

Care competences and well-being of Vietnamese student teachers

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## Abstract

The competencies to receive care, develop self-care and extend care to others integrate with each other to positively influence teachers' well-being. Increasing teachers' well-being by enhancing these care competencies, thus, should not be overlooked as 'nice to have' skills but as essential skills for teachers. However, there is limited evidence to support such assumptions, mainly due to a lack of good care competencies measures. This study firstly developed and validated the *Questionnaire of Care Competencies for Student Teachers (QCC-ST)* and then examined the associations between three dimensions of care and well-being in student teachers. A total 111 female and 94 male student teachers participated in this study ( $M = 22.26$ ;  $SD = 0.43$ ). Well-being was assessed as overall life satisfaction, perceived stress, and depressive symptoms. Results based on Confirmatory Factor Analysis showed that each subscale of the QCC-ST included two constructs: care competencies and care failures. Overall, the findings from this present study support the assumption that student teachers' well-being depends on their ability to receive care from others, develop self-care and extend care to others. For example, student teachers who possessed higher self-care competencies were less likely to experience stress symptoms and student teachers who showed more failures in receiving care tended to have a lower level of life satisfaction. These results have strong implications for promotion of teachers' and student teachers' well-being, extending to school-based care-cultivation programs.

## **Care Competencies and Well-being of Vietnamese Student Teachers**

“Teaching can be wonderful - but it can also be very stressful” (Heyes, 2006, p. 1). Teaching has been ranked as one of the highest stress-evoking professions from a database of 26 occupations (Johnson et al., 2005). Teachers report the highest level of occupational stress in Australia, the United Kingdom and America (Milburn, 2011). Studies found unprecedented levels of stress and dissatisfaction among teachers and principals, with over half of teachers reporting great stress at least several days a week (Brackett, Palomera, Mojsa, Reyes, & Salovey, 2010; Chang, 2009). High levels of stress are affecting teacher health and well-being, causing teacher burnout, lack of engagement, job dissatisfaction, poor performance, and might even negatively impact student well-being (O’Connell, Boat, & Warner, 2009; Roffey, 2012). Well teachers promote well students (McCallum & Price 2010), so for students to flourish, we must cherish teachers. This starts with supporting student teachers, because stress and burnout may begin as early as the student-teaching experience (Fives, Hamman, & Olivarez, 2007). Promoting positive well-being in student teachers will contribute to their healthiness, longevity and productivity in their life and their career, which later brings many educational and psychological benefits for their future students.

As argued by the Mind and Life Institute (MLI; 2014), teachers’ well-being depends on their competencies to balance extending care to others, receiving care from others and self-care. According to the MLI (2014), all dimensions of care empower each other and the training in all three dimensions provides the fullest framework to support the development of our competencies for care. The concept “care” is understood in a similar manner throughout the world, but it is interpreted and defined in different ways. Nevertheless, in

literature, most authors agreed on the fact that care can be construed as both an attitude and actions for the sake and benefit of someone or something (Gastmans, 1999; Graham, 1983; Gilbert et al. 2017; Kittay, 2002). Accordingly, care consists of cognitive, affective, and behavioral elements. Therefore, receiving care may be interpreted as the competencies to (1) receive the understanding of one's own needs/situations from others (cognitive); (2) receive empathetic feelings from others to one's own needs/situations (affective); (3) receive the actions to meet one's own needs/situations from others (behavioral). Self-care is regarded as the competencies to (1) notice and understanding needs/situations of oneself (cognitive); (2) experience positive emotional reactions to needs/situations of oneself (affective); (3) act to meet needs/situations of oneself. Extending care can be described as the competencies to (1) notice and understanding others' needs/situations (cognitive); (2) experience positive emotional reactions to others' needs or situations (affective); (3) act to meet others' needs/situation.

