = 242$) for persons with serious mental illness, supervised by two university-affiliated psychiatric hospitals.

Participants—Twenty caregivers, selected according to years of experience and number of residents in the home, were diverse in terms of age, cultural background, family composition, education and occupational background.

Results—Caregivers possess a clearly articulated value system, and 21 specific qualities which reflect the attributes of both professional and informal helpers. These values and qualities provide caregivers with a “professional” or “vocational” orientation.

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Conclusions—A deeply held system of values and qualities is critically important to caregiver effectiveness and job satisfaction. Findings suggest that caregivers are highly motivated, and should be recognized as full participants in the mental health system at both policy and practice levels.

Keywords

Caregivers; Adult foster homes; Helping relationship; Qualitative research

This article reports findings from a study on the helping relationship in adult foster homes for persons with serious mental illness in Montreal, Canada. Foster homes have existed in Canada for the past 50 years, as the majority of patients discharged from psychiatric hospitals were placed into these homes. Unlike other services for persons with serious mental illness which rely heavily on professional staffing (e.g., Assertive Community Treatment), adult foster homes are operated by non-professional caregivers, the majority of whom are women.¹ Indistinguishable from ordinary homes in the community, foster homes may house as many as nine persons and foster home caregivers live with their residents.

Adult foster homes in the Canadian context have evolved from a “caretaking” to a “professional” model. Multidisciplinary teams (social workers, nurses) supervise these homes, and act as intermediaries between the foster homes and formal mental health services (Dorvil et al., 1997). An Individual Service Plan for each resident is developed collaboratively by professionals and caregivers. The mandate of adult foster home caregivers is to support persons with serious mental illness, and reintegrate them into the community. At the time of this study, there were 1402 individuals living in 242 Montreal foster homes (Régie régionale de Montréal-Centre, 2001).

Foster home caregivers are non-professionals, mostly women, who house and care for up to nine residents, whom they are mandated to reintegrate into the community. Caregivers share their personal and family life with residents. When successful, caregivers and residents usually live together for many years. The Quebec Ministry of Health (MSSS) stipulates that caregivers be paid a per diem for supporting adults with serious mental illness in their homes. Caregiving offers advantages such as a flexible schedule, the possibility to be one’s own boss, opportunities to learn, and the rewards of seeing good results with residents. Yet caregiving also involves a heavy commitment of time and energy. Caregivers must be either present in the home or available by telephone 24/7. Otherwise, they must arrange for replacement workers. Caregivers must contend with illness-related issues, difficult resident behaviors and crises, and the stress of never “shutting off”.

The foster home is unique for a number of reasons. Often it is the only viable option for persons with serious mental illness who after many years of hospitalization, or unsuccessful efforts to live in the community, have few choices but to live in this type of housing. Both caregivers and residents are supervised by multidisciplinary professionals, with their own concerns. Foster home residents are vulnerable, due to their illnesses and frequently lack

¹Adult foster homes are also known as “family type residences”, and are regulated by Bill 120 Law Respecting Health and Social Services, Quebec.

family or other social supports. Yet, foster home caregivers are also vulnerable, in that they lack formal status as mental health workers; they have limited training, little voice about their working conditions, and no specific professional identity to guide them (Piat et al., 2005).

While there is consensus among mental health professionals that adult foster homes are important in the continuum of housing services available to this population, little is known about the helping relationship between caregivers and their residents or what caregivers perceive as necessary in order to be a caregiver for this population. Our lack of knowledge about the kinds of helping that occur in adult foster homes, coupled with increasing caregiver responsibility in the area of community reintegration, underlined the need for an exploratory study on this topic.

3. Objectives

The overall objective of this study was to better understand the nature of the helping relationship between caregivers and residents living in Montreal adult foster homes. The study provided an opportunity for caregivers and residents, whose views are rarely taken into account, to describe their experiences with the kind of helping that takes place in foster homes. The study emerged from the practice milieu. Multidisciplinary team members first identified the need to better understand the helping relationship in foster homes, as the quality of relationships developed between caregivers and residents over time may impact on the extent of rehabilitation that takes place there. This article reports the caregiver's perspective on the values and qualities required to help people living in adult foster homes.² The findings on qualities of a good caregiver emerged from two related questions: "Based on your experience, what does it take to help a person with mental health problems?" and "What do you think are your qualities as a helper?" By contrast, findings on the values of a good caregiver emerged spontaneously at various junctures of the interviews.

4. Context

Historically, adult foster homes have *not* been viewed in a positive light. This poor image dates back to the 1970s when Murphy et al. (1972) completed one of the earliest studies on foster care in Canada. This study's findings were highly critical of foster homes, which were viewed as places that merely provide room and board, are too structured and controlling and do little to reintegrate people with serious mental illness into the community.

