

EFFECTS OF PATIENTS' AGE AND PERSONAL
DISPOSITION UPON CHARGE NURSES'
ATTITUDES AND ASSIGNMENTS

by

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TO MY FATHER

". . . more than a hundred schoolmasters."

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CHAPTER I

INTRODUCTION

The elderly are becoming an increasingly significant portion of our population. In 1960, the number of persons 65 years of age and older was increasing by 1.9 percent (U.S. Bureau of Census, 1976). By 1974 the percentage had grown to 2.6 percent (Census Bureau, 1976). In 1900 four percent of the population was 65 and older. In 1976, ten percent were in this age group and some demographers project that by the year 2,000, the percentage will be 12.6 (Hawkins, 1977).

Not only are the aged becoming more significant in terms of size of population, they are also posing more important problems for themselves and the rest of society. Because of increased mobility and breakdown of the extended family, many older persons are lonely and unable to take care of themselves (Saul, 1974). Some are destitute.

Of persons over 65, 15.3 percent are below the poverty level (Census Bureau, 1976). Most are on fixed incomes, either social security or some sort of pension.

One of the most important problems facing aged Americans is health care. Medicare has been of great benefit in assuring that more of the elderly have access to medical facilities. Since the advent of Medicare, the proportion of hospital beds occupied by persons 65 and older has increased dramatically. From July, 1962 to June, 1964, this age group used over 25 percent of all hospital days (Somers & Somers, 1967). In 1975, persons over 65 accounted for sixty percent

of the hospital beds used per day (Census Bureau, 1976). These figures are for acute care general hospitals, not for nursing homes where the percentages are much higher. Eighty-five percent of the long term care dollar is spent on older Americans (Eisdorfer, 1976).

Although these statistics indicate the number of persons receiving health care, they do not indicate the quality of the care they receive. That quality is determined at least in part by the health care team's willingness to help older people.

Nurse As Part of the Health Care Team

The research reported here was designed to investigate an important part of the health care team: the registered nurse. In hospitals, nurses have much more patient contact than do physicians. Not only do they observe and record data concerning the patients' physical condition, but they also are being relied on more frequently to observe and record patients' psychological activities (Putnam, 1973).

Although some medical observations are objective, others are somewhat subjective. Estimation of a patient's color and activity are medical observations, yet may vary from nurse to nurse. Psychological observations are certainly more subjective. Judgments about a patient's alertness, interaction with nurses, interaction with other patients are certainly colored by the nurses' perceptions and frame of reference. When recorded in a patient's chart, the nurses' observations may be influential in determining the course of treatment the physician prescribes. It is obvious, then, that the way in which a nurse perceives a patient has important implications for the future medical treatment of the patient.

Nursing As Premeditated Helping

Not only do nurses' perceptions of patients influence the long-term course of treatment for the patients, the perceptions also are likely to influence the quality of care the nurses themselves give to the patients. For example, nurses who perceive a patient as needing more help are likely to help that patient more than another patient.

The behavior of a nurse can be considered helping behavior. Helping behavior can be divided into two classes: emergency, or non-professional helping and pre-meditated helping. Pre-meditated helping occurs in situations where a person has made a commitment to helping others in somewhat narrowly defined situations. Counselors, psychotherapists, social workers and others who enter the helping professions may consider their work to be premeditated helping. On the other hand, emergency helping occurs when a person encounters a situation where (s)he has not given much thought to being of help. A person stopping to help someone with a flat tire would be an example of emergency helping.

Although nurses certainly help in many emergencies in a hospital, their helping behavior is not considered emergency helping as defined above. They have made a prior commitment to help in such situations, helping or not helping is not a spur of the moment decision. Therefore, a nurse's professional duties can be considered premeditated helping and studies about helping behavior as part of the helping professions therefore apply.

At least part of a nurse's helping behavior is altruistically motivated (Muhlenkamp & Parsons, 1972). To be sure, a nurse receives pay and other compensation, but at least part of the reason for entering

the nursing profession doubtless reflects a desire to help others, simply because they need help. This part of the motivation to help is the altruistic component.

Thus far, we have seen that because they are becoming a larger proportion of the population and because of easier access to health facilities since the advent of Medicare, older Americans are becoming a significant health care problem for society. The nurse is an important part of the team which cares for the health of these older Americans for two reasons. First, the nurse's observations are influential in deciding future course of treatment for the patients. And second, the quality of the care a nurse gives to older people depends on his/her perception of them.

This study is concerned with conditions assumed to affect the helping behavior of nurses towards older persons. Variables which are thought to influence whether a nurse is willing to help an older person will be of primary interest. The variables which were most important in this investigation are empathy and perceptions and attitudes toward older people. In the remainder of this chapter, the literature relevant to these two areas will be reviewed and the specific hypotheses of the study will be detailed.

REVIEW OF THE LITERATURE

Orientations Toward the Elderly

The most important set of variables included in this study relates to the perceptions and attitudes, i.e., social orientations, toward the elderly. A substantial body of literature indicates that a number of different samples of the people tend to have negative stereo-

types of the elderly. If the same is true for nurses, then a negative social orientation toward older people should induce them to avoid older patients and be less willing to help them. Still the question requires investigation to determine whether, in fact, older patients are offered less help than younger ones.

Early studies of perceptions of older people. Research on the perceptions of the elderly began in earnest in the early fifties with a series of articles published by Tuckman and Lorge. In one of the initial studies (Tuckman & Lorge, 1953), an Attitudes Toward Old People scale was developed. Statements about age were gathered from interviews with professionals and other adults and from a review of the literature. A questionnaire covering thirteen categories was developed from these sources. Items were grouped into the categories on the basis of face validity. The items were worded so that a "yes" answer indicated a negative attitude toward old people. The questionnaire was administered to a class in the Psychology of the Adult. Results were interpreted as supporting the notion that people have negative stereotypes of older persons. Specifically, older persons were thought to be characterized by economic insecurity, poor health, loneliness, resistance to change, and failing physical and mental powers.

The questionnaire developed in the Tuckman and Lorge (1953) study along with another instrument designed to measure attitudes toward older workers (Tuckman & Lorge, 1952) have been used with a number of other samples, yielding results similar to the initial ones.

Although no attempt was made in the original studies to establish the reliability and validity of the instruments, Axelrod and Eisdorfer

(1961) later made an attempt at refining the scale. They administered the scale to five groups of students. Each group received different instructions regarding the age of the person to whom the scale should apply. The age referent was varied as 35, 45, 55, 65, or 75 years. Only 96 of the original 137 items were found to discriminate among these age groups. Eisdorfer (1966) suggested further modifications.

Another instrument developed early also became quite popular: The Golde and Kogan (1959) sentence-completion questionnaire which was designed to tap perceptions of older people. Other techniques such as the semantic differential (Eisdorfer & Altrocchi, 1961; Kogan & Wallach, 1961), Likert scaling procedures (Kogan, 1961), and attitude checklists (Aaronson, 1966) have also been used.

Regardless of the measuring instrument used, the most pervasive outcome reflected in the literature is that Americans hold a negative stereotype of older people (Ginzberg, 1952; McTavish, 1971; Slater, 1963). Older people have been found to be perceived as generally ill, tired, not sexually interested, mentally slower, forgetful, and less able to learn new things, grouchy, withdrawn, feeling sorry for themselves, less likely to participate in activities (except, perhaps, religion), isolated, in the least happy or fortunate time of life, unproductive, and defensive.

Studies of professional helpers' involvement with elderly clients.

It may be that this negative stereotype is one of the factors influencing the reluctance of persons in the helping professions to treat older people. Kastenbaum (1964) suggested that most psychotherapists were reluctant to accept an older person as a patient because they thought an older person was more likely to have organic dysfunction, rather than

a treatable neurosis. Similarly, the older person is considered less likely to be physically attractive and less likely to change. This interpretation was later substantiated by a survey of physicians, including psychiatrists (Miller, Lowenstein, & Winston, 1976).

Perceptions of age and helping in a social service context were investigated in a series of studies done at the Boston University School of Social Work (Mutschler, 1971). The Boston studies used practitioners and social work students as their sample. Two of the four studies investigated the effects of stereotypes on the amount of help offered to older persons. In one study, only a questionnaire was used. In a second study, both a questionnaire and TAT type pictures were used to determine attitudes and orientations. Mutschler (1971) concluded that the findings are mixed. The first study found that holding negative stereotypes was associated with a low desire to work with the aged. However, the second study found that with both trained and non-trained workers, beliefs in stereotypes about aging did not adversely affect their choice of or perseveration in work with the aged.

Other than these few studies, little research has been done investigating the relationship between the perceptions that service professionals hold of older people and helping or willingness to help. There remains, however, the assumption that if the stereotype of an older person is accepted, the quality of helping will be reduced (Galton, 1975, Miller, Brimington, & Keller, 1972; Miller, 1972).

Perceptions of the aged by medical professionals. Although few studies have been done on attitudes toward old people in the non-medical helping professions, a number of studies have been done in medical

settings, using patients and members of the medical profession.

Merril and Gunter (1969) investigated patient attitudes toward old people. One hundred patients of a large metropolitan hospital responded to the Tuckman Lorge Attitudes Toward Old People scale and were asked the preferred age for their hospital roommate. Results showed that all age groups held negative stereotypes of the aged, with respondents 65 years of age and older having more stereotypical responses toward older people than either the young or middle-aged groups. No relationship was found between stereotyped responses and the preferred age for roommates.

Medical student attitudes toward the geriatric patient have also been investigated (Parker, 1960; Spence, Feigenbaum, Fitzgerald, & Roth, 1968). Parker (1960) conducted a small-scale exploratory study among medical students. Comparing the attitudes of first year medical students with senior medical students, he found that there had been no apparent change in attitudes toward the aged.

Spence, et. al. (1968) surveyed the entire freshman and senior classes of the University of California School of Medicine to determine the effects of medical training on attitudes toward the geriatric patient. Although the response rate among the seniors was only about 50 percent, they were used as a comparison group for the freshmen who were assumed to have no prior medical training. Both groups of students adhered to negative stereotypes of the aging. Apparently, the authors conclude, three years of medical training had little or not effect on attitudes toward aged patients.

This same predominance of stereotypes has been found in several studies of physicians. Coe (1967) conducted a pilot study in which

group discussions were held with small groups of physicians, dentists, physical therapists, nurses, and social workers. A content analysis was done of the tape recordings of the sessions. Physicians saw older patients as being rigid in behavior and unadaptable to change, either in environment or in habits. Not surprisingly, most of their comments were from a medical, as opposed to a psychological perspective.

Cyrus-Lutz and Gaitz (1972) mailed Golde and Kogan's (1959) sentence-completion questionnaire to 435 psychiatrists. Forty percent of those to whom the questionnaire was mailed (it is not reported how the 435 were selected) returned complete and usable instruments. Their responses from the completed questionnaires were compared with those from the college students in Golde and Kogan's (1959) study. The only significant difference was on perceptions of death and dying. The college students saw older people as more concerned with death and dying than did the psychiatrists. Some of the negative comments from the psychiatrists' responses indicated impatience and boredom when treating older patients and resentment of the physical and mental deterioration of the aged. Some (it was not reported how many) felt inadequate to treat older patients.