Studies indicated that teachers' extending care is a significant factor contributing to all domains of students' life skills development and to their academic achievement, which in turn was linked to students' well-being (Chan, Lau & Yuen, 2011). However, unfortunately, caring teachers are expected to extend care to their students all the time, so many teachers lack the time and resources to care for and nurture themselves. They feel pressured to perform at extremely high standards, yet are overworked and underpaid (MLI, 2014). Compassion fatigue is a form of burnout prevalent in caring professions that so many teachers have experienced. To create and maintain supportive learning environments while retaining their well-being and love of teaching, teachers themselves must feel safe, secure and relaxed first, as MLI (2014, p. 29) puts it:

*“Our ability to create safe, trusting environments in which children feel that they are valued depends on our capacity to experience ourselves in the same way. Moreover, when they feel seen, welcomed and excepted, they easily value, love and treasure ourselves instead of self-criticizing ourselves”.*

In other words, to embody caring practices for students, teachers first should learn to deepen their competencies to receive care. They should learn to seek social support and collaboration from their colleagues, from principals and especially their students (MLI, 2014). Besides, to maintain a sustainable caring relationship and their well-being, teachers also need to take care of themselves before taking care of students. It is necessary for teachers to learn to cope with the many and varied stresses involved in their profession. By this way, extending care which flows naturally out of the worthiness, dignity and self-compassion that are cultivated by receiving care and self-care would greatly contribute to teachers' well-being (MLI, 2014).

Theoretically, the competencies to receive care, to develop self-care and to extend care integrate with each other to maintain teachers' well-being. Enhancing teachers' well-being by enhancing their competencies to receive care, develop self-care and extend care, thus, should not be overlooked as a 'nice to have' but as very essential. However, there is limited evidence to support such assumptions, particularly due to lack of good care competencies measures for teachers. Moreover, earlier research rarely focused on a pedagogy of care for in-service-teachers and pre-service teachers, which helps cultivate teachers' care competencies which improve their well-being. Similarly, lacking from the literature is empirical research directly focusing on the relationship between all three dimensions of care competencies of teachers and their well-being. Empirical evidence, therefore, is needed to

confirm the psychological benefits of care competencies and to set the basis for future care-cultivating programs among in-service and pre-service teachers. The present study, therefore, was designed to empirically test the following hypothesis:

Competencies in receiving care, self-care and extending care will be positively correlated with indicators of well-being and negatively correlated with indicators with ill-being. As a tool for investigating this hypothesis, we developed and validated the Questionnaire of Care Competencies for Students Teachers (QCC-ST).

## **Methods**

### **Participants**

The sample for this study comprised 205 student teachers, who were randomly selected from Hue University of Education (94 men and 111 women;  $M_{age} = 22.26$  years;  $SD = 0.43$ ). The community breakdown of the sample was 57 rural residents and 41 urban ones of Thua Thien Hue Province and 111 student teachers from other provinces. Participants filled out a self-report questionnaire during their internship at high schools in Springtime 2018. Completion rates were high, with no missing responses on any items.

### **Measures**

**Care competencies of student teachers.** A questionnaire was developed containing 36 potential scale items previously generated by the researchers through brainstorming based on the multidimensional definition of care competencies described above. The scale includes three subscales: receiving care, self-care and extending care. Each subscale is composed of 12 items with 6 positively worded statements and 6 negatively worded statements which are tapped into three facets of care (cognitive, affective and behavioural facets). Sample items

are in Table 1. The items were rated on a Likert scale from 1 (*totally untrue about me*) to 6 (*totally true of me*). The validity and reliability of the QCC-ST will be presented in the first part of the Results section.