In Canada, as elsewhere in North America, current policy favours more autonomous living arrangements; policy makers are questioning the efficacy of the traditional foster home model (Kirby and Keon, 2006; Ministère de la Santé et des Services sociaux, 2005). Most mental health consumers also prefer independent living, according to numerous preference studies (Browne and Courtney, 2005; Carling and Allott, 2000; Keck, 1990; Ogilvie, 1997; Srebnik et al., 1995; Tanzman, 1993; Thomas, 1987). However, a comparison by housing status reveals greater consumer preference for independent living among those who live, or

²Findings presented in this study are part of a larger study funded by the Canadian Institutes of Health Research MOP # 90029.

previously lived, independently (Carling and Allott, 2000; Rogers et al., 1991; Thomas, 1987). Consumers living in supervised housing express lower preferences for living independently (Elliott et al., 1990; Rogers et al., 1991; Thomas, 1987).

A recent study of 102 caregiver–resident pairs reported a high level of satisfaction among foster home residents with their living situation (Piat et al., 2006). Although the majority of respondents (59%) did not choose to live in a foster home—most often a family member or someone else chose for them—89% preferred living in a foster home over other arrangements. Over two-thirds of residents interviewed wanted their foster home to be their permanent home. The majority of respondents (80%) noted positive changes since their arrival in the foster home. Almost all residents (95%) recommended the foster home as a good place to live. For patients discharged after many years in a psychiatric hospital, the foster home often replaced lost family relationships, and provided a permanent home as well as primary links to the community. This study concluded that there is a group of mental health consumers who will never live autonomously, or who have tried independent living unsuccessfully, but need the structure and security of a foster home.

5. The helping relationship and caring

Despite the influence of evidence-based care, the helping relationship and caring processes remain key elements in nursing education, practice and ethics (Felgen, 2004; Héту, 2000; McCance et al., 1999; Perraud et al., 2006; Robinson and Kish, 2001). Hood and Leddy (2006) identified five caring perspectives in nursing: caring as a human trait (Benner & Wrugel; Gaut & Leininger); caring as a moral imperative (Watson); caring as an interpersonal relationship (Parse); caring as a therapeutic intervention (Orem); and caring as an affect (Morse et al.).

Watson (1990) describes a model of human caring that gives equal credence to “the power of love, faith, compassion, caring, community and intention...” as to conventional treatment approaches (Young et al., 2001). A number of factors in this model resonate with the requirements of non-professional as well as professional caregiving: the formation of a humanistic–altruistic value system; cultivation of sensitivity to others; development of trusting relationships; use of creative problem-solving processes; the creation of supportive, protective, environments and assistance with the gratification of human needs. Care ethics based on character and the exercise of virtues such as compassion, honesty, altruism, good judgment and patience have been recommended not only for nursing practice, but as an ethical framework for psychiatry as well (Armstrong, 2006; Bloch, 2006; McCamant, 2006; Winch, 2006).

Professional versus non-professional helping relationships are an important distinction in the literature, and pivotal to this study. Whereas professional helping relationships are, by definition, contractual and time-limited (Lapworth et al., 2001); purposeful and goal-directed (Brill, 1990), non-professional helping, whether by family and friends of “help-seekers” or employed caregivers, is viewed as less structured, more personal and biased (Nystul, 2003).

Most research on non-professional helping has focused on family caregivers (Biegel et al., 1991; Lefley, 1996). The literature on foster home caregivers and their experiences is limited. The characteristics of caregivers, their motivation, caregiver satisfaction and caregiver relationships with their residents were topics of earlier research (Beatty and Seeley, 1980; Blaustein and Viek, 1987; Mousseau-Glaser, 1988). More recent studies have dealt with issues such as stress and burden (Cook et al., 1997; Jones et al., 1995; Karp and Tanarugsachock, 2000; Ricard, 1991; Ricard and Fortin, 1993; Song et al., 1997; Tucker et al., 1998; Wijngaarden et al., 2003), and coping strategies (Hatfield, 1987; Olshevski et al., 1999; Stengard, 2002; Turnbull and Turnbull, 1988). Some research has begun to look at the positive aspects of non-professional caregiving (Chen and Greenberg, 2004) as well as caregiver meaning (Chang, 2006; Rhoades and McFarland, 1999), and the goals of caregiving (Heaney and Burke, 1995). There is, however, no known research on the helping relationship in adult psychiatric foster homes.

6. Methods

This qualitative study used a naturalistic paradigm, as developed by Lincoln and Guba (1985). The objective of naturalistic inquiry is to “develop shared constructions that illuminate a particular context and provide working hypotheses for the investigation of others” (Erlandson et al., 1993, p. 45). Given the exploratory nature of the study, an inductive approach was chosen to help us better understand the helping dynamics that occur between foster home caregivers and residents.