Miller, Lowenstein and Winston (1976) surveyed physicians in several areas of specialization concerning their attitudes toward nursing homes and the ill aged. While in general the attitudes were not overwhelmingly negative, the authors stated that the relatively positive attitudes were not matched by the behavior of the physicians: it was difficult to get a physician to treat a patient in a nursing home.

Attitudes of nurses toward elderly patients have also been studied.

O'Neill (1964) reported the results of a training program designed to help nurses deal with elderly patients. Although apparently no systematic measure was made, those who participated in the training program reported they were better able to understand the problems of the elderly and less likely to be impatient with geriatric patients than before the training.

In another study of nurses' attitudes, Coe (1967) found that nurses focused on "social-psychological" variables of treating older patients. They saw aged patients as being slow, and believed that it was sometimes hard to deal with or to communicate with them. They also felt that older patients were annoying because of their complaints, demands, incontinence, inability to feed themselves, and the like. In sum, there was apparently a generally negative attitude toward older patients. Moreover, there was evidence that this attitude was transmitted to student nurses by older students and by their instructors.

Critique of survey studies. As can be seen from the above review, almost all of the studies dealing with attitudes toward old people have used some form of survey. One criticism that can be leveled at the survey studies is that they are not measuring the same dimensions of attitudes toward the elderly. In fact, correlations among different measures have been found to be low (Hicks, Rogers, & Shember, 1976). However, a more fundamental issue can be raised. Items on the questionnaires were usually phrased in general terms, e.g., "most old people..." Since a stereotype is "a set of characteristics which is assumed to fit a category of people" (Hastorf, Schneider, & Polefka, 1970, p. 46), and since the items were phrased in terms of the category of old people, it is not too surprising that these studies find stereotypes.

Whether these stereotypes are altogether negative is a different question, one which requires a value judgment. Several of the items may reflect the values of a young person, rather than an older person. The results of several studies indicate that older persons may be even more likely to "stereotype" older persons than are younger persons (Merrill & Gunter, 1969). It may be that older persons do not consider that stereotype to be negative (Brubaker & Powers, 1976).

It may be, furthermore, that subjects' judgments about older people are general and are not reflected in their reactions to a specific older individual. Indeed, this has been observed in two published studies and in one unpublished study. Weinberger and Millham (1976) administered an attitude questionnaire to assess youths' attitudes toward a "representative" 25-year-old and a "representative" 75-year-old to students in an introductory psychology class. A subsample from the class was recruited as volunteers for an experiment that was not related to the questionnaire survey. In the experiment, subjects read autobiographical sketches of two persons, one 25 years old and the other 75 years old. The two sketches were equated for social desirability. On the scales in the attitudes questionnaire, the representative younger person was rated more favorably than the representative older person. However, the measures accompanying the autobiographical sketches the opposite was true: the older person was rated more favorably than the younger person.

Bell and Stanfield (1973) report results which corroborate those of Weinberger and Millham (1976). Two hundred eighty college students heard a recorded discussion on ecology by a stimulus person described as being either 25 or 65 years of age. The dependent measure was a

set of 46 items taken from the Tuckman-Lorge (1953) stereotype scale and arranged in semantic differential format. Although differences were not statistically significant, the college students tended to rate the older individual more positively than the younger one.

A third study (Crockett, Press, & Osterkamp, Note 1) found similar results. Crockett et al. had 240 students enrolled in basic communication courses read an interview attributed to either a 36 year old woman or a 76 year old woman. The final paragraph in the interview was varied so that the woman was described as being engaged in different kinds of activities. Regardless of the kind of activity, the older woman was liked better than the younger woman.

The results of these three studies seem to contradict the findings of the large number of surveys of attitudes toward older people. One possible explanation for this is that in these studies respondents were asked to evaluate a "real" individual person, not a group of people. By doing so, the stereotype may have been "broken" in a sense. That is, the expected stereotype was violated by a person who contrasts with that stereotype. The situation is analagous to the bigot who works with and likes a black man, "but he is an exception."

Hypotheses about stereotypes of the elderly. Two hypotheses of the present study deal directly with stereotypes of older people. The first hypothesis is that nurses will be more likely to see a complaining older person in negative stereotypical terms than they will a complaining younger person. Among some of the components of the negative stereotype of older persons are the characteristics of complaining, grouchiness, and demandingness, as opposed to the characteristics of considerateness, cooperativeness, and helpfulness.

The second hypothesis relates stereotypes with helping. It is hypothesized that age will interact with complainingness in determining reported helping. For the purposes of this study, the primary dimension of stereotype is complaining. An older person who is "complaining" is more stereotypical than an older person who is uncomplaining. Early studies (cf. McTavish, 1971) found that stereotypes of the elderly included the perception that older people were likely to be complainers, dissatisfied with their lot in life, and communicating that dissatisfaction to whomever would listen.

Consequently, the prediction is made that nurses will report more willingness to help an uncomplaining older person than an uncomplaining younger person. It is also predicted that nurses will be less willing to help a complaining older person than a complaining young person. The second prediction is made because it is assumed that a complaining older person will be seen more negatively and as being more stereotypical and therefore will be less likely to be helped.

The hypotheses relating to stereotypes basically are concerned with attitudes and perceptions and the relationships of those variables with intentions to help. Although a considerable amount of research (Fishbein & Ajzen, 1975; Mischel, 1968) indicates that there is little relationship between attitudes and behavior, it is likely that attitudes influence more subtle forms of behavior than are typically measured. Those subtle differences in behavior may affect the quality of care a patient may receive from a nurse, although it may not overtly affect general statements about willingness to help.

Empathy and Helping

A second set of variables included in the present study were designed to elicit an empathic response. The literature on helping in general, including premeditated helping, suggests the possibility that empathy may be a mediating factor in helping. In this section, variables from the literature on helping behavior and on premeditated helping will be reviewed and, based on that review, a hypothesis will be posited.

Research on helping by non-professionals. Stotland (1969) and Latané and Darley (1970) were among the first to propose empathy as a possible mediating factor in helping. Factors other than empathy were initially proposed. However, empathic arousal has been gaining favor as an explanation of altruism and helping behavior.

For example, it has been suggested that empathy results from a direct observation of another person's experience (Aronfreed, 1970). This empathic response is involved as a necessary and sufficient condition for altruistic behavior. In his review of the literature on altruism, Krebs (1970a) includes several studies (Aderman & Berkowitz, 1970; Krebs, 1970b, Stotland, 1969) which would support an empathic-arousal interpretation. Krebs (1975) later conducted research which also supports this interpretation. Two studies and two models which were built on these studies will be discussed here.

Two recent models of altruism are based on an explanation of helping behavior as being mediated or caused by empathic arousal to the victim's plight (Batson, Darley, & Coke, in press; Piliavin & Piliavin, Note 2). One of the elements common to both of these models is an assumption of physiological arousal. Stotland and Sherman

(Stotland, 1969), for example, induced emotional arousal by having subjects watch a person receive a diathermy treatment which was described as either painful, pleasurable, or neutral. Subjects were given one of three observational sets. In one set, they were asked simply to watch the person receiving the treatment (watch-him). In another set they were asked to imagine what the person's responses were (imagine-him). And in the final set, the subjects were asked to imagine how they would feel in the situation (imagine-me). Physiological measurements indicated the subjects in the imagine-him condition were more aroused than those in the other two conditions. Stotland considers this arousal to reflect the existence of empathy in that condition.

Subsequent observations (Adelman & Berkowitz, 1970) have found that an empathic observational set elicits differences in helping behavior. They had male college students listen to a speaker, either imagining themselves as that speaker or imagining that speaker's reactions. The observational set by itself had no significant effect. However, there was an interaction effect between the kind of speaker, the set and the mood of the subject. Subjects in the imagine-him condition were more likely to help a person when they had listened to the speaker who had helped and was thanked for helping.

Moreover, Coke, Batson, and McDavis (in press) performed two experiments designed to test a two-stage empathic mediational model of helping. The model suggests that taking the perspective of a person in need increases empathic emotion which in turn increases helping. In the first experiment, the subjects, introductory psychology students, were given a capsule and told that the drug contained

therein would either arouse them (arouse condition) or relax them (relax condition). After participating in an apparently unrelated short-term memory experiment, subjects then heard a tape of a radio newscast containing an interview with a young woman in need. Half of the subjects were asked to imagine how the woman in need was feeling (imagine-her condition) or to identify the techniques that made the broadcast warm and personal (observe condition). The resulting 2 x 2 design was analyzed using a planned comparison. The subjects in the imagine-relax condition indicated a greater willingness to help than did the subjects in the other three conditions. The second experiment replicated the first except that arousal was manipulated by means of false feedback. The subjects in the high arousal condition perceived themselves as being more aroused and indicated a greater willingness to help than did those in the low arousal condition. The results were interpreted as providing support to the two-stage model of helping.

There is a fair amount of evidence, then, that empathy as defined by Coke, Batson, and McDavis (Note 1), is likely to be influential in determining whether a person in a non-professional setting is likely to help.

Premeditated helping. Premeditated helping, as we have already remarked, exists when a prior commitment has been made to help in somewhat narrowly-defined situations. Most of the research dealing with such helping comes from the fields of counseling and psychotherapy.

One of the first persons to articulate the need for empathy in a helping relationship was Rogers (1951, 1961). He considered empathy part of a triad of essential ingredients in therapeutic relationships: empathic understanding, genuineness, and warmth. Truax and Carkhuff

(1967) have summarized research relevant to the Rogers triad. They consistently found a relationship between accurate empathy and positive therapeutic outcome.

Empathy is defined in this study from the viewpoint of the helper: empathy is a positive emotional response to someone in distress. That emotional response is commonly labeled "compassion."

Hypothesis regarding empathy and helping. Based on the literature, a third hypothesis becomes apparent: a nurse who reacts empathically to a patient will be more likely to help that patient than a nurse who reacts with more negative emotions.

Other Variables

Several other variables are likely to be relevant to helping older people. Among these are previous acquaintance with older people, the criticalness of the problem, and the quality of the interpersonal relationship between the helper and the helpee.

Acquaintance with an older person. The evidence on the relationship between the amount of acquaintance with older people and perceptions of them is somewhat mixed (Bekker & Taylor, 1966; Bengtson, 1971; Fox, 1937, Rosencranz & McNevin, 1969; Tuckman & Lorge, 1958). One possible reason for the lack of consistency in results is that different studies have used different methods and that the conclusions the authors suggest are inferences based on data which do not directly test the hypothesis of contact with older persons.

For example, Bekker and Taylor (1966) used the Tuckman and Lorge (1953) questionnaire as revised by Axelrod and Eisdorfer (1961). They administered the questionnaire to college students in order to test

the hypothesis that students who had living great-grandparents would perceive their grandparents as having fewer characteristics of old age than would students having no living great-grandparents. Their hypothesis was supported. This study is frequently cited as evidence that people who know an aged person are less likely to perceive older people in a stereotypical manner.

Bengtson (1971) reanalyzed the data from a study that he had done previously in which, using a questionnaire, he measured attitudes within three generation families. He found no relationship between acquaintanceship with an older person and stereotypes of older people.

