Reciprocity: The Case of Aged Care Nurses’ Work

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Abstract

Feminist economists have identified reciprocity as a motivation for caring work. In this paper we investigate the role of reciprocity in nurses’ work and its impact on the quality of care provided. We identify three forms of reciprocity suggested by feminist economics and find empirical support for their impacts on the quality of care: (1) positive reciprocity, which is the impulse to be kind to those who have been kind to us, (2) negative reciprocity, which is based on “an eye for an eye and a tooth for a tooth,” and (3) generalized reciprocity, which is based on a moral norm of helping someone who will in turn help someone else. By drawing on academic nursing literature and our qualitative studies in residential aged care we identify a new category: professional reciprocity. This form of reciprocity involves deliberate relational work by nurses to facilitate mutual and interdependent exchanges with care recipients so that the well-being and health goals of