The setting for the study included adult foster homes for persons with serious mental illness supervised by two university-affiliated psychiatric hospitals mandated to provide community-based housing for mental health consumers. Sample selection was purposeful, and involved a two-step process. First, a list of all foster homes ($n = 242$) was compiled according to: (1) the caregiver's years of experience as a foster home caregiver (less than 5, 5–9, 10–14, 15 or more years); and (2) the number of residents living in the foster home (one to three residents, four to six residents, seven to nine residents). Following this, maximum variation sampling was used to select a sample of caregivers that would reflect the greatest variety of caregiver experience and size of the foster home. These two selection criteria were used based on consultations with staff, who felt that these were important issues to consider when selecting a diversified sample of foster home caregivers. The final sample presented in Table 1 took into account the original number of foster homes within each category (i.e., the majority of foster homes housed between seven and nine residents and this is reflected in the sample).

In all, 21 foster home caregivers were contacted to participate in the research. Twenty agreed to participate, and 1 refused because of difficulties in her home at the time. Their average age was 54, but they ranged from 31 to 66 years. Their caregiving experience was from 2 to 26 years. Eleven caregivers were born in Canada, whereas 9 were immigrants from the Philippines, Africa or the Caribbean. Regarding marital status, 13 were married, 5 were divorced, widowed or single, and two did not respond. Four caregivers had children under 18 living at home and 1 had a grandchild; 3 had grandparents in the home; and another caregiver had her brother living with her.

Caregivers were evenly divided between those with less than high school, and those with higher education; 3 caregivers were university educated. Eleven of the 20 stated that they had previously worked in occupations related to caregiving. They were nurses' aids, and educators for persons with disabilities or behavioral problems. Fifteen caregivers had training in some area of helping, such as hospital courses in caregiving, nursing, psychology, counseling, rehabilitation or special education. For 17 caregivers, the foster home was their primary source of revenue.

The ethics review boards of both hospitals approved the research. Participants gave written, informed consent and retained a copy of the consent form. No identifying information is reported in the findings.

Semi-structured interview guides were developed from a series of consultations between the research team and members of the multidisciplinary teams. The final interview guide included 13 open-ended questions in the following areas: (1) the qualities and skills of caregivers; (2) how caregivers learned their job; (3) perceived difficulties, needs and expectations of residents; (4) goals in caring for residents; (5) approaches to helping; (6) caregiver–resident relationships; (7) caregiver–professional relationships; (8) differences between caregiving and professional helping; (9) their time allocation between work, family and social life; and (10) the advantages and disadvantages of caregiving.

The principal investigator and two research assistants conducted semi-structured interviews with 20 caregivers between February and September, 2003. Interviews ranged from 45 to 90 min in duration, were audio-recorded and transcribed verbatim. After each interview, a short demographic questionnaire was administered. Interviewers took notes during the interviews to improve understanding or to generate new questions. Field notes were written after the interviews for later use in data analysis (Patton, 1990). The interview guide was pre-tested with two caregivers, and resulted in minor modifications.

Data analysis was inductive and ongoing throughout this study (Erlandson et al., 1993; Lincoln and Guba, 1985). No pre-set theoretical framework influenced data analysis. Thus, conceptualization of the phenomena under investigation was dependent on the findings that emerged from the data. The analysis took place over a 2-year period and involved three distinct stages. First, seven interview transcriptions were coded individually by three members of the research team, and the remaining interviews were coded by a research assistant. Inter-rater reliability was high (between 70% and 80%), which meets acceptable standards for qualitative research (Boyatzis, 1998). Initial codes were developed from the questionnaire and new codes were added as they emerged from the data. In all, there were nine iterations of the codes. Second, the data reduction process began and analytical summaries were completed for 50% of the interviews. These summaries provide a detailed reconstruction of each interview. All the summaries were then compared and contrasted, and rewritten as a single analytic summary, to which the data from the remaining 50% of the interviews were integrated. Third, all categories were then merged into major themes. For example, the following categories: love, caring, compassion/understanding, affection/tenderness, generosity, spirit of were put into the major theme “qualities of the heart” which

became the basis for the findings of this article. The complete list of categories and themes related to the values and qualities of caregivers appears in Figs. 1 and 2, respectively.

Specific efforts were made to ensure the trustworthiness of the study. Data analysis was a shared process involving constant feedback and discussion among members of the research team. Throughout the data analysis, many drafts of each set of findings were revised individually and then by team members. The principal investigator and one research assistant met weekly over a 2-year period. The entire team read all drafts of the findings individually, and met in work sessions on 12 occasions between February and November, 2005, in preparation of the final report. A detailed audit trail was kept over the course of the study. This included: raw data (interview guides/transcriptions), and data reduction and analysis materials (interview summaries, code-books, and field/process notes).