Another possible reason for the mixed results is that few studies have included, as part of the measure, the quality of the relationships with older person. If someone has had negative experiences with the aged, e.g., has known them only in a nursing home, then that person seems likely to give more negative stereotypical responses on a questionnaire than someone who has had more positive experiences with the aged.

A fourth hypothesis is intended to more explicitly state a relationship between previous experiences with the elderly and intention to help. This hypothesis proposes that a nurse who has previously had favorable contact with older persons will be more likely to report willingness to help older persons than one who has not had such contact. Favorable contact is contact the nurses recall as being pleasant and favorable.

Criticalness of the problem. Another variable which influences helping behavior is the perception of the criticalness of the situation. Piliavin and Piliavin (Note 3) report two experiments in which this

variable is investigated. In an experiment which was conducted on the New York subway system, a person with a cane fell down. In one condition, the person merely needed help getting back on his feet. In the other condition, the stimulus person's problem was made to appear worse by having him bleed at the mouth after he fell down. Other passengers were more likely to help the person whose problem was less critical.

The other experiment compared the helping behavior of persons on a subway platform with persons at an airport. Those at the airport were less likely to help than people on the subway system. The explanation for both these experiments appears to lie in the subject's self-perception of how capable he is to handle the situation. Although not suggested by Piliavin and Piliavin, one possible interpretation is that people feel more competent to help someone who merely falls down than someone who may need more sophisticated medical attention. Similarly, people in the subway are more familiar with their environment, for example a subway platform they traverse everyday, than are those in an airport which they probably pass through infrequently; consequently, they feel more competent to handle problems in the more familiar environment.

It would seem, then, that for help to be given, a situation must be interpreted as one which is serious enough to warrant assistance but not so critical that the potential helper feels incapable of handling the problem.

Because in this study we wanted the nurses to focus primarily on the psychological needs, rather than the physical needs of the patients, the study was designed so that the medical needs of the patients were

not critical. Most nurses should have felt competent to deal with the medical needs of all the patients portrayed in this study. Because it is assumed that nurses have already made a commitment to help by accepting a position as a nurse, the decision of whom to help, then, should be based on the perception of need. The more critical the problem is perceived to be, the more likely it is that a nurse will find helping with that problem to be challenging and rewarding. Therefore, the fifth hypothesis holds: a nurse will be more likely to indicate a willingness to help a person who is perceived as needing more help than a person who is perceived as needing less help.

Interpersonal relationships. There is some evidence to indicate that a liked person will receive more help than a disliked person. Epstein and Hornstein (1969), testing a different hypothesis, found that subjects' selfish behavior increased when that behavior was directed toward a disliked person.

The final hypothesis addressed the relationship between liking and helping: the more a nurse reports liking a patient, the more likely she is to report willingness to help that patient.

Summary of Hypotheses

Each of the hypotheses is concerned with a variable presumed to influence the helping behavior of nurses. However, the hypotheses and, consequently, the design of the study do not always specify a direction of causality. The results of the study are subject to dual interpretations of causality: either the self-reported variables influence the degree of helping; or, the nurses, having made a simulated commitment to help, may justify their decision, in terms of

reports of liking, acquaintance with an older person, etc. This lack of causal direction is particularly noticable in the fourth, fifth, and sixth hypotheses.

Moreover, each hypothesis suggests at least one reason why nurses may help patients. This study is not directly concerned with how nurses may help patients.

CHAPTER 2

METHOD

The purpose of the study was to investigate nurses' cognitive and affective orientations toward geriatric patients and the effect of those orientations on measures of willingness to help. A simulation technique was used. Nurses read the cases of four fictitious patients and indicated the assignments they would make of those patients to nursing personnel. Additional measures were made of cognitive and affective orientations toward each patient.

In this chapter, a detailed description of the method will be given. The description will be divided into five parts: sample, design, procedure, dependent variables, and data analysis.

Sample

The sample consisted of 48 volunteers from the population of registered nurses in Douglas County, Kansas. Because the preponderance of such nurses were female, it was decided to limit the sample to females. It was also decided to limit the sample to nurses who had had patient contact within the last five years.

Subjects were contacted in one of three ways. First, an attempt was made to reach them by telephone. Using a list of nurses registered in Douglas County supplied by the Kansas State Board of Nursing, calls were made to the residences of nurses, usually in mid to late afternoon. Nurses were told that:

We are asking nurses in Douglas County to participate in a research project concerned with the way nurses form impressions of patients. The project is being sponsored by a government grant and is also being a part of my dissertation. What would be involved is for you to read some brief medical histories and excerpts from interviews with patients. Then you would fill out some questionnaires. It would take about 45 minutes to an hour and you would be paid \$5.00.

Approximately twenty of the 31 nurses reached by phone agreed to participate.

A second method of contacting subjects was by posting sign-up sheets in nurses stations in Lawrence Memorial Hospital. The sign-up sheet included essentially the same information as was given during the telephone call except that nurses were asked to sign their name, home telephone number, and indicate a "best time to call." The assistant director of nursing and the inservice training director of the hospital encouraged nurses to sign up. Those who did sign up were then contacted by telephone to make an appointment for a mutually agreeable time and place to meet. Approximately ten subjects were attained with this method.

The third way subjects were contacted was by visiting local physicians' offices and the Douglas County Public Health Department and Visiting Nurses Association. Each subject was given the same information as those contacted by telephone, and an appointment was made for a mutually agreeable time and place. Approximately fifteen subjects were recruited in this way. Five of the nurses who were contacted either refused to participate or a mutually agreeable time and place could not be worked out.

Age of the nurses ranged from 22 to 59, with a mean of 35. In general, training of the sample was more advanced than training of the

population. Only 35 percent of the sample were diploma graduates, compared with 62 percent of the population. Eleven percent of the sample had degrees beyond a B.S., whereas only five percent of the population had advanced degrees. Nurses in the sample were employed in more responsible positions than those in the population as a whole: thirty-nine percent of the sample held supervisory positions, ranging from charge nurse to nursing director. The sample, then, was generally superior to the population in training and employment status. This is typical of volunteer samples (Rosenthal & Rosnow, 1975).

Procedure

Subjects met the experimenter in one of two places: the Speech Communication experimental area at the University of Kansas or the In-service Training Library at Lawrence Memorial Hospital. In about half of the cases, the experiment was conducted one subject at a time. The other half of the subjects met in groups of from two to five. In all cases, subjects were free from outside distractions and talked only with the experimenter before and during the experiment.

As subjects entered the experimental room, they were handed a stack of six folders. The experimenter asked that the subjects open the first folder, read and sign the first page which was a consent form (Appendix A). He then asked that subjects read the second page, labelled "Introduction" (Appendix B). The instructions in the introduction asked the subjects to imagine themselves as a charge nurse in a hospital using a team approach to nursing. They were asked to make assignments to members of the team based on the information included in the folders. After they had read the introduction, the experimenter re-emphasized that

the subjects were asked to read four folders, each of which contained a brief medical history, an excerpt from an interview with a social worker and a questionnaire. Subjects were also told that there was a folder at the end which contained two more questionnaires.

Each subject then read the cases of four fictitious patients. For each patient, a brief medical history and an excerpt from an interview with a social worker was provided. The medical histories were designed to be roughly equivalent in terms of amount of nursing care required and criticalness of the patients' medical problems. Pre-testing with a panel of nurses, and analyses subsequent to the study, indicated that the histories were, in fact, perceived to be equivalent. Variations in the interviews involved the patient's personal disposition (two were pleasant and two unpleasant), sex (two were male and two female), and age (two were approximately 75 and two approximately 27).

After the subjects completed reading the patient cases and filling out the questionnaires, a debriefing procedure was followed. Beginning with the fourteenth subject, each subject was also given a form which asked them to estimate the age of the patients, and to say whether age made any difference in making their assignments. None of the subjects indicated any suspicion while filling out the Assignment Form or the Questionnaire, although some did begin to suspect age as a factor when they were given the manipulation check. Because those subjects who were suspicious did not become aware of the age manipulation until after they had filled out all of the questionnaires, it was judged that none of the subjects needed to be discarded for suspiciousness. Subjects were asked if the patients portrayed in the study were like patients they had encountered. All subjects found the patients' cases to be

typical of many real-life patients and therefore believable. The experiment was then explained in detail and subjects were cautioned not to mention age or personal disposition to anyone else. The experimenter also encouraged reactions to the experiment.

Design

The design was a repeated measures factorial design, with age and personal disposition of the patient as the factors varied. Disposition was varied by having the excerpts from the interviews portray people who were either pleasant or unpleasant. The two "pleasant" interviews depicted persons who generally had a positive outlook on life, were satisfied with the care they were receiving in the hospital, and demonstrated an understanding of the problems nurses might have in caring for patients. The two "unpleasant" interviews depicted patients who complained about the poor treatment they were receiving and about their illness, and displayed a generally negative outlook on life.

Age was varied by indicated the age and sex of the patient at the top left corner underneath the patient's name on the medical history and on the interview forms. In addition, age was mentioned in the first sentence of the medical history, i.e., the first sentence the subjects read about each patient. After the first fourteen subjects, checks were made on the age manipulation by asking subjects to write the age for each of the four patients on a form given them after they had completed all of the other questionnaires. Of the total 144 patients (36 subjects, four patients per subject) on whom checks were made, 129 patient ages were identified within five years of the correct age.

Interviews were systematically rotated across cases so that, for different subjects, the age and personal disposition of a patient was

assigned equally often to each medical history. The order in which the cases were read was varied so that, for different subjects, half the subjects read the cases in one order and the other half read the cases in the reverse order. This counterbalancing resulting in sixteen different combinations of order, medical history, age, sex and interview (Table 1). Three subjects were administered cases in each combination, resulting in a total of 48 subjects. Interviews 1 and 3 represented uncomplaining patients, interviews 2 and 4 represented complaining patients.

Variations in Patients' Disposition

The disposition of the patients was varied by changing the character of the interviews. The interviews were not excerpts from real ones. Rather, they were constructed to portray either complaining or uncomplaining patients. The interviews were shown to a panel, and after several minor revisions, were judged to reflect either a complaining person or an uncomplaining person. Analysis of the results show the manipulation to be highly successful.

Dependent Variables

All of the dependent variables took the form of written responses to items on one of two questionnaires. The dependent variables were intended to measure the subjects' reactions to the patients, and in particular, their reactions to the age and personal disposition of the patients.

The first questionnaire, the Assignment Form (Appendix C), was included in each of the four folders having a medical history and an excerpt from an interview. Thus, subjects filled out four Assignment

TABLE 1
COMBINATIONS OF MEDICAL HISTORY, INTERVIEW, AND AGE
IN ORDER OF PRESENTATION TO SUBJECTS

Combination Number	First Case Presented	Second Case Presented	Third Case Presented	Fourth Case Presented
1	*A1Y	B20	C30	D4Y
2	A10	B2Y	C3Y	D40
3	D4Y	C30	B20	A1Y
4	D40	C3Y	B2Y	A10
5	A2Y	B30	C40	D1Y
6	A20	B3Y	C4Y	D10
7	D1Y	C10	B30	A2Y
8	D10	C4Y	B3Y	A20
9	A3Y	B40	C10	D2Y
10	A30	B4Y	C1Y	D20
11	D2Y	C10	B40	A3Y
12	D20	C1Y	B4Y	A30
13	A4Y	B10	C20	D3Y
14	A40	B1Y	C2Y	D30
15	D3Y	C20	B10	A4Y
16	D30	C2Y	B1Y	A40

*Note: A = medical history of Joseph Cook, B = medical history of Helen Morse, C = medical history of Steve Janis, D = medical history of Susan Rieker; Numbers refer to interviews 1 through 4; Y = young age, 0 = old age.