**Well-being.** Well-being was measured using three validated scales. First, *The Self-Reporting Questionnaire-20* (SRQ-20) for adults was used to measure common mental disorders among student teachers. Developed by the WHO in 1994 to be used across cultures to explore symptoms of depression, anxiety and somatic complaints (Stewart et al., 2009), the SRQ-20 is a 20-item tool that includes questions about feelings of unhappiness, physical symptoms, effects on activities of daily living, and one question on current (in the past four weeks) suicidal thoughts. For example, “*Do you often have headaches?*”; “*Do you feel nervous, tense or worried?*”. These questions have to be answered by *yes* (1), *unknown* (2) or *no* (3). The higher score is, the more positive the mental health is. The SRQ-20 has been extensively validated in many countries including Vietnam (Giang, Allebeck, Kullgren & Nguyen, 2006). In the present study, Cronbach’s alpha of the scale (.76) was satisfactory. Second, the 10-item version of the *Perceived Stress Scale* was used to measure the degree to which situations in the participants' life are appraised as stressful. Items were both positively worded and negatively worded to tap how unpredictable, uncontrollable, and overloaded respondents find their lives during the last month (e.g. *In the past month, how often have you been upset because of something that happened unexpectedly; In the last month, how often have you been able to control irritations in your life?*). The answers were rated on a Likert scale ranging from 0 *never* to 4 *very often*. This scale was adapted in Vietnamese settings by Tran (2017). In the present study, Cronbach’s alpha of the scale (.68) was acceptable. Third, *The Satisfaction with Life Scale* (SWLS, Diener, Emmons, Larsen & Griffin, 1985) was used

to assess overall life satisfaction of the participants, rather than specific satisfaction domains. The 5 items are all phrased positively (e.g., *In most ways my life is close to ideal*) and answered using 7-point ratings (1 *strongly disagree* to 7 *strongly agree*). In Vietnam, this scale was validated in medical university students in Nguyen's (2012) study with a satisfactory level of reliability ( $\alpha = .75$ ). In the present study, Cronbach's alpha was .80.

**Data analysis.** In order to test the construct validity of the QCC-ST, an initial exploratory factor analysis (EFA) was performed. Based on this, we analyzed the factor structure by confirmatory factor analysis (CFA) and using robust maximum likelihood estimation (MLR) given non-normality of most item scores. With CFA, any item that does not fit the measurement model due to low factor loading should be removed from the model. The fitness of a measurement model is indicated through the following fit indices: ratio of chi-square to its degrees of freedom ( $\chi^2/df$ ; normed  $\chi^2$ ), comparative fit index (CFI), standardized root-mean-square residual (SRMR), and root mean square error of approximation (RMSEA). For a good model fit, normed  $\chi^2$  should be  $< 2$ , RMSEA should be  $< .05$  ( $< .08$  is acceptable), CFI  $> .95$  ( $> .90$  is acceptable), and SRMR  $< .05$  ( $< .08$  is acceptable) (Hu & Bentler, 1999; Kline, 2011; Little, 2013). Besides, in order to test convergent validity, Pearson correlation coefficients were calculated between the factors.

Reliability of the scale scores was measured via internal consistency coefficient alpha (Cronbach, 1951). Because the reliance on Cronbach's alpha as a sole index of reliability is no longer sufficiently warranted, we also evaluated the average inter-item correlation to estimate internal consistency as recommended by Clark and Watson (1995). Accordingly, average inter-item correlations should fall between .15 and .50 as anything below .15 would be too broad of a construct while anything above .50 would indicate redundancy of items.



In the second phase, we first examined the relationship of the care competencies with the well-being of student teachers using Pearson correlations. SPSS 15.0 was used for the descriptive analysis and Mplus version 8.0 was used for CFA.

## **Results**

### **Factor Analysis of the QCC-ST**

EFA with principal components extraction was conducted. KMO (0.72) and Barlett's test ( $df = 630$ ;  $\chi^2 = 2100.94$ ;  $p = .000$ ) indicated that the sample was adequate and the factor analysis was valid. Analysis of eigenvalues, screen plot and interpretability of the factors suggested a two-factor solution for each of the three care competencies. After rotation all the positively-worded items loaded the first factor and all the negatively-worded items on the second factor. These two latent constructs in each dimension of care were named as care competencies and care failures.

Based on results of the EFA, a two-factor model for each care dimension was evaluated using CFA. After removing items with poor factor loadings ( $< .35$ ; 8 in total), the model fitted the data sufficiently for receiving care: normed  $\chi^2 = 1.36$ ; CFI = .81; RMSEA = .05; SRMR = .05. However, for self-care and extending care scale, the model still did not fit the data adequately.