7. Results

One of the most important findings is that caregivers are able to articulate the values they bring to their work, as well as the personal qualities required to help others. These findings reveal a close link between underlying values and the personal qualities of a good caregiver.

7.1. The values of foster home caregivers

Although there was no specific question in the interview guide regarding the beliefs and values of caregivers, 19 out of 20 caregivers made frequent reference to fundamental ideas about human beings, beliefs about mental illness and the principles that animate their work as caregivers. Fig. 1 presents three sets of caregiver values that emerged from the findings

First, regarding human beings, caregivers stated that each person is unique and has intrinsic value. Each person, mentally ill or not, is “full of richness” (*Francine*). Caregivers recognized that their treatment must be tailored to the individual: “...no one person is the same...so we can’t function the same way for each person” (*Bianca*). Some caregivers felt that a good way to acknowledge their residents as valuable human beings was to further their capabilities: residents must not be “infantilized”, which would have the effect of disabling them further:

I think you have to, most of all, see them as people with capacities...because I think the more you baby them, the more you see them as children and take them by the hand...the more they become handicapped...and that’s not the illness; it’s people who make them handicapped. (Gabrielle)

Basic equality is the second attribute of the person: “we are all human...we are all equal, and we work with this...” (*Diane*). This belief in equality led caregivers to prefer a more egalitarian relationship with residents.

Caregivers also see persons as equal in terms of their imperfections and defects: “we all have something...no one is perfect” (*Francine*). An important awareness of caregivers in this connection is that anyone can be the victim of illness: “We need to love each other, and care for them much more than we do,” said Gwen, “because sickness comes at any time; and I could be just like any one of them....” Caregivers extended the notion that “nobody is

perfect” to their own faults. Describing her own struggle with forgiveness, Dorice recounted her day-long sulk over the resident who stole eight Laura Secord puddings from the pantry, consumed them, then refused to admit to the crime. Happy expressed regret for the times when her actions fell short of her ideals as a caregiver:

...sometimes we, as human beings, we profess to have certain values...; (but) you watch the behaviour; you can come back and say: ‘Hey, I thought you said you valued respect’ or ‘I thought you said you valued, you know, love for the others, or whatever...So...to me, the helping part, it comes more theoretically than actual...

Another implication of equality is that people have rights. Fausta challenged a local restaurant owner who tried to exclude her residents from his establishment, and insisted with her residents:“(l)ook, you guys, (don’t be) shy to go where you see other people is, because you’re the same; you’re human!” Caregivers believe that persons with mental health challenges have a right to their intimacy. They felt obliged to protect “their little secrets” (*Bianca*), and maintain discretion. Residents also need a place free from intrusion—“a space of their own” (*Dorice*).

The third principle concerning human beings is that relationships must be based on mutual respect. Two caregivers pointed out that the respect they show to their residents provides the basis for how residents will respond:

...what I have observed is when you respond to people based on ‘this is a person’ — I think that person responds back to you with a...with a sort of response that says ‘I acknowledge that you acknowledge me’. (Debbie)

In the second set of values, caregivers associate their regard for the person with illness or disability. First, human beings are “whole”, according to caregivers, regardless of their physical or mental condition. As one expressed this, “we always have the tendency to say that he has a little mental health problem, but, in a way, they’re people in their own right.” (*Bianca*) Another caregiver emphasized the respect due to the essence of the person: “I respect them in what they do; I respect them as they are”. Or, “it’s to value them...to accept them as they are” (*Annie*).

Second, caregivers believe that mental health residents are ill through no fault of their own. Candy described the intense suffering of a resident, and how she tried to find compensations: “it’s not your fault that you get sick; you can still do things that are important like... whatever you’re doing here; you’re helping me a lot, helping me with work in the kitchen...” Third, mental illness entitles the person to care. Residents deserve to be treated well simply because they are ill: “they are human beings, and they are ill; it’s not their fault. That’s how I see it...” (*Linda*). Happy asserted:

I see them as people with an illness, and my approach is “I serve you in the way you need to be served. You know it’s very, very simple; it’s not technical.”

The final set of values concerns the work of caring for people with serious mental illness. More than a job, caregiving is “almost a vocation” (*Pauline*) As Gwen expressed the intensity she feels for both her work and those in her charge:

You have to like what you're doing. You have to love what you're doing. You have to treat the person like you would treat your own, and you have to care and fear for that person.

While caregivers admitted that they had to make a living, they insisted that it is not enough to be in this business for the income. As Bertha underlined:

I like to think that what I do here is (worth) more than \$.95 an hour, which is what I get; and I'm one of the highest paid...it's not a thing you go into for the money, right?