Forms, one for each patient case history. The Assignment Form consisted in a number of types of items, in addition to the type of assignment made. Specifically, it included four main sets of dependent variables. The first, that having to do with assignment, was the primary dependent variable. Subjects were asked to indicate how they "would assign the patient based on his/her psychological and medical needs." Five choices were given, representing decreasing levels of willingness to help the patient. They could

- (a) assign primary responsibility to yourself,
- (b) assign primary responsibility to another RN with you actively checking on the patient's progress,
- (c) assign primary responsibility to another RN in the unit,
- (d) assign primary responsibility to a student nurse with another RN actively checking on the patient's progress,
- (e) assign primary responsibility to a student nurse.

These choices were checked with a panel of six nurses to see that

- 1) they would be interpreted as decreasing levels of helpfulness, and
- 2) they were approximately equal intervals apart.

Subjects were then asked to take two or three minutes to write an explanation of the reason for making their assessment.

The second set of variables on the Assignment Form was designed to tap the subjects' impressions of the patients. Subjects were asked to make ratings on eight point scales. The scales were designed to test the fourth, fifth, and sixth hypotheses, that is, those having to do with previous experiences with the elderly, criticalness of the problem, and liking of the patient.

The fourth hypothesis suggested a relationship between previous acquaintance with an older person and willingness to help older people

in general. Three items on the Assignment Form measured previous relationships with older persons. Because age could not be mentioned without possibly artificially sensitizing subjects to that variable, the first item asked "Does the patient remind you of someone you know well?" The second item was intended to unobtrusively measure the age of the person mentioned in the first item by asking the relationship (friend, grandfather, etc.) of the person to the subject. If the response was "grandfather", for example, we could assume the person to be old; if the person was "friend" or "spouse" we could assume the person was young. The final item directed to test this hypothesis asked the subject to indicate the favorableness or unfavorableness of previous experiences with that person.

The fifth hypothesis had to do with the relationship between criticalness of the problem and helping. One item on the Assignment Form simply asked the subjects to rate the criticalness of the patient's problem. Similarly, the sixth hypothesis posited a relationship between liking and helping; one item asked subjects to rate how much they liked the patient.

A third set of variables on the Assignment Form was designed to test the third hypothesis, that of the mediating role of empathy in helping behavior. On this set of variables, subjects were asked to indicate their emotional state by indicating on eight-point scales the extent to which they were feeling various emotions. The items in this set have been found (Coke, Batson, & McDavis, in press) to be associated with willingness to help.

The last large set of variables was a list of characteristics which might be associated with the elderly. This set of variables was included

to test the first hypothesis, that having to do with stereotypes.

Two other variables were included in this first questionnaire. They were used to determine whether patients were attending to the medical or psychological needs of the patients. This was one way to check to see if subjects were perceiving medical needs as being equivalent.

The second questionnaire (Appendix D) was in the last folder in the stack given the subjects. Each subject filled out one of these questionnaires after having responded to each of the patients individually on the Assignment Form. The general purpose of the questionnaire was to ask the subjects to make comparisons among the patients. First, subjects were asked to rank order the patients according to how much help the patients needed. Then they were asked to rank order the patients according to how much the subjects would enjoy taking care of the patients.

The last instrument to be filled out was used to collect demographic data on the nurses (Appendix E). Of particular interest on this instrument were items having to do with training and previous experience with geriatric patients.

Data Analysis

After the data were collected, three different kinds of analyses were performed. First, separate repeated-measures analyses of variance were computed for each of the items on the Assignment Forms. The same kind of analysis was done for the items on the questionnaire which asked the subjects to rank the patients according to how much they thought the patient needed help and according to how much they would enjoy caring for the patient.

The second kind of analyses were Pearson product-moment correlations between the variable "Assignment" and the other variables on the Assignment Form. These analyses were done to test for the relationship between the extent to which the subjects were willing to get involved with the patients and the other variables.

Finally, analyses were done of the open-ended responses. Open-ended responses were for one of three items: (1) reason for assignment, (2) reason for giving a "1" ranking to the patient perceived as needing the most help, and (3) reason for giving a "1" ranking to the patient perceived as being the most enjoyable to care for. After having examined the responses, four categories for analyzing those responses were devised. Each category was considered separately. The categories were age, expertise, subjects' own feelings toward the patient or situation, and amount of time it would take to care for the patient.

CHAPTER 3

RESULTS

This chapter reports results of the analyses described in the Method chapter. Results will be reported for each hypothesis in order. Then evidence is presented on manipulation effectiveness.

Hypothesis I

The first hypothesis stated that nurses will be more likely to perceive a complaining older person in negative stereotypical terms than they will a complaining younger person. Two sets of variables on the Assignment Form were intended to test this hypothesis. A repeated measures analysis of variance, with age and personal disposition being the within group factors, was performed on the data from both sets of variables.

Impressions of patients. One set was impressions of patients, specifically: Typicalness of Behavior, Dependency, Trouble to Take Care Of, Extent Patient Needs Help, and Comfort With Patient. In general, we see highly significant personal disposition effects, but not differences due to age.

Analysis of the variable, Trouble to Take Care Of, reveals a highly significant effect for personal disposition ($F = 114.40$, $df = 1,46$; $p < .001$ N.B. Analysis of variance tables for this and other variables can be found in Appendix F). Age was not significant ($F = 1.43$, $df = 1,46$) nor was Age x Personal Disposition ($F = 1.64$, $df = 1,46$). Looking at the cell means (Table 2) we see that the complaining patients were rated

TABLE 2
CELL MEANS FOR VARIABLE
TROUBLE TO TAKE CARE OF

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	6.875	6.458	6.667
Complaining	3.667	3.771	3.719 ^c
Marginal	5.271	5.115	

^cDifferences between these means, significant, $p < .001$.

TABLE 3
CELL MEANS FOR VARIABLE
DEPENDENCY OF PATIENT

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	5.542	5.500	5.521 ^c
Complaining	2.771	2.688	2.729 ^c
Marginal	4.156	4.094	

^cDifferences between these means are significant, $p < .001$.

as being significantly more trouble to take care of than were the uncomplaining patients.

A similar pattern holds for dependency of the patient. Subjects rated the uncomplaining patients as being significantly less dependent than the complaining patients ($F = 112.55$; $df = 1,46$; $p < .001$). The effects due to Age and the Age \times Disposition interaction are not significant. Table 3 shows in detail that the complaining patients were rated as more dependent than were the uncomplaining patients.

Using a similar measure, the extent the patient needs help, we find again that Disposition has made a difference ($F = 84.37$; $df = 1,46$; $p < .001$) but that Age and the Age \times Disposition interaction term are not at all significant. The complaining patients were seen as needing more help (Table 4).

One variable in this first set, Typicalness of Behavior, was intended to provide a measurement of the patients age-related behavior. We had hoped that subjects would make the rating of the patient's typicalness on the basis of how typical the patient was for his/her age, and we had considered wording the item so that it would be clear that the comparison should be made on the basis of age. However, it was likely that a reference to age would alert subjects to the probability that age was one of the variables being investigated. Consequently, reference to age was deleted and therefore the meaning of the item may have been unclear to the subjects. At any rate, there were no significant differences for this item due to Disposition, Age, or Age \times Disposition. Cell means are presented in Table 5.

TABLE 4
CELL MEANS FOR VARIABLE
EXTENT PATIENT NEEDS HELP

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	3.667	3.896	3.781 ^c
Complaining	2.167	2.229	2.198 ^c
Marginal	2.889	2.684	

^cDifferences between these means, significant, $p < .001$.

TABLE 5
CELL MEANS FOR VARIABLE
TYPICALNESS OF BEHAVIOR

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	2.938	3.063	3.000
Complaining	3.563	3.271	3.417
Marginal	3.250	3.167	

Ratings of patient characteristics. A second set of variables was included in the Assignment Form for the purpose of testing the first hypothesis. Subjects were asked to rate each patient on a number of characteristics which might be considered part of a stereotype of the elderly. Again, we find a similar pattern: the personal disposition of the patient made a difference in the way the patient was ranked, but neither age nor a combination of age and personal disposition had any effect.

Looking at these variables in more detail, we see that subjects rated the complaining patients as less considerate than the uncomplaining patients (Table 6). This difference was significant ($F = 219.00$; $df = 1,44$, $p < .001$), whereas the Age term and the interaction term were not significant.

Not surprisingly, the complaining patients were rated significantly more complaining than were the uncomplaining patients ($F = 339.47$; $df = 1,44$, $p < .001$) (Table 7). Of course, this result simply reaffirms the effectiveness of the personal disposition manipulation. The Age and Age x Disposition effects are not significant.

Neither Age nor the interaction term were significant for the rating of the patient according to how grouchy (s)he was. However, the complaining patients were perceived as being significantly more grouchy than the uncomplaining patients ($F = 188.91$; $df = 1,44$; $p < .001$) (Table 8).

Subjects also ranked the patients according to their perception of how cooperative they believed the patients were. Again, age effects are not significant, nor are Age x Disposition. Again, though, the Disposition term is highly significant ($F = 96.53$, $df = 1,44$; $p < .001$):

TABLE 6
CELL MEANS FOR VARIABLE CONSIDERATE

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	2.043	1.891	1.967 ^c
Complaining	5.152	5.152	5.152 ^c
Marginal	3.598	3.522	

^cDifferences between these means significant, $p < .001$.

TABLE 7
CELL MEANS FOR VARIABLE COMPLAINING

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	6.804	6.717	6.761 ^c
Complaining	2.522	2.826	2.674 ^c
Marginal	4.663	4.772	

^cDifferences between these means significant, $p < .001$.

TABLE 8
CELL MEANS FOR VARIABLE GROUCHY

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	6.652	7.022	6.837 ^c
Complaining	3.326	3.022	3.174 ^c
Marginal	4.989	5.022	

^cDifferences between these means significant, $p < .001$.

TABLE 9
CELL MEANS FOR VARIABLE COOPERATIVE

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	2.109	2.174	2.141 ^c
Complaining	4.543	4.565	4.554 ^c
Marginal	3.326	3.370	

^cDifferences between these means significant, $p < .001$.

the uncomplaining patients were seen as being more cooperative (Table 9).

Another variable in this second set was Wise. The results of ratings on this variable hold to the same pattern: the Age and interaction terms are not significant, whereas the Disposition term is significant ($F = 68.57$, $df = 1,44$, $p < .001$). The uncomplaining patients were rated as being wiser than were the complaining patients (Table 10).

The characteristics of demandingness is frequently associated with the elderly, but such was not the case in this instance. Again, Age had no effect nor did the combination of Age and Disposition. In this study, subjects rated the complaining patients as being more demanding (Table 11; $F = 158.83$, $df = 1,44$; $p < .001$).

