HELP ORIENTATIONS OF GERIATRIC NURSING CARE GIVERS

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ABSTRACT: Four help orientation models (moral, enlightenment, compensatory, medical) are represented in a Q sort administered to 68 geriatric nursing care givers (Registered and non-Registered Nurses in nursing homes and home care programs), who are instructed to express their orientations in a hypothetical case. The resulting three factors could not be explained in terms of demographic characteristics, but the first was consistent with the medical model, the second rejects the compensatory model, and the third is a combination of the enlightenment and medical models.

Nursing care givers in geriatric care settings are faced continuously with decisions about what form

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of help to give patients, particularly when there are multiple, complex problems. Knowledge about the bases on which nurses decide what to do to help their elderly patients would be valuable to the practitioner, as well as to the educator, for the development of attitudes, perceptions, and skills most consistent with good and effective nursing care. Such knowledge would have further value as a basis for future research to determine the most effective help orientations for giving care to specific patients in given situations.

Four help orientation models (moral, enlightenment, compensatory, medical), representing sets of attitudes and perceptions related to attribution of responsibility for cause and for solution of problems, were published by Brickman et al. in 1982. As shown in Figure 1, the *moral* model attributes high responsibility to the person both for the problem and for its solution; consequently, the patient, being willful, is viewed as lazy for failing to exert enough effort to resolve the problem. People are expected to help themselves. The *enlightenment* model sees the patient as responsible for having caused the problem, but as too ignorant (guilty, undisciplined, lacking in will power) to solve the problem without help. The *compensatory* model views patients as innocent victims (deprived, disadvantaged, handicapped), as victims of bad fortune who nevertheless have the responsibility and ability to solve their problems. The *medical* model invests patients with low responsibility both for causing their problems and for finding solutions: they are passive, weak, ill, and helpless against superior forces and are unable to rely on themselves.

Rabinowitz (1978/1979) validated the occurrence of these models in four natural group settings. Only five studies (Coates, Renzaglia, & Embree, 1983; Cohn, 1983; Karuza & Karuza, 1984; Levy, 1987; Modly, 1988) based on this theory have been published. The only uses of the theory in nursing research are Levy's (1987) description of the help orientation of psychiatric nurses in response to four case studies and Modly's (1988) descriptive survey of nurse-client dyads and their perceptions about help in four health care settings. There are no reports of replication of any of these studies and no

		(B) Hi	Lo
(A)	Hi	moral	enlightenment
	Lo	compensatory	medical

(A) Responsibility for causing problems
(B) Responsibility for solving problems

Figure 1. Four help orientation models

studies of help orientation have been published that have used Q methodology.

Study Design

The subjects for this study were Registered Nurses (RN) and non-Registered (non-RN) nursing care givers employed in two nursing homes and two home care programs in the Cleveland area. A sample of 68 volunteer subjects was obtained consisting of 19 RNs and 17 non-RNs employed in nursing homes, and 17 RNs and 15 non-RNs employed in home care programs.

After describing procedures, the Help Orientation Test (taken from Rabinowitz, 1979) was administered.[1] The subject then read the following vignette describing a typical situation of an elderly person, Mrs. B:

> Mrs. B is an elderly woman who was widowed several years ago. She has just recently taken early retirement from her long-time job as a small business executive due to increasing difficulty with arthritis. Since her retirement she has moved from her long-time home in a small town in New England to live near her children who are residents of Cleveland. Her

1. For details concerning tests administered, consult Taylor (forthcoming).

children are concerned about her difficulty sleeping, her increasingly poor hygiene, and her occasional problem with incontinence. Mrs. B complains of being tired and tends to isolate herself by staying in her apartment, saying there is nothing she can do. She frequently apologizes for upsetting her family. They have asked you to help.

The help-orientation Q sort was then used to describe Mrs. B's needs from the helper's standpoint.[2] The Revised Levy Questionnaire (Levy, 1987) was then also administered.

Factor Descriptions

The data collection procedures were designed to answer a number of research questions, among them being the connection between the help-orientation Q factors and Brickman et al.'s (1982) theory. Three factors were obtained from a principal axis analysis (varimax rotation). No significant correlation was found between any demographic variable and any factor. Registered Nurses and non-RNs were distributed across all three factors, as were subjects employed in both nursing homes and home care programs. Age, race, religion, level of education, and length of experience in nursing and in the present position were similarly distributed across the factors.

Looking first at the results from the standpoint of Brickman et al.'s theory, it can be concluded that some features of the help orientation models are identifiable in the three factors: factor A is predominantly consistent with the medical model; factor B appears to reject the compensatory model; and

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2. Sample statements are as follows: "Mrs. B will need help again only as a reminder that she is responsible for herself" (moral); "Mrs. B will fail unless she accepts guidance from those who have 'been there'" (enlightenment); "Mrs. B will fail unless she is given the resources she deserves" (compensatory); "The best person to help Mrs. B is a doctor" (medical). The entire Q sample is available upon request.

factor C is consistent with two models, enlightenment and medical, and rejects the moral and compensatory models. When the four models are broken down into their two components of attribution of responsibility, for problem cause and for problem solution, the similarities and differences among the factors are somewhat clearer. Although all three support low attribution to the patient of responsibility for problem solution, they vary in the degree to which they do so, with factor A representing the greatest amount of attribution of low responsibility for solution and factor B representing the lowest amount. They also vary in the degree to which they support the attribution to the patient of high responsibility for problem cause. Factor B represents the greatest attribution of high responsibility for cause and factor A represents the least attribution of high responsibility for problem cause.