Another caregiver injected her sense of humor into the issue: "You have to love the job you do... if not, you'll freak out...you're going to be...a 'case' if you don't...if you don't like it. You're not doing this for the money; that's for sure!" (Tamara)

Finally, caregivers stated that good results are not guaranteed in their work. Progress is uneven, and residents are changeable, as Francine pointed out:

You have to accept them as they are...and you should not expect big things from them...things go well one day and the following day it's something else. You shouldn't expect big advances. You should expect little things.

Another caregiver cautioned that caregivers need to work gratuitously. As Bianca put it, "you shouldn't expect anything. You need to do this (work) freely, you know. If you expect something, to feel valued...you shouldn't". Insensitivity or ingratitude are part of mental illness. Bianca adds, "They don't do it on purpose..."

7.2. The personal qualities of a good caregiver

The values of caregivers provide a foundation for other findings that emerged from the study on the personal qualities of a good caregiver. Asked what it takes to work as a caregiver, or what qualities did they themselves possess, foster home caregivers responded with a portrait of the effective helper as one who is equipped with "the tools of being human" (*Stephanie*). Caregivers identified four categories which describe the personal qualities of a good caregiver as: (1) qualities of the heart, (2) qualities of the will, (3) qualities of the intellect, and (4) qualities of the spirit. These are presented in Fig. 2.

7.2.1. Qualities of the heart—Caregiving is, first of all, an undertaking of the heart, according to 16 of the 20 caregivers. Love for people is the primary requirement in caring for people with serious mental illness. In the eyes of one caregiver: "what skills?...nothing in particular...what I mean is we are people who like others..." (*Diane*) Another caregiver added: "when...you listen to them, you love them...it doesn't take long to win their confidence" (*Magali*).

Gestures that spring from the heart are often more spontaneous than deliberate; but the caregiver's genuine love for people and capacity to identify closely with their pain is paramount:

You have to give love...you have to feel it, and do it as a caregiver...always, always, always in your heart, when you're working with these types of clients, you

have to feel for them...we, as caregivers, have to try and work with them, to care for them...and once they feel that loving, tender care, you will get lots (of results).
(Gwen)

A deeply felt love for people becomes a powerful force in one's ability to help: "...the love of human beings, love of others...if we have these two things, we are able to help enormously..."(*Diane*).

The ability to care for others, a related quality, was considered by caregivers as almost inborn: they expressed this as "a gift for caring"(*Fausta*) or "the touch" (*Darlene*). Compassion and understanding were other qualities of the heart. Living at close range with residents gives the caregiver a particular grasp or perceptivity toward them. Some caregivers linked understanding specifically to compassion: one engenders the other.

Caregivers spoke about expressing affection, or tenderness. They stated that they were not shy to express these qualities openly with their residents: "I'm someone who shows her emotions, and I'm not shy to call them 'my little man, my little sweetness..." (*Bianca*). Caregivers must also be generous at different levels. As one caregiver asserted: "...I am generous, I think, with my time as well, or I will share with them the little things that I experience with my family..." (*Bianca*).

Finally, caregivers described a spirit of service as a necessary quality. For these caregivers, "it's all about...the serving stuff; you know...with every nurse or worker...what we've all got (is) that server thing" (*Bertha*), which is why, for example, someone with the mindset of a caregiver would prefer to use her home as a foster residence for vulnerable people rather than simply set up a rooming house.

7.2.2. Qualities of the will—All 20 caregivers described character traits, or what we categorized as "qualities of the will", as important for the good caregiver. These qualities are aspects of the self that are worked on over a lifetime. They are habits that emerge through an ongoing struggle against one's natural, opposing tendencies. The qualities of the will, or character, identified by caregivers included: patience, flexibility, self-mastery, industriousness, responsibility, good judgment, honesty and sociability.

Patience was identified most frequently, by 14 of the 20 caregivers, as the most necessary quality of the will. Patience is key in handling mental illness. Patience is necessary to withstand years of repetition, before residents are able to integrate the most basic daily routines. Caregivers get actively involved in attempting to change their residents' dysfunctional behaviors, which requires patience and respect for the resident's pace: "My sense of his journey has to be tied to his sense of his journey, and not my idea of it."
(*Happy*).