The final variable intended to test the first hypothesis was Helpful. The complaining patients were ranked as being less helpful than the uncomplaining patients (Table 12; $F = 136.32$; $df = 1,44$; $p < .001$). Age and the combination of Age and Disposition did not make any difference in the way subjects rated the patients' helpfulness.

Summary. A highly consistent pattern emerges when we look at the results of the variables intended to test the first hypothesis. Analysis of each of the variables reveals no significant effects for the Age factor, nor for the Age x Disposition interaction. However, the Disposition factor for all of these variables is highly significant. The uncomplaining patients were rated as being less trouble to take care of, less dependent, needing less help, less complaining, less grouchy, and less demanding than the complaining patients. They were also perceived as being more considerate, more cooperative, more helpful and

TABLE 10
CELL MEANS FOR VARIABLE WISE

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	4.022	3.600	3.811 ^c
Complaining	4.511	4.489	4.500 ^c
Marginal	4.266	4.044	

^cDifferences between these means significant, $p < .001$.

TABLE 11
CELL MEANS FOR VARIABLE DEMANDING

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	6.333	6.979	6.656 ^c
Complaining	2.354	2.645	2.499 ^c
Marginal	4.343	4.812	

^cDifferences between these means significant, $p < .001$.

TABLE 12
CELL MEANS FOR VARIABLE HELPFUL

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	2.771	2.708	2.739 ^c
Complaining	4.833	5.042	4.937 ^c
Marginal	3.802	3.875	

^cDifferences between these means significant, $p < .001$.

TABLE 13
CELL MEANS FOR VARIABLE ASSIGNMENT

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	3.445	3.468	3.457 ^c
Complaining	2.364	2.559	2.462 ^c
Marginal	2.904	3.014	

^cDifferences between these means are significant, $p < .001$.

wiser than were the complaining patients.

Hypothesis II

The second hypothesis posited that nurses will report more willingness to help an older person who does not conform to a stereotype of the elderly. Specifically it was predicted that: (1) nurses will be more likely to help pleasant older patients than pleasant younger patients, and (2) nurses will be less likely to help unpleasant older patients than unpleasant or complaining younger patients.

Since this hypothesis was most central to the primary purpose of the study, several variables and types of analysis were employed in testing the hypothesis. The results of the analyses will be presented in three groups, each group representing a different kind of analysis testing the hypothesis.

Assignment of case. The first group consists of analysis of the primary dependent variables: those concerned with the way nurses assigned patients. It will be recalled that the subjects assigned patients to a member of the nursing team and then wrote for two or three minutes explaining their reasons for making the assignments.

In analyzing the assignment itself, it was assumed that the lower the score, the more willing the subjects would be to become involved in helping the patient. The only significant effect was for personal disposition (Table 13; $F = 23.27$; $df = 1,45$; $p < .001$). Subjects were more likely to take on the complaining patients as their own or to assign them to a staff nurse. On the other hand, uncomplaining patients were more likely to be assigned less skilled help. Age and interaction effects were not significant.

Analyses were also made of the subjects' open-ended responses, reasons given for having made the assignment. The first step in the analysis of these responses was to simply read through them to find themes. Four major themes were found: expertise of the RN or student, reference to age of the patient, indication of the subjects' own feelings, and amount of time it would take to care for the patient.

The second step was to analyze responses within each of those four themes for differences resulting from age or disposition of the patient. Each open-ended response was examined for comments which would fall into one of the four themes. The comment was then written on one of four coding sheets, one sheet for each theme.

Two kinds of analyses were done after responses had been categorized into each theme. First, responses were examined by a panel of three judges not connected with the study and blind to the hypotheses. The judges were instructed to examine the responses looking for patterns. No patterns were found.

Secondly, Chi-square analyses were done for the themes Expertise and Time. The other two themes were not analyzed using Chi-square statistic because there were an insufficient number of responses. The two uncomplaining interviews and the two complaining interviews were collapsed for the analyses as were the two levels of age. A 2 x 2 contingency table resulted, with two levels of age (young and old) and two levels of personal disposition (uncomplaining and complaining). For an individual observation to fall into a given cell, it had to (1) be categorized into the theme being analyzed, and (2) be a response to a patient having the characteristics of age and personal disposition appropriate to that cell. The resulting Chi-square analysis for the

theme Expertise, yielded $\chi^2 = .095$, which with one degree of freedom is not significant (Table 14). The responses to the theme Time (Table 15) also do not differ significantly ($\chi^2 = 1.422$, $df = 1$).

In sum, analyses of the open-ended responses on the Assignment Form did not reveal significant effects of the age or personal disposition of the patient.

Correlations with assignment. To further investigate possible reasons for making assignments to one or another nurse, correlations were calculated between the Assignment variable and the group of variables labeled Impressions of Patients and the group labeled Characteristics of Patients. Of course, these are correlational analyses and do not indicate direction of causality, but the analyses indicate elements which are possibly associated with the assignment process.

Looking at Table 16, we see a pattern of positive correlations between the way subjects assigned patients and several of the impressions of the young, complaining patients. Nurses are more likely to assign young, complaining patients to themselves or another RN the more they perceive the patient to be trouble to take care of, typical, and in need of help. Assignment correlates significantly with the extent the nurses felt comfortable with the patient. The same pattern holds, although not as strongly for correlations with the older complaining patients.

No significant correlations emerge for the uncomplaining patients, either young or old. Correlations between Assignment and the variables labeled Characteristics of Patient are low and not significantly different from zero.

TABLE 14
 FREQUENCY OF RESPONSES IN CATEGORY
 "EXPERTISE", BY DISPOSITION AND AGE

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	32	32	64
Complaining	36	40	76
Marginal	68	72	140

$\chi^2 = .095$, $df = 1$. n.s.

TABLE 15
 FREQUENCY OF RESPONSES IN CATEGORY
 "TIME", BY DISPOSITION AND AGE

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	17	7	24
Complaining	13	11	24
Marginal	30	18	48

$\chi^2 = 1.422$, $df = 1$. n.s.

TABLE 16

CORRELATIONS BETWEEN ASSIGNMENT AND IMPRESSIONS OF PATIENT
AND CHARACTERISTICS OF PATIENT, BY AGE AND DISPOSITION

Variables on Assignment Form	Assignment			
	Young		Old	
	Uncomplaining	Complaining	Uncomplaining	Complaining
<u>Impressions of Patient</u>				
Trouble to take care of	-.023	-.005	.190	.230
Typicalness of behavior	.078	.247*	.125	.053
Dependency	.210	-.145	.063	.117
Needs help	.112	.280*	.218	.350**
Comfort with patient	.237*	.249*	.046	.116
<u>Characteristics of Patient</u>				
Considerate	.012	-.030	.195	.059
Complaining	-.116	.057	-.086	.048
Grouchy	-.138	-.031	-.185	.044
Cooperative	-.022	.112	.000	.122
Wise	-.115	-.038	-.173	.095
Demanding	-.039	-.083	-.221	.168
Helpful	-.279*	.164	-.067	.194

*p < .05

**p < .01

***p < .001

Rank order of patients. In addition to rating each patient on a number of dimensions, subjects were asked after they had read and responded to all four cases, to rank order the patients according to how much they would enjoy caring for the patients and according to how much help they perceived the patients as needing.

We were interested in determining reactions to age and disposition. For that reason, the interviews were grouped so that an analysis was made of the way subjects ranked the four different age/sex combinations.

Kendall's Coefficient of Concordance was calculated both for the rankings of the extent the subjects would enjoy caring for the patient, and for the extent subjects perceived the patients as needing help. For the variable Needs Help, $\underline{W} = .94$. Looking at the means displayed in Table 17, the primary source for this high value is the difference between the way subjects reacted to the complaining and uncomplaining patients, rather than any difference due to age.

Similarly, $\underline{W} = .92$ when calculated using the scores from the variable Enjoy Caring (Table 18). The disposition factor, rather than the age factor, again is primarily instrumental in the high value for \underline{W} .

Summary. Analysis of the variables testing the second hypothesis reveals that subjects did not perceive the combination of age and personal disposition to be as important in making nursing assignments as they found personal disposition in and of itself. There is some correlational evidence to indicate reactions to the characteristics of young, complaining patients is more important in determining assignment than are reactions to any other group of patients.

TABLE 17
CELL MEANS FOR RANKING OF PATIENT ACCORDING TO
EXTENT PATIENT NEEDS HELP

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	3.312	3.000	3.156
Complaining	1.937	1.729	1.883
Marginal	2.628	2.368	

TABLE 18
CELL MEANS FOR RANKING OF PATIENT ACCORDING TO
EXTENT SUBJECT WOULD ENJOY CARING FOR THE PATIENT

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	2.271	2.083	2.177
Complaining	3.000	2.729	2.864
Marginal	2.631	2.406	

Hypothesis III

The third hypothesis was that nurses who react empathically to a patient will be more likely to help that patient than a nurse who reacts with more negative emotions. Two kinds of analyses were performed to test this hypothesis, one using analysis of variance, the other correlational analysis.

ANOVA. First, repeated measures analyses of variance were calculated using Age and Disposition as within group factors. Separate analyses were done for all of the variables on the Assignment Form where the subjects reported emotional reactions to the patients.

Age effects occurred on three variables: subjects felt more soft-hearted (Table 19, $p < .01$), more compassionate (Table 20, $p < .001$), and warmer (Table 21, $p < .01$) toward the older patients than toward the younger ones. (Analysis of variance tables for these and the other variables in this section appear in Appendix E.)

The personal disposition of the patient made a difference in subjects' reactions for all six of these items. Subjects reported feeling significantly ($p < .001$) more soft-hearted (Table 19), more compassionate (Table 20), and warmer (Table 21) toward the uncomplaining patients; they also felt less alarmed (Table 22, $p < .05$) and less upset (Table 23, $p < .001$) and less irritated (Table 24, $p < .001$) while reading the cases of the uncomplaining patients than those of the complaining ones. No significant interaction effects were found for this set of variables.

Correlations. A correlational analysis was also done using subjects' reports of emotional reactions to the patients. The ratings of reactions were correlated with the variable Assignment. The resulting Pearson r coefficients are displayed in Table 25. Most of the

TABLE 19
CELL MEANS FOR VARIABLE SOFT-HEARTED

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	3.478	2.435	2.957 ^c
Complaining	4.500	4.130	4.315 ^c
Marginal	3.989 ^b	3.283 ^b	

^bDifferences between means significant, $p < .01$.

^cDifferences between means significant, $p < .001$.

TABLE 20
CELL MEANS FOR VARIABLE COMPASSIONATE

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	3.109	2.239	2.674 ^b
Complaining	3.543	3.152	3.348 ^b
Marginal	3.326 ^c	2.696 ^c	

^bDifferences between these means significant, $p < .01$.

^cDifferences between these means significant, $p < .001$.

TABLE 21
CELL MEANS FOR VARIABLE WARM

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	2.500	2.000	2.250 ^c
Complaining	4.065	3.522	3.793 ^c
Marginal	3.283 ^b	2.721 ^b	

^bDifferences between these means significant, $p < .01$.

^cDifferences between these means significant, $p < .001$.