Table 1  
*Factor Loadings of 6-factor CFA of the QCC-ST*

Items	Receiving care		Self-care		Extending care	
	C	F	C	F	C	F
1. I am open to express what I think and feel so that others can understand my needs.	.36					
2. I am happy when others share my joys and sorrows.	.50					
3. I know there is always someone there for me when I need comforting.	.57					
4. I am grateful and express my gratitude to the one who has helped me to overcome my difficulties.	.55					
5. I feel comfortable to receive support from others when in need because receiving support is part of being human.	.44					
6. I notice that no one can understand my circumstances.		.43				
7. When in sadness, I often avoid the comfort from others.		.45				
8. Even when I am happy, I do not know who to share this happiness with.		.46				
9. When needing someone to help me to deal with a personal problem, I do not know who I can turn to.		.83				
10. I notice and am sensitive to the changes of my emotions			.37			
11. I try to understand the cause of negative emotions (sadness, anger, disappointment...)			.50			
12. I gently accept bad things happening to me because I see the difficulties as part of life that everyone goes through.			.54			
13. "Human is imperfect", so I do not get disappointed with some bad habits of mine; instead, I try to change them.			.49			
14. I make time for my hobbies.			.52			
15. I cannot identify my own emotions.				.56		
16. I pretend something has not happened in order to avoid thinking about my difficulties.				.50		
17. When failing or feeling very sad, I often withdraw and feel like the whole world abandons me.				.77		
18. When doing something wrong, I often criticize and hate myself.				.64		
19. I force myself to work intensively.				.41		
20. I notice others' joys and sorrows, even if they don't say anything.					.51	
21. I try to put myself in others' shoes when they are in trouble in order to understand their needs					.55	
22. I feel happy when I see others happy.					.72	
23. I am touched when I see miserable and starving people.					.59	
24. I spend time helping people in need.					.62	
25. When others are suffering, I try my best to help them.					.65	
26. I avoid noticing others' needs and feelings.						.28
27. When people cry in front of me, I often don't feel anything at all.						.57
28. When I see someone in pain or difficulties, I walk away.						.67

*Note.* C = competencies; F = failures

Based on modification indices, the goodness of fit of these models was improved by allowing error correlations between items 13 and 14 of self-care scale ( $r = .38$ ); items 25 and 26 of extending care scale ( $r = .38$ ), resulting in good fit for the model for self-care, normed  $\chi^2 = 1.78$ ; CFI = .92; RMSEA = .06; SRMR = .06, and adequate fit for the model for extending care, normed  $\chi^2 = 2.19$ ; CFI = .91; RMSEA = .08; SRMR = .05.

Next, an overall 6-factor CFA model was conducted on 28 items of the QCC-ST, based on the 2-factor models above. In this step, nine additional error correlations were allowed based on modification indices for similarly worded items. This CFA revealed this 6-factor model demonstrated good fit, normed  $\chi^2 = 1.31$ ; CFI = .91; RMSEA = .04; SRMR = .06. The standardized loadings are in Table 1. A final CFA in which the three care competencies were summarized in a higher-order competence factor and the three care failures in a second higher order failure factor showed as significantly worse fit to the data compared to the previous model ( $\Delta\chi^2 = 52.82, p < .001$ ;  $\Delta\text{CFI} = .046$ ), conforming that six factors within the QCC-ST is the best representation of these data.

The Cronbach's alpha for each subscale is reported in Table 2. They ranged between .50 and .80. That the Cronbach's alpha was not satisfactory for some scales may be due to the limited number of items. Nevertheless, the mean inter-item correlation for each fell within the recommended range (Clark & Watson, 1995) and item-to-total correlations were all over .03. Means and standards deviations of the QCC-ST subscales are also in Table 2 and indicated that the level of care competencies was not very high on the 1 to 6 scale whereas the level of care failures was below average.

Next, correlations among competencies and failures of the three dimensions of care are presented in Table 3. As can be seen, several of these inter-correlations between factors

were meaningful and quite strong. Finally, two multivariate ANOVAs were conducted with seven sociodemographic variables (gender, family structure, family size, rank in family, family income, location, and academic achievement) as independent variables, and with the care dimensions and well-being indicators as dependent variables. Findings revealed no significant associations between the care competencies/failures or well-being indicators and the seven demographic variables, except there was a very small association between mental health and family size ( $F(6,262) = .53, p < .05$ ), with lower mental health in larger families. Consequently, controlling for demographic variables was not necessary in further analyses.