Flexibility, another key quality of the will, implies the ability to "go with the flow"(*Bertha*) and adjust to the needs and preferences of residents. It may mean altering daily routines in the home to accommodate residents' work schedules. Flexibility is required especially when crisis situations arise. As one caregiver pointed out, residents can be accident-prone under

normal circumstances, but even more so during their psychotic periods. Without a flexible attitude toward life, the caregiver would not be able to survive:

...for somebody to be a successful caregiver...a happy caregiver, you have to be willing to go with the flow. If you're fairly rigid yourself, I don't think it's going to be a...very satisfying thing...You know, in terms of simple stuff like tidiness or messiness, or...if you're a person who needs to have perfectly tidy rooms, and...stuff lined up in the fridge in alphabetical order; I'm not too sure this is the business for you. (Bertha)

Flexibility is also the ability to perform many different tasks interchangeably: "it's not like, 'Okay, this is my job, and I'm going to do this...'" (*Fausta*). Caregivers pride themselves on their ability to "wear many hats" and "fill...the need", whatever is required: "sometimes I may come like a janitor; sometimes I might be like a mother; sometimes I might be like a friend...I have no problem with whatever the label..." (*Happy*).

Self-mastery or self-control, another quality of the will, emerged because the caregiver must be able to maintain personal stability, but also instil stability into her residents and into the atmosphere of the home itself. Self-mastery involves standing firm in situations where residents need protection from harm; so it touches on the question of maintaining proper authority. Self mastery and the caregiver's consistency make residents feel confident and secure; she is a predictable and reassuring presence for them:

...they need stability, and consistency...if I'm always the same in situations...I don't want them to be afraid...(Dorice)

Industriousness is another quality of the will that serves to enhance the residents' sense of security. Industriousness keeps the home orderly, in a material sense, as well as in the sense of keeping residents "on track" (*Francine*) with both daily activities and their longer-range goals. Foster home residents often rely on the industriousness of their caregivers in following up and helping them with activities of daily living, as in taking notes or verifying appointments. As Gwen put it, "you have to be...one step ahead of what you're doing".

Caregiving involves round-the-clock responsibility and commitment, similar to that of a mother with young children who sleeps "with one eye closed." (*Gabrielle*) "My time, in whatever I do, is based around my (residents)", Gwen asserted. The caregiver's sense of responsibility leads her to spend time with the residents, supporting and supervising them. Caregivers live on call; as Debbie said, "you're always 'on'". Tina described her reflection before taking on the foster home; "It's not everyone who can...I think...become a foster home like that. It takes...an investment...at many levels".

Good judgement or discernment is another vital quality of the will for the good caregiver. Good advice requires good judgement; but caregivers must be able to discern when to advise, and when to just listen: "...sometimes to, to discern little things...sometime-s...really ordinary (things)...Because sometimes...it can be nothing for us, but a big problem for them" (*Francine*).

Caregivers spoke about honesty as an important quality of the will, and about their struggles to uphold this quality. While some “creative manipulation” (*Bertha*) might be required in handling certain issues, other situations call for the hard truth and a clear portrayal of consequences. Candy described the wrenching experience of being forced to withhold her support for a resident who seemed unready to live on his own, but concluded: “I think you need to be very honest...all the time...you don’t play games with them...” Honesty also involves winning the trust of residents, “just being a genuine person to them...” (*Stephanie*), or authenticity.

Caregivers articulated a particularly interesting aspect of honesty, which was the need to critically assess their own performance, and the willingness to stand corrected. At times, this was a question of not pretending to know more than is actually the case or not making promises that would not be followed through. Caregivers struggled to be fair, and to be aware of their human tendency to prefer some residents over others:

...it isn’t true that we like everyone equally, and one doesn’t always feel well...So, the capacity to look at oneself from time to time, and say: ‘what I just did wasn’t nice.’ The capacity to stop (and reflect)...(*Gabrielle*)

Taking correction requires sincerity and humility. As Candy asserted: “I’m not one to take things really personal...I can accept things as it happens, and we can talk.”

Finally, among the qualities of the will, caregivers talked about sociability and the capacity for friendship as a natural quality of the caregiver. Being a friend might be the most important requirement for a good caregiver: “...if we are able to be friends with each other, then it’s easier for the person, no matter what problem they have, to come to us and try to talk” (*Fausta*).

7.2.3. Qualities of the intellect—Ten of the 20 caregivers offered a variety of perspectives on what they consider to be the intellectual qualities required to help persons with mental illness. These involved natural intelligence, creative thinking and the kind of resourcefulness that develops more from life experience than formal education. Findings revealed four specific qualities of the intellect: formal education, experiential knowledge or “street smarts”, intellectual curiosity, and mental preparedness.

One caregiver with a university degree insisted on the value of higher education for good organization. However, other caregivers asserted that formal education was not essential for good performance. *Bertha*, who considers herself more “cerebral” than “hands on” asserted: “I don’t think you need a whole lot of fancy degrees at all”, but added, “to have natural intelligence wouldn’t hurt!”