This analysis, however, still does not give much meaning to the factors. The consistency of the help orientations, as defined by the three factors, is not clear. There is no picture, yet, of the basis on which the subjects would decide the form of help to give.

Factor A

Drawing on the distinction made by Roth (1974) between professionalism and love in the care of the sick, factor A might be seen as the medical professionalism factor with emphasis on the patient's sickness and professional diagnosis and care. According to the factor scores, the patient, Mrs. B, is seen as sick, self-destructive, withdrawing, and in need of experienced, trained care, therapy, and skillful help. She is seen as not being deprived, violent, in need of learning, or likely to get better without help. The "resources she deserves" may well be in the form of medical treatment, since they are not the "resources of those more fortunate." There is support in the post Q sort interviews for the professional character of this factor: Mrs. B would "probably drink herself to death," it was asserted. "It isn't a problem that cures itself." The social worker, nurse, and physician were named as the expert professional helpers for her identified alcoholism, depression, mental and physical sickness, medical problems, ar-

thritis, and bladder problems. The four statements concerning Mrs. B's views of helpers all carry small negative factor scores. It would seem that the patient's view of the helper is not important. Or could it be that the subjects were avoiding any indication of what they believed a helper should be? The factor is defined by 26 subjects, of whom 9 are RNs employed in nursing homes and 7 are non-RNs employed in nursing homes.

Factor B

Continuing with, but adapting, Roth's system of classification, one might identify factor B as the skilled love factor with emphasis on the patient's social problems and need for skilled intervention and help. Although Mrs. B is seen as sick and needing therapy, she is also seen as needing a tutor, to be shown how to improve and to reorient herself. She is capable of getting herself together so that she can carry on by herself unless and until she falls sick again. Although they were not distinguishing statements, the characteristics most like Mrs. B were that she needs a friend and to see that she is not alone. This "not alone" might well be interpreted to mean that she is not physically alone or that she is the only person in her situation. Supporting statements from the post Q interviews include that Mrs. B has a "common human experience;" that she has "just had lots of losses;" that she is sick because of inactivity, loneliness, and age; and that she "couldn't cope." She is seen as needing someone to talk to, a good friend to let her feel she's not alone, more communication, and practical help for her grief and loss. Other comments were, "It takes skilled intervention to see the problem;" "I doubt that people get well without intervention, but I allow the possibility;" and "It would be nice if she could find a little job." This factor was defined by 10 subjects, of whom 4 were non-RNs working in nursing homes. Five of these 10 subjects had no more than a high school education but the average length of experience, in nursing and in their present position, was greater for the subjects defining this factor than for the subjects defining either of the other factors.

Factor C

This factor might be seen as the skilled advocacy factor with emphasis on the patient's inner strengths in the face of the deprivation and lack of fairness that society has so far dealt her. Again, the patient needs a friend and "needs to see that she is not alone," although this time that might be interpreted as assistance against a harsh and cruel world. She is seen as needing "the fair chance that she has so far been denied," and more than just being shown how to improve. She is seen as being in danger of getting increasingly sick if she does not get help. This danger could be seen as coming from the harsh environment rather than from her medical or social situation. Uncharacteristic of Mrs. B, according to this factor, is an illusion that she can do everything by herself and the belief that she will fail unless she is completely self-reliant. The post Q interviews yield support in terms of referring to her move from New England where "self-sufficiency leads to being passive and not asking for help," her being isolated, but a self-reliant and strong person, whose "inner strengths are still there," and her "not making use of what she had." This factor was defined by 11 subjects, of whom 4 were RNs working in nursing homes and 4 were non-RNs working in home care. These defining subjects, as a group, had the least experience both in nursing and in their present positions.

Summary

Review of the factor arrays and the distinguishing statements indicates the differences in the three factors. Factor A represents medical professionalism with its concern for the sickness and expertise of the helper. Factor B represents skilled love with its concern for social losses and the patient's need for companionship. Factor C represents skilled advocacy with its concern for the harsh environment and need for supporting the patient against that cruel world.

These then are the factors of help orientation of nursing care givers. Although there are commonalities to be found between the medical professionalism factor and the Brickman et al. (1982) medical model,

in terms of the accepted attribution to the patient of low responsibility for the problem solution, it is difficult to find other similarities between the factors and the models. Additional research may further clarify the bases on which geriatric nursing care givers decide what form of help to give their patients.

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Through and through the world is infested with quantity: to talk sense is to talk quantities. It is no use saying the nation is large--how large? It is no use saying that radium is scarece--how scarce? You cannot evade quantity. You may fly to poetry and music, and quantity and number will face you in your rythyms and your octaves. (Alfred North Whitehead)