Table 2  
*Internal Consistencies and Descriptives of the QCC-ST Subscales*

	# items	Cronbach's alpha	Average $r_{\text{item,item}}$	Average $r_{\text{item,total}}$	<i>M</i>	<i>SD</i>
Receiving care competencies	5	.60	.24	.36	4.49	0.68
Receiving care failures	4	.64	.31	.43	2.93	0.90
Self-care competencies	5	.66	.28	.42	4.40	0.72
Self-care failures	5	.70	.32	.46	3.24	0.91
Extending care competencies	6	.80	.41	.56	4.52	0.72
Extending care failures	3	.56	.30	.38	2.19	0.73

### **Care Competencies and Well-being of Student Teachers**

As shown in Table 3 correlations among competencies and failures of the three care dimensions and the three well-being indicators mostly were significant in the expected direction.

Table 3  
*Correlations between Measured Variables*

	<i>Care Competencies</i>			<i>Care Failures</i>		
	Receiving care	Self-care	Extending care	Receiving care	Self-care	Extending care
<i>Care Competencies</i>						
Receiving care						
Self-care	.83***					
Extending care	.64***	.77***				
<i>Care Failures</i>						
Receiving care	-.63***	-.30***	-.17*			
Self-care	-.42***	-.20**	-.07	.83***		
Extending care	-.56***	-.68***	-.87***	.35***	.13	
<i>Well-being</i>						
Positive mental health	.07	.00	-.00	-.22**	-.28**	-.03
Perceived stress	-.29***	-.22**	-.13	.35**	.42**	.07
Life satisfaction	.25***	.16*	.12	-.37***	-.29**	-.11

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$

Receiving care and self-care competencies were negatively associated with perceived stress and positively related to life satisfaction; whereas, receiving care and self-care failures were all negatively related to positive mental health and life satisfaction and positively correlated with perceived stress. However, noticeably, both extending care competencies and failures had no significant correlations with all three well-being indicators.

## Discussion

Teachers feel relatively safe in their work environment but still experience a high level of stress (Smith, Brice, Collins, Matthews, & McNamara, 2000). Teachers who experience high levels of stress will not perform to the best of their ability and impact students' well-being and achievement; whereas teachers with higher health and well-being can add to improved student educational outcomes and well-being (Roffey, 2012). As such, there is an urgent call for enhancing in-service and pre-service teachers' well-being. As proposed by the MLI (2014), teaching themes of care or enhancing care competencies for teachers can empower their inner strength to feel well, learn well and help make the world a better place (Dinh & Nguyen, 2016; Tran & Nguyen, 2016). However, a lack of empirical evidence exists to support the assumption that teachers' well-being depends on their ability to receive care from others, extend care to others and develop care for themselves, particularly due to a lack of good care competencies measures for this group. The present study, therefore, tested this assumption by empirically measuring and investigating all three dimensions of care in an integrated framework and relating them to student teachers' well-being.

First, we developed and validated the new QCC-ST. The EFA and CFA supported a six-factor model in which items indicated two factors each for 1) receiving care, 2) self-care and 3) extending care: care competencies and care failures. It is understandable that care competencies and care failures are not necessarily mutually exclusive. For example, a person who does not feel happy when he/she sees others are happy, does not necessarily feel envious when others get achievements and happiness in their life. In sum, the refined 28-item version had satisfactory construct validity and internal consistency.

Overall, the descriptive statistics revealed that the student teachers in this sample did not show very high level of care competencies. However, their care failures were not too serious suggested by the finding that the total scores for failures of each dimension of care were below average. Besides, failures in self-care seemed to be higher than those in receiving care and extending care. Overcoming self-care failures should be intentionally done by student teachers.