According to *Bertha*, another of the good caregiver’s assets is rationality, which in a potential crisis may elude those who are more emotionally involved with the residents, such as their families:

...it’s just about being a calm and loving presence with some brains, you know; brains not to walk them further into something...you know... to keep...situation(s) going in the right direction...to walk them out of (difficulties), not further in...I say

that thinking of families who sometimes don't realize which way is going to make a situation worse.

Caregivers possessed the "knowledge of people and behaviours" that comes from on-the-job training. Roseanne stated: "I don't think...you have to be a professional or something, because...you will learn everyday...from experience you learn". Bertha gave an example of ingenuity in using words and images to allay the anxiety of a new resident with schizophrenia, who asked if her voices could also move in. Bertha replied, "That's fine; they can sleep in the tree in the driveway." Years later, the resident is still comforted by this image. Caregivers repeatedly pointed out that: "everyone is different...and when you are dealing with psychiatric patients, you really have to know how to deal with them" (*Darlène*).

Caregiving builds not only on "street smarts", but also a certain experience with caring that occurs in family life:

...some people, they have a certain knowledge of things (as a result of study); and some people have a certain knowledge of the streets...sort of thing. So our knowledge is just the basic everyday care we give to our family...and then we have to learn the extra, about the medication and so on...(Fausta)

Mental preparedness, a third quality of the intellect is essential for caregivers, because "you never know what to expect" (*Tamara*) in a residence for persons with serious mental illness. Caregivers spoke of how they use their heads in all kinds of situations. For one caregiver, it takes "solid nerves" (*Magali*).

If crisis cannot be avoided, caregivers must be armed with a set of tools, skills and resources to draw upon. They described such resources as their "arms", combined with the power of "self talk" (*Happy*).

7.2.4. Qualities of the spirit—Good helping requires, finally, a particular spirit. Eleven caregivers commented on the feelings, moods or mental outlooks that they maintain in their work. Three main qualities of the spirit emerged: openness or a non-judgmental attitude, inner happiness or good humor, and optimism or good morale.

First, caregivers emphasized the need for openness in helping, so that they would not judge residents, but would be able to maintain a positive regard in whatever residents might disclose. Happy described this as "a neutral kind of love", and continued "...that's one quality we need to have, a very open attitude...".

Openness involves the ability to see situations through the eyes of another: "So, you have to put yourself in their context...so, to do this...it takes a certain openness of spirit, and it takes resourcefulness." (*Dorice*). Openness also implies being able to change one's own ideas or courses of action.

Inner happiness is another key to a good spirit. Caregivers express this quality without necessarily using words, through the way in which they do their work. Inner happiness often overflows as good humor, which helps caregivers to create a good atmosphere in the home. Annie described this:

In some ways, I'm pretty simple...like a simple nature, and jovial...sometimes we burst out laughing...we make jokes...and I don't like to have a long face...No, I'm not complicated.

Even for the caregiver herself, humor is a great coping skill, and the best protection, as Happy puts it, for her “internal parts”, which get “messed up” under stress. Caregivers felt that their residents will discern the inner attitude of the caregiver toward her work and will react accordingly. Genuine happiness guarantees a good relationship.

Finally, caregivers named optimism or an excellent morale as an important quality of the spirit. They talked about avoiding negatives, even in speech, and how they root themselves in a positive outlook. As Diane insisted: “Well myself, my strength is that I have an excellent morale...I am positive”. Optimism is important because, as Happy stated: “caregiving is a real challenge...you need to have some faith.”

8. Discussion

This study is the first time that adult foster home caregivers have shared their views on the values and qualities of helping persons with serious mental illness. It is clear that, given the opportunity, caregivers were willing and most capable of doing this. One of the most important findings is that non-professional foster home caregivers possess a clearly articulated value system. These values serve as the foundation for the qualities required to work with people who have serious mental illness.

This study is of interest to nursing from various perspectives. Eliciting the viewpoints of foster home caregivers, or non-professional workers in other settings, is important for nurses, whose primary responsibilities include the supervision or “mediation” of others’ work (Allen, 2004). In this study, caregivers provide us with a very different perspective from the popular image of foster homes as mini-institutions where people receive custodial care and little else. The caregivers interviewed in this study demonstrated an active awareness of themselves, their beliefs and ideals, a reverence for human life in all conditions, intuitive ability, strong character and maturity. The values and qualities they describe as indicative of a good foster home caregiver reveal a close congruence between caregiver ideals and the caring and humanistic culture of professional nurses (Watson, 1999, 2002).