TABLE 22
CELL MEANS FOR VARIABLE ALARMED

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	6.696	6.739	6.717 ^a
Complaining	6.000	5.957	5.978 ^a
Marginal	6.348	6.548	

^aDifferences between these means significant, $p < .05$.

TABLE 23
CELL MEANS FOR VARIABLE UPSET

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	7.130	7.174	7.152 ^c
Complaining	5.348	5.522	5.435 ^c
Marginal	6.239	6.348	

^cDifferences between these means significant, $p < .001$.

TABLE 24
CELL MEANS FOR VARIABLE IRRITATED

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	7.370	7.152	7.261 ^c
Complaining	4.870	5.109	4.489 ^c
Marginal	6.120	6.130	

^cDifferences between these means significant, $p < .001$.

TABLE 25

CORRELATIONS BETWEEN ASSIGNMENT AND EMOTIONS OF PATIENT
BY AGE AND DISPOSITION

	Assignment			
	Young		Old	
	Uncomplaining	Complaining	Uncomplaining	Complaining
Soft-hearted	-.012	.317**	.239*	.186
Upset	-.031	.315**	.076	.136
Alarmed	-.049	.393**	.076	.075
Compassionate	.069	.088	.245*	.330**
Warm	.112	.116	.110	.269*
Irritated	-.264*	.085	.061	-.138

*p < .05

**p < .01

***p < .001

significant correlations are in the predicted direction. Subjects tended to assign patients to themselves the more they felt soft-hearted toward the patients, when the patients were young complaining and old uncomplaining. A similar relationship is found between Compassion and Assignment when the patients are old, regardless of disposition. A significant correlation is found between Warm and Assignment for the complaining older patients. A negative correlation emerged between Assignment and Irritated, another finding in the predicted direction.

Some surprises also emerged from the correlational analysis. Assignment is positively correlated with Upset and Alarmed for the young complaining patient. This result is discussed in more detail in the next chapter.

Summary. In addition to providing evidence to support the hypothesis, the analyses demonstrated some age differences. The differences occurred when subjects reported their feelings of soft-heartedness, compassion, and warmth toward the patients.

Hypothesis IV

Hypothesis IV posited that a nurse who has had previous favorable contact with older persons will be more likely to indicate a willingness to help older persons than nurses who have not had such contact. Three variables were intended to test this hypothesis: items 7, 8, and 9 on the Assignment Form. These items asked the subjects to rate the extent to which the patient reminded the subjects of someone they knew well, to indicate the relationship of the known person to the subject, and finally to rate the extent that previous experiences with

that person were favorable.

Unfortunately, this hypothesis could not be tested. The analysis hinged upon being able to calculate an analysis of variance for Item 8, relationship to person known well. However, since we were unable to assign ages values to responses to this item for reasons mentioned earlier, an analysis could not be performed and, consequently, the hypothesis could not be tested.

Hypothesis V

The prediction that nurses will be more willing to help a person perceived as needing more help than a person perceived as needing less help formed the basis for the fifth hypothesis.

To test the hypothesis, an item on the Assignment Form asked the subjects to rate the criticalness of the patients problem. These ratings were then correlated with the Assignment variable. As can be seen from Table 26, a significant positive correlation appears only for the complaining patients.

As will be described in the last section of this chapter, subjects perceived the patients' problems as being primarily psychological, rather than physical, especially for the complaining patients. The evidence suggests subjects believed that the complaining patients had greater problems than did the uncomplaining patients. Given this interpretation, the correlationship analyses offer some support to the hypothesis.

TABLE 26
CORRELATIONS BETWEEN ASSIGNMENT AND CRITICALNESS OF
PROBLEM, BY AGE AND DISPOSITION

	Assignment			
	Young		Old	
	Uncomplaining	Complaining	Uncomplaining	Complaining
Criticalness of problem	.162	.251*	.195	.244*

* $p < .05$

TABLE 27
CORRELATIONS BETWEEN ASSIGNMENT AND LIKING,
BY AGE AND DISPOSITION

	Assignment			
	Young		Old	
	Uncomplaining	Complaining	Uncomplaining	Complaining
Liking	.107	.425***	.062	-.006

*** $p < .001$

Hypothesis VI

The last hypothesis suggested that the more a nurse reports liking a patient, the more likely (s)he is to indicate a willingness to help that patient. This hypothesis was also tested by a correlational analysis: in this case, between subjects' ratings of how well they liked the patient and Assignment.

Table 27 shows a significant positive correlation only for the young, complaining patient. The other correlations are so low that they are not at all statistically significant.

Manipulation Checks

An effort was made to check to see if the intended manipulations were perceived by the subjects. First, the age manipulation was checked after the fourteenth subject, by having subjects recall the approximate age of the patients. A response was considered accurate if it was within five years of the patient's age indicated in the case. Although none of the subjects missed all four patients, only fourteen recalled all of the subjects' ages. Twenty missed one age, eight missed two ages and six missed three ages.

The disposition manipulation was more successful. Table 28 shows that subjects paid greater attention to psychological needs when the patients were complaining than when they were uncomplaining ($F = 75.89$; $df = 1,44$, $p < .001$). This coupled with the fact that the complaining patients were perceived as being complaining (Table 7), suggests that subjects attended to the complaining, psychological dimension of the patients.

TABLE 28
CELL MEANS FOR VARIABLE PSYCHOLOGICAL NEEDS

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	2.562	2.520	2.541 ^c
Complaining	1.875	1.792	1.833 ^c
Marginal	2.218	2.156	

^cDifferences between these means significant, $p < .001$.

TABLE 29
CELL MEANS FOR VARIABLE MEDICAL NEEDS

Disposition	Age		
	Young	Old	Marginal
Uncomplaining	3.417	3.333	3.375
Complaining	3.875	4.000	3.937
Marginal	3.646	3.666	

Medical needs, on the other hand, were judged as about equal for all patients (Table 29), regardless of age or personal disposition. This was as planned and was intended to reduce the impact of an additional confounding variable.

CHAPTER 4

DISCUSSION

In the previous chapter, results from the data analyses were presented. This chapter will be a discussion of the implications of those results.

The chapter is divided into four parts. First, the results will be discussed in relation to the original hypotheses. Second, some alternative explanations will be suggested. Third, the contributions of attribution theory will be examined, and fourth, suggestions for further research will be made.

Tests of Hypotheses

It will be recalled that this study was designed to test six hypotheses. From even a cursory glance at the results, it is obvious that support for these hypotheses is limited. Even so, some interesting findings emerge.

Stereotypes. Most of the data do not support the first hypothesis. This hypothesis stated that nurses would be more likely to dislike a complaining older person than a complaining younger person. The expected age x personal disposition interaction did not occur. Essentially, the analyses only showed that the manipulation of personal disposition worked. The complaining patients were seen in more negative stereotypical terms than were the uncomplaining patients.

Willingness to become involved. The second hypothesis stated that nurses would be more willing to help, or to become involved with, an

older, uncomplaining patient than they would with a younger, uncomplaining patient. Conversely, nurses would be less likely to become involved with old, complaining patients than with young, complaining patients.

The results of analyses of the variables do not support the hypothesis. The predicted interaction between age and personal disposition did not occur. Rather, there was a highly significant personal disposition effect in an unexpected direction. The unpleasant patients were more likely to receive more skilled help. This, taken with the findings of the subjects' reports of how well they liked the patients, is puzzling at first glance.

Because the findings of previous research on the relationship between liking and helping (Krebs, 1970) are unclear, it is difficult to interpret the results of the present study in light of what has been done before. Perhaps the folk wisdom of "It's the squeaky wheel that gets the oil," holds true, at least in hospitals.

However, it should be pointed out that the subjects were asked to imagine themselves as having never met the patient before. Their only knowledge of the patient was from the medical history and interview. Moreover, many of the open-ended responses contained references to the subjects' desire to see if the complaints the complaining patients made were, in fact, true. It may be that if the subjects had had contact with the complaining patients over a period of time and had observed that their complaints were not especially justified, they would not be as likely to indicate a willingness to become involved with them.

Support for this interpretation can be seen in the correlational analyses of subjects' reported emotional reactions with their assignment of the patients. Subjects were more likely to indicate a willingness to become involved with the patients if they responded with any emotional reaction, except irritation. Not only were their reports of the "empathic" emotions of soft-hearted, compassionate, and warm highly correlated with Assignment of the patients to themselves, but so were the reports of the less empathic emotions of being alarmed and upset. The only reported reaction which was negatively correlated with assignment to themselves was Irritated. One would expect that if the patient were complaining over a period of time, that the other emotions would give way to irritation and the patient would not get as much help.

Empathic reactions. The third hypothesis was supported in part. The correlations of assignment of the patient to themselves with the emotional reactions to the patient show that there is a relationship between empathic reactions and willingness to become involved. This supports an empathic arousal model of helping (Piliavin & Piliavin, Note 1; Batson, Coke & Darley, in press). However, there is also a slight relationship between Assignment and the items Alarmed and Upset.

In a previous study (Coke, Batson, & McDavis, in press), these items were found to be part of a personal distress factor, not part of an empathy factor. Indeed, feelings of "alarm" and "upset" are indications of personal distress when intense. However, it may be that since the mean on these items showed that the reactions are not strong, these two items tapped concern, rather than a strong negative reaction. Mild feelings of alarm suggest that one's attention is

aroused. If subjects had reported that they were not at all alarmed or upset, we could assume they were also unconcerned.

The results also show that subjects were more empathic toward older persons, regardless of personal disposition. The most obvious explanation for these results is that the subjects reacted in a positive, empathic way to the older patients. Since there is at least a weak relationship between empathic response and helping, one would expect that the older patients would be more likely to be helped than the younger patients. However, the analysis of the Assignment variable does not support that interpretation. An alternative explanation, suggesting an attitude of condescension, is proposed in a later section of this chapter.

Previous contact. Unfortunately, the variables used to test the fourth hypothesis could not be analyzed. The hypothesis was that nurses who have had previous favorable contact with older persons would be more likely to indicate a willingness to help patients. However, for reasons explained in the Results chapter, the data from the items intended to tap previous favorable contact with the aging yielded ambiguous results and were not analyzed in detail. Consequently no conclusions can be drawn regarding this hypothesis.

Criticalness of problem. The fifth hypothesis was that the more critical the nurses perceived a patient's problem to be, the more likely they would indicate a willingness to help. There was also partial support for this hypothesis. Since the subjects made their assessment of the patients' problems primarily on the basis of psychological needs, it is likely that the complaining patients were perceived as

having a more critical problem; namely, a psychological problem. Therefore, the significant correlations for the complaining patients may be interpreted as giving support to the hypothesis: there was a relationship between Criticalness of Problem and Willingness to Help for the patients whose problem was more severe, but no such relationship for patients whose problem was less severe.

However, it should be pointed out that although the correlations are significant, they are only moderately high. So only partial support for the hypothesis can be claimed. Moreover, none of the problems, medical or psychological, were really severe. It may be that if the problems were really severe, the subject would not feel competent enough to handle them and would be less likely to become involved.