There was no significant relationship with sociodemographic characteristics and care competencies/failures. These results are not consistent with previous findings indicating women have higher levels of care-seeking and care-giving than men (Hermanto & Zuroff, year; Kunkel & Burlison, 1998; Tamres, Janicki & Helgeson, 2002). Possibly in the current sample the similar educational background (social sciences) of the student teachers explains the lack of gender differences. Our findings however seem to suggest that care support programs should address student teachers from various backgrounds with the same priority.

Findings also revealed that there was a strong and meaningful relationship between the six care dimensions. This finding proves that the dimensions of care are mutually interdependent. The competencies to receive care deepen the sense of our own self-worth and empowers us to relate to others more fully. Besides, the competence to experience and recognize our own needs and struggles also helps us to sense these in others, and to response to their needs in more caring and effective ways (MLI, 2014). If teachers do not learn to receive care for themselves nor learn to take care of themselves, their ability to extend care to others, including their students, children, families, and colleagues, is built on a fragile base and compassion fatigues will easily come.

As expected, findings also showed that the correlation among competencies and failures and the well-being indicators were significant. It can be inferred from the findings that not only did competencies contribute to well-being, but the care failures appear to impact ill-being more strongly. Noticeably, receiving care and self-care competencies were related only to perceived stress; while receiving care and self-care failures moderately predicted both perceived stress and mental health. Specifically, the findings indicated that student teachers with higher receiving care and self-care competencies were less likely to experience stress. Those who had a deficiency in receiving care and self-care perceived more stress and lower mental health. Besides, those who experienced in receiving care and self-care failures also tend to have lower life satisfaction; while those with higher receiving care and self-care competencies are more likely to be satisfied with life. This finding supports the conclusion from Kasprzak (2010), Young (2006) and Yang, Zhang and Kou (2016) that the strongest determinants of life-satisfaction are practical support and satisfaction with the relationships with others and self-compassion. These findings reveal on one hand that, opening up to and cherishing the fact that other people care about them, helps student teachers to feel connected, needed, and included in the lives of others; on another hand, that their reluctance to receive support from others might limit their belongingness to others and prevent them from trusting and cooperative sources of help, which decreases their coping efficacy. In terms of self-care, by truly accepting themselves, being kind to themselves by stopping comparing them with others and criticizing themselves, teacher students value themselves and assess their worth as a human being, which increases their self-efficacy. The competence or failure in receiving care and self-care, therefore, affect their psychological well-being. In general, the study results suggest focusing on receiving care and self-care training in care-cultivation programs



for student teachers, both strengthening competence as well as help to overcome failures, in order to improve the well-being of student teachers.

Unexpectedly, no significant relationship is found between extending care competencies/failures and well-being. This result is not in line with the findings from the meta-analysis by Jenkinson et al. (2013) that people who volunteer in care for others tend to have better psychological well-being. This unexpected finding needs replication in future studies with other samples of student teachers. It might however be the case that extending care to other not directly predicts the carer's well-being, but that this relationship depends on the other care competencies, self-care and receiving care. Future studies, therefore, should deeply explore this relationship as well as the interaction between care dimensions to predict well-being, which might provide us a more comprehensive understanding about the link between care competencies and well-being.

In general, the findings from this present study supports the assumption that student teachers' well-being depends on their ability and failure to receive care from others and to develop self-care. In the current educational environment, where schools are trying to increase student well-being through social-emotional learning programs with a diminishing budget, teachers' well-being still is neglected. Educators typically receive little training and support for supporting students' social and emotional development and even less training and support for their own social and emotional well-being (Jones & Bouffard, 2012). Teacher training curricula, especially, have little room for themes of care (Tran & Nguyen, 2017). A call for implementing care-cultivation programs for pre-service teachers, therefore, should be put forward. As Schonert-Reichl et al. (2016) highlighted, it is necessary to provide social-emotional skills training not only for in-service teachers but also for pre-service teachers.

The present study provides empirical evidence for the importance and content of care-cultivation programs for in-service and pre-service teachers. The different dimensions of care were mutually interdependent, and contributed to student teachers' well-being; therefore, training in all dimensions will provide the highest well-being. Besides, as suggested above, self-care and receiving care should be the first focus of the training programs in order to overcome failures in extending care by student teachers.

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