Adult foster home caregivers, similar to nurses who often intervene over long periods of time with persons under their care, must maintain a delicate balance between authority and equality. The caregiver’s awareness that she shares the same human condition as her residents, and perhaps her own experience at the margins of the mental health system, seem to make caregivers more comfortable with an egalitarian, as opposed to asymmetrical, position vis-à-vis residents. Parallels may be drawn to nursing where the prospects of recovery are enhanced when there is a working partnership between patient and nurse. In the case of the foster home, a professional barrier, even if desirable, would be difficult to sustain when caregivers and residents live together in close proximity. Being exposed to their residents under all conditions, and being constantly “on call” tends to have a leveling effect.

Whereas the literature makes a clear distinction between formal and informal helpers, this study sheds new light on foster home caregivers. In many ways, caregivers combine the affective qualities of informal natural helpers with the more conscious qualities of professionals. Relationships with residents must be based on mutual respect and affection similar to family relationships. Yet, as caregivers pointed out, they are able to respond to the daily challenges with such qualities as rationality, mental preparedness, and flexibility that families of mental health consumers may sometimes find difficult to provide given their emotional ties with their loved ones. The values and qualities of a good caregiver are so many “tools of being human”. For caregivers, much like nurse practitioners, helping is about the challenge of sustaining this humane outlook toward both residents and the work itself.

In describing the values that motivate them and the personal qualities that they would bring to their work, caregivers give us a great deal of insight into what constitutes and what motivates the good caregiver which may be applied to the helping professions. They reveal that the ability to care for highly vulnerable persons is not motivated by money, prestige, recognition or even specific training. Caregivers did not talk about the obligations of contract, or the input of multidisciplinary professionals. Their values and qualities tell us that a good caregiver is essentially one who strives to be a good or virtuous person (see also Armstrong, 2006). Foster home caregivers describe caring as an interior impulse developed and enriched through life experience. Good caregiving is grounded in universal values or beliefs about the nature of all human beings, about the person’s right to care and respect.

In many ways, caregiving in these foster homes may be viewed as a “professional” model, not because of the intervention of professionals and links with the mental health system, but because caregivers themselves have developed their own self-imposed “professional” or “vocational” orientation and standards.

These findings should be nuanced by certain limits of the study and its research methods. It should be noted that although the caregivers were selected in order to reflect the maximum variation in the types of caregivers/homes it does not represent a generalized portrait of all foster home caregivers. The sample is small and biases of social desirability must be acknowledged. Further comparative studies between informal and formal caregivers should be conducted with other population groups.

9. Conclusions

This study suggests that, in the context of the adult foster home, caregivers possess the qualities of natural caregivers as well as many attributes of good professionals, despite caregivers’ lack of formal education, power and status. The value basis of caregiving and the qualities, which this study presents for the first time, are critically important to caregivers’ effectiveness and job satisfaction. The values and qualities of non-professional caregivers are consonant with the caring culture of nurses. These findings have important implications for the delivery of services for this population. Caregivers should be encouraged in their efforts to uphold these standards and ideals. It would be helpful, and more fair, if caregivers were integrated as full participants in planning for the mental health population at both policy and practice levels.

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What is already known about the topic?

- Very little is known about the values and qualities of non-professional foster home caregivers.
- To our knowledge, no such study has been undertaken before.

What this paper adds

- Despite the lack of formal education, non-professional caregivers possess a clearly articulated value system which serves as the foundation for the qualities required to work with people who have serious mental illness.
- Adult foster home caregivers, similar to nurses must maintain a balance between authority and equality.
- Although the literature makes a distinction between formal and informal helpers, this study demonstrates that caregivers combine the qualities of both informal natural helpers and the qualities of professionals.

Values about Human Beings

- Each person is unique and has intrinsic value
- All persons are equal
- Relationships are based on respect

Values about Illness/Disability

- Person is “whole”, more than an illness
- Person is not responsible for illness
- Disability entitles person to help

Values about the Work of Caring

- Caring is more than just a job
- Love of work valued over monetary reward
- Good results are not guaranteed

Fig. 1.
Caregiver values

<u>Heart</u>	<u>Will</u>	<u>Intellect</u>	<u>Spirit</u>
Love	Patience/tolerance	Formal education	Openness/non-judgmental attitude
Caring	Flexibility/versatility	Experiential knowing/	Inner happiness/good
Compassion/	Self-mastery/	Street smarts”	Humour
Understanding	Industriousness	Rationality	Optimism/good morale
Affection/tenderness	Responsibility	Mental preparedness	
Generosity	Good judgment/discernment		
Spirit of service	Honesty/authenticity		
	Sociability/friendship		

Fig. 2.

Personal qualities required to help people with mental illness.

Table 1

Sample—foster homes

No. of residents living in foster home	Caregiver's years of experience					Total
	<5	5–9	10–14	15+		
1–3 residents	1	1	0	1		3
4–6 residents	1	1	1	4		7
7–9 residents	2	2	3	3		10
Total	4	4	4	8		20