In any case, the results from this study can be interpreted as extending the results of Piliavin and Piliavin (Note 1) and their subway study reviewed in the first chapter. It may be there is an optimum criticalness of problem for eliciting help. If a problem is not severe enough, for example, the uncomplaining patients in this study, no help may be given. On the other hand, if the problem is so critical that it requires help beyond the potential helpers self-perceived competence level, no help may be given in the situation, either. The situation where help is most likely to be given is where some minimal level of aid is needed, but not so much that the self-perceived help-giving capacity of the potential helper is exceeded.

In the Piliavin and Piliavin (Note 1) study, the middle and higher extremes of the criticalness of problem/self-perceived competency ratio scale were investigated. In this study, it was the lower and middle ranges of the scale which were investigated.

Liking and helping. The final hypothesis was that the more a subject reports liking a patient, the more likely help will be given. The correlations between Liking and Assignment give only partial support to this hypothesis. Only for the complaining young patients was the correlation between Liking and Assignment significant.

It may be this was more a measure of the relationship between disliking a patient and not helping. The younger complaining person showed a tendency, although not significant, to be the most disliked of the four patients. Thus, subjects who dislike this patient intensely did not help; those who expressed less extreme dislike were more likely to help.

For the uncomplaining patients, there was no relationship between Liking and Assignment. This is certainly in line with the interpretation that disliking is more of a predictor of helping than is liking.

Summary. Of the six hypotheses partial support was found for four, no support was found for one and the remaining hypothesis could not be tested. Although the results were not overwhelming, they form a consistent pattern. Age had less of an effect than personal disposition of the patients. However, there are some differences due to age. These differences are primarily in the emotional reactions to the patients.

Alternative Explanations

Salience of independent variables. The hypotheses for this study were formulated in order to investigate whether older people, because of their age, receive less help from nurses. Moreover, it was thought that age and personal disposition would interact in such a way that an

uncomplaining, older person would elicit positive reactions and a complaining older person would generate very negative reactions. The data indicate that in this study personal disposition had a far more powerful effect on the subjects' reactions than did age of the patients. The obvious interpretation, and the one given in the preceding section, is that personal disposition is more important than age in determining the reactions and quality of help that a patient receives.

However, there is at least one alternative explanation. The relative saliency of the independent variables in the study, age and personal disposition, were disproportionate to the saliency of those two factors in a real hospital setting. That is, it may be that age is more important to nurses when they make decisions on their jobs, than it was when they made decisions in the simulated setting of the study.

There are at least two reasons for this. First, in a real life situation, nurses confront a patient face-to-face. The person's appearance and behavior are likely to make age much more apparent and important. Second, the experimental manipulations in the study were disproportionate. Age was mentioned only briefly: at the top of the medical history and interview and in the first line of the medical history. On the other hand, the entire interview was used to give an impression of whether the patient was complaining or uncomplaining. Given these two factors, it is reasonable that personal disposition was more important than age in the study than it is in actual hospital settings, at least in some circumstances.

Although this problem limits the findings of the study, it certainly does not negate them. There are a number of circumstances in which a

charge nurse does not come directly into contact with a patient before making assignments, yet has more information about the personal disposition of the patient than about the patient's age. For example, age is only a small part of a psychiatric patient's record. However, close observations are made of the patient's cooperativeness and attitude. Similarly, there are occasions when a charge nurse may hear of a patient's personal disposition in an informal way, and only a brief mention of age is made on the patient's chart. Certainly there are a number of occasions in hospitals where personal disposition is likely to be more salient to nurses than is age.

Condescension. In the discussion of the hypotheses, it was suggested that one interpretation of the positive emotional reactions to the older people was that indeed the subjects did feel warmer and more compassionate toward the older patients. Yet one alternative explanation is likely an attitude of condescension toward older patients. This explanation is supported by analyses of the data and by informal comments made by the subjects during the debriefing.

During the debriefing, and in other interviews with nurses, a number of people mentioned that working with older people is not much different from working with children. They used adjectives like "cute" and "refreshing" in describing both geriatric and pediatric patients. Moreover, the tone of voice in describing both kinds of patients was similar.

Admittedly, this evidence of condescension is subjective, but the data can also be interpreted in this way. The adjective "soft-hearted" which was used to describe the older patients comes close to the notion

of pity. Pity is certainly an attitude of condescension. The other "empathic" adjectives can be interpreted similarly.

Condescension implies "one-upmanship." The word itself includes an "up-down" element. When a person condescends, he comes down to the level of another person. Even though the two people end up on the same level, the fact remains that the condescending person lowered himself and is likely to raise himself again. There is inherent in the attitude and resulting act of condescension a core dimension of inequality. This inequality is exhibited by using adjectives like "cute" and "refreshing." It is also evident in attitudes like pity, where the pitying person "hands down" any help he may give. No wonder, handicapped persons detest pity from others, they are made to feel less than equal to other human beings.

Social desirability. An additional alternative explanation is evident when one considers that what has been analyzed are reports of empathic emotions. It may be that subjects reported feeling warmer, more compassionate, and so on, because they know they were supposed to feel that way toward older people, not because they were, in fact, feeling more empathic. The measure had a built-in demand characteristic.

Attribution Theory

Even taking the alternative explanations into account, the results of this study suggest that the relationship between the ways in which we perceive situations, the ways in which we form impressions of people, and any consequent action is more complex than is currently thought. Early work by Heider (1958) was addressed to exactly this problem. Jones and Davis (1965) and Kelley (1967) developed Heider's work into what is

presently called Attribution Theory. One aspect of attribution theory holds that we attribute our own failure to the situation and we attribute the failure of others to personal causes. That is, if we do something wrong, then we tend to propose that the situation caused us to do it. On the other hand, if we see another person do something wrong, then we presume it is his own fault, not the fault of the environment.

A logical extension of this would be if we saw someone we like with a problem we would have a tendency to attribute situational causality to the problem. If we saw someone we did not like with a problem, we would have a tendency to attribute personal causality to the problem. This extension rests on two assumptions. First, we perceive others as similar or dissimilar to ourselves (Hastorf, Schneider & Polefka, 1970), and second, we like those we perceive as similar to ourselves (Berscheid & Walster, 1969). So, if we saw someone we did not like whom we thought was dissimilar to ourselves, we would attribute internal causality to the person's problem.

Extending this analysis even further, we should be more likely to help someone whose problem was caused by external factors in a situation than someone whose problems were self-generated. We would feel more competent to do something about the situation and more willing to help a person who appears to be a victim of circumstances (Middlebrook, 1974). It is this last extension which is not borne out by the data from this study. The uncomplaining patients who were more liked and to whom we would have expected subjects to attribute situational causality, were actually helped less than the unpleasant patients.

Why does this last extension fail to be supported? One explanation is that subjects did not, in fact, attribute external causality to the patients' problems. At first glance, it would appear that this is impossible. After all, it is difficult to attribute internal causality to a surgical patient. However, subjects were more likely to judge a patient's case on the basis of psychological, rather than medical needs. The mean of the medical needs item was 4.00, whereas the mean of the psychological needs item was 1.91. Given that fact, subjects could attribute internal causality based on the patient's psychological problem, or not see a problem at all.

On the other hand, it may be that in the case of the complaining patients, the subjects saw an opportunity to change the person, but not the situation. The medical problems of all the patients were basically the same. Although all of the cases were major surgery, none were critical and all were in the third post-op day and progressing without complications. However, there was considerable variation in the psychological problems of the patients. It may be that the subjects perceived the psychological problems as caused by the person and wanted to act in a way that would change the person. By coming in contact with the person, that is, by assigning the patient to themselves or another RN with them checking in on the patient, the subjects may believe that they can make some change in the person. Batson (1975) reports results which support this interpretation. In a study with seminarians and undergraduates, he found that if a problem was attributed by the helper to the person rather than the situation, the helper was more likely to give personal, rather than situational help.

Implications for Further Research

Given the discussion of the results in this study, at least three lines of research appear worth following.

Field studies. One line of research is to move the study from the laboratory to the field. This would have several advantages over the present laboratory experiment. The most obvious advantage is that it makes it possible to balance the independent variables of age and personal disposition by making age more salient. Although this would result in a loss of control of some variables, this lack of control could be minimized. For example, although the same patient with the same case could not be both old and young, observations could be made of reactions to a number of patients both old and young. Then those observations could be grouped according to age, creating a fixed factor design.

Another advantage would be that the effect of contact over a period of time could be measured. As suggested in the discussion of the hypotheses in this chapter, it is likely that both impressions and behavior of nurses in reaction to different patients may change after a period of exposure to the patients. It would be expected that the complaining patients would be helped less than the uncomplaining patients and the age x personal disposition interaction predicted in the present study would be more easily observed.

Condescension. Investigation of the suspected condescension phenomenon is a second line of research. Two basic issues could be investigated. First, it ought to be determined if people actually do tend to be more condescending toward the aging than they do toward younger adults. If they do, then the second issue, the effects of condescension,

should be investigated. One could look at the effects of condescension upon the kinds of recommendations and treatment given by professionals who work with the aging to older versus younger patients or clients. An equally important way in which condescension could affect the aging is to lower already declining self-esteem. If a man has just retired, the last thing he needs is for someone to treat him as a child.

Attribution theory. The third line of research is the further investigation of the contributions of Attribution Theory to research on helping. The relationship between age and attribution of causality is one important line of research. One might expect that younger persons would make more personal than situational attributions of older people. The reasoning would go something like this: as a person becomes older, he becomes weaker in relation to the environment, and therefore less able to cope with it. It may be, however, that older people may not make the same kind of attributions to persons their same age. They may not see themselves becoming weaker in relationship to the environment. Rather, they may see the environment growing weaker as they do. The caricature of an old man beginning a sentence with "When I was your age..." suggests that at least some older people believe that both young and old are better able to control their surroundings now than they were half a century ago.

If people of different ages make different kinds of attributions toward older people, this could have important implications for the kind of help the aging receive. An older person may resent an attribution of external causality, with the implication of a concomitant loss of strength in comparison to the environment.

Another area for investigation would be the relationship between liking and causality. This would test some of the assumptions made in the discussion of Attribution Theory in the previous section. Although the research on self-attribution is not conclusive (Miller & Ross, 1975), there is still some indication that we tend to bias attributions of causality in favor of ourselves. It would be interesting to see if this same phenomenon occurs when we perceive failure in someone we like well.

The conclusions of this study, as with any empirical investigation, are tentative. Rather than conclusively answering questions, new questions have arisen: What are the attitudinal dimensions of discrimination toward the aging? Are attributions of causality important in determining helping behavior different for people of different ages? Are the aging being discriminated against on the basis of age, per se?

The answers to these broadly phrased questions can provide greater insight into ways of improving the helping professions' ability to work with and to help the aging retain their personal dignity.

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APPENDIX A
CONSENT FORM

CONSENT FORM

The Department of Speech at the University of Kansas supports the practice of protection for human subjects participating in research. The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate you are free to withdraw at any time.

This study is about the kinds of assignments nurses might make in hospitals. You will be asked to read several case histories of patients and then fill out a questionnaire. The case histories will include brief medical histories and excerpts from interviews with patients.

Your participation is solicited, but is strictly voluntary. Do not hesitate to ask any questions about the study. Be assured that your name will not be associated in any way with the research findings. We appreciate your cooperation very much.

Sincerely,

James "Mike" Flynn
Principal Investigator

I agree to participate in the study.

Signature of participant

APPENDIX B
INTRODUCTION

INTRODUCTION

This is a study of how nurses assign patients. So that everyone will be operating from a similar reference, you are asked to imagine yourself in a specific situation. You are a charge nurse at Grace Memorial Hospital. This hospital uses a variation of the team approach to nursing. You are the charge nurse on a surgical floor, and you assign the nurses in your unit to particular patients. Because the unit is small, you are expected to assign some patients to yourself. Other members of the teams include other RNs and some student nurses. You make your decisions by reading over the patients' cases and from a knowledge of what the patients are like. Assignments are not made according to room number or bed. Rather, they are made on the basis of individual patients' psychological and medical needs.

In the folders in front of you are brief medical histories and excerpts from interviews with each of four patients on a surgical unit. The excerpt from the interview with a social worker is provided to give you an idea of what the patient is like as a person. The medical history includes only enough information to give you an idea of the medical background of the patient.

In order to standardize the patients' cases, assume the day you are reading the cases and making the assignments is the third post-op day for all the patients.

Please read each of the cases and fill out the questionnaires at the end of each case.

There are no right or wrong answers. We are simply interested in the way you assign the patients.

APPENDIX C
ASSIGNMENT FORM

Code # _____

ASSIGNMENT FORM

Indicate how you would assign the patient based on his/her psychological and medical needs: (Check one)

- _____ Assign primary responsibility entirely to yourself.
- _____ Assign primary responsibility to another RN with you actively checking on the patient's progress.
- _____ Assign primary responsibility to another RN in the unit.
- _____ Assign primary responsibility to a student nurse with another RN actively checking on the patient's progress.
- _____ Assign primary responsibility to a student nurse.

Please take about two or three minutes to write an explanation of why you decided to make the assignment you did. (Use the back of this sheet if necessary)

Below are listed some emotions which you might have been feeling toward the patient as you were reading the patient's case. Make a check on the line indicating how much you felt that emotion.

- | | | | | | | |
|-------------------|-----------------------------|-------|-------|-------|-------|---------------------------------|
| 11. Soft-hearted | Definitely
soft-hearted | _____ | _____ | _____ | _____ | Definitely
not soft-hearted |
| 12. Upset | Definitely
upset | _____ | _____ | _____ | _____ | Definitely
not upset |
| 13. Alarmed | Definitely
alarmed | _____ | _____ | _____ | _____ | Definitely
not alarmed |
| 14. Compassionate | Definitely
compassionate | _____ | _____ | _____ | _____ | Definitely
not compassionate |
| 15. Warm | Definitely
warm | _____ | _____ | _____ | _____ | Definitely
not warm |
| 16. Irritated | Definitely
irritated | _____ | _____ | _____ | _____ | Definitely
not irritated |

Below are a number of characteristics that describe people's personalities. For each one, please check whether you think this patient would have that characteristic or not.

- | | | | | | | |
|-----------------|---------------------------|-------|-------|-------|-------|-------------------------------|
| 17. Considerate | Definitely
considerate | _____ | _____ | _____ | _____ | Definitely
not considerate |
| 18. Complaining | Definitely
complaining | _____ | _____ | _____ | _____ | Definitely
not complaining |
| 19. Grouchy | Definitely
grouchy | _____ | _____ | _____ | _____ | Definitely
not grouchy |
| 20. Cooperative | Definitely
cooperative | _____ | _____ | _____ | _____ | Definitely
not cooperative |
| 21. Wise | Definitely
wise | _____ | _____ | _____ | _____ | Definitely
not wise |

22. Demanding

Definitely
demanding

Definitely
not demanding

23. Helpful

Definitely
helpful

Definitely
not helpful

 24. To what extent
 did you make your
 assignment based on
 the patient's
 medical needs?

Based
a lot

Based very
little

 25. To what extent did
 you make your assign-
 ment based on the
 patient's psycholo-
 gical needs?

Based
a lot

Based very
little

APPENDIX D
QUESTIONNAIRE

QUESTIONNAIRE

In reading these cases, did you try to take the point of view of the patient or did you try to be objective and make an evaluation?

_____ Tried to take the patient's point of view.

_____ Tried to be objective and make an evaluation.

Take a few minutes to look back over the cases so that you can respond to the items below.

Rank order the patients according to how much help they need. Put a "1" beside the name of the person you think needs the most help, a "2" beside the name of the person next most needing help, a "3" beside the name of the person third most needing help, and a "4" beside the name of the person you think needs the least help.

_____ Joseph Cook

_____ Steve Janis

_____ Helen Morse

_____ Susan Rieker

Why do you think the person you ranked number one is in most need of help?

Rank order the patients according to how much you would enjoy taking care of them.

_____ Joseph Cook

_____ Steve Janis

_____ Helen Morse

_____ Susan Rieker

Why would you most enjoy taking care of the person you ranked number one?

Overall, to what extent
did you base your
assignments on the
medical needs of the
patients?

Based a lot _____ Based very
little

Overall, to what extent
did you base your assign-
ments on the basis of
the psychological needs
of the patients?

Based a lot _____ Based very
little

APPENDIX E
DEMOGRAPHIC DATA COLLECTION INSTRUMENT

BACKGROUND INFORMATION

Age: _____

Sex: _____

Training: (check one)

____ Diploma graduate

____ Graduate of a two-year program (A.D.)

____ Graduate of three-year program

____ B. S.

____ M. S.

____ Ph. D.

What kind of inservice or continuing education training have you had for dealing with geriatric patients?

How much contact have you had in dealing with geriatric patients?

____ Less than a year

____ 1 - 2 years

____ 3 - 5 years

____ More than five years

In what kind of setting have you dealt with geriatric patients?

____ Nursing home

____ General hospital (acute care)

____ Other (specify) .

Employment status:

____ Staff nurse/private duty

____ Team leader/charge nurse

____ Head nurse

____ Supervisor

____ Area director/area assistant director

____ Director

____ Other (specify):

APPENDIX F
ANALYSIS OF VARIANCE TABLES

TABLE 30
ANALYSIS OF VARIANCE OF VARIABLE
TROUBLE TO TAKE CARE OF

		df	MS	F
Age	(A)	1	1.172	1.433
Disposition	(B)	1	417.130	114.221
A x B		1	3.255	1.857
Error		46	4.592	

TABLE 31
ANALYSIS OF VARIANCE OF VARIABLE
DEPENDENCY OF PATIENT

		df	MS	F
Age	(A)	1	.270	.110
Disposition	(B)	1	374.083	112.546
A x B		1	.021	.006
Error		46	3.876	

TABLE 32
ANALYSIS OF VARIANCE FOR VARIABLE
EXTENT PATIENT NEEDS HELP

		df	MS	F
Age	(A)	1	1.021	.723
Disposition	(B)	1	121.660	84.373
A x B		1	3.333	1.620
Error		46	3.923	

TABLE 33
ANALYSIS OF VARIANCE FOR VARIABLE
TYPICALNESS OF BEHAVIOR

		df	MS	F
Age	(A)	1	1.354	.731
Disposition	(B)	1	8.333	2.346
A x B		1	2.083	.984
Error		46	4.471	

TABLE 34
ANALYSIS OF VARIANCE FOR VARIABLE
CONSIDERATE

		df	MS	F
Age	(A)	1	.266	.307
Disposition	(B)	1	466.571	219.003
A x B		1	.266	.364
Error		44	1.555	

TABLE 35
ANALYSIS OF VARIANCE FOR VARIABLE
COMPLAINING

		df	MS	F
Age	(A)	1	.544	.459
Disposition	(B)	1	768.348	334.475
A x B		1	1.761	1.506
Error		44	1.806	

TABLE 36
CELL MEANS FOR VARIABLE
WISE

		df	MS	F
Age	(A)	1	1.003	.061
Disposition	(B)	1	289.102	68.571
A x B		1	4.666	1.033
Error		44	4.603	

TABLE 37
CELL MEANS FOR VARIABLE
DEMANDING

		df	MS	F
Age	(A)	1	2.667	1.223
Disposition	(B)	1	424.666	158.832
A x B		1	8.203	2.116
Error		44	2.304	

TABLE 38
ANALYSIS OF VARIANCE FOR VARIABLE
GROUCHY

		df	MS	F
Age	(A)	1	.049	.022
Disposition	(B)	1	617.223	188.910
A x B		1	5.223	4.807
Error		44	2.422	

TABLE 39
ANALYSIS OF VARIANCE FOR VARIABLE
COOPERATIVE

		df	MS	F
Age	(A)	1	.087	.106
Disposition	(B)	1	267.848	96.532
A x B		1	.022	.023
Error		44	2.061	

TABLE 40
ANALYSIS OF VARIANCE FOR VARIABLE
HELPFUL

		df	MS	F
Age	(A)	1	3.002	1.641
Disposition	(B)	1	289.632	136.320
A x B		1	2.345	1.009
Error		44	2.227	

TABLE 41
ANALYSIS OF VARIANCE FOR VARIABLE
ASSIGNMENT

		df	MS	F
Age	(A)	1	1.354	.935
Disposition	(B)	1	49.088	23.275
A x B		1	.369	.267
Error		45		

TABLE 42
ANALYSIS OF VARIANCE FOR VARIABLE
SOFT-HEARTED

		df	MS	F
Age	(A)	1	22.962	12.078
Disposition	(B)	1	84.918	29.360
A x B		1	5.223	2.834
Error		44	3.166	

TABLE 43
ANALYSIS OF VARIANCE FOR VARIABLE
COMPASSIONATE

		df	MS	F
Age	(A)	1	18.283	16.998
Disposition	(B)	1	20.891	8.432
A x B		1	2.630	2.432
Error		44	2.618	

TABLE 44
ANALYSIS OF VARIANCE FOR VARIABLE
WARM

		df	MS	F
Age	(A)	1	12.522	11.067
Disposition	(B)	1	104.587	55.702
A x B		1	.022	.019
Error		44		

TABLE 45
ANALYSIS OF VARIANCE FOR VARIABLE
ALARMED

		df	MS	F
Age	(A)	1	0.000	0.000
Disposition	(B)	1	25.131	7.119
A x B		1	.087	.059
Error		44	6.440	

TABLE 46
ANALYSIS OF VARIANCE FOR VARIABLE
UPSET

		df	MS	F
Age	(A)	1	.543	.274
Disposition	(B)	1	135.674	36.184
A x B		1	.196	.118
Error		44	6.238	

TABLE 47
ANALYSIS OF VARIANCE FOR VARIABLE
IRRITATED

		df	MS	F
Age	(A)	1	.005	.003
Disposition	(B)	1	237.397	62.564
A x B		1	2.397	1.950
Error		44	5.651	

TABLE 48
ANALYSIS OF VARIANCE FOR VARIABLE
PSYCHOLOGICAL NEEDS

		df	MS	F
Age	(A)	1	3.988	.021
Disposition	(B)	1	226.344	75.89
A x B		1	3.411	.066
Error		44	3.010	

TABLE 49
ANALYSIS OF VARIANCE FOR VARIABLE
MEDICAL NEEDS

		df	MS	F
Age	(A)	1	1.666	1.009
Disposition	(B)	1	1.348	.023
A x B		1	2.766	.998
Error		44	1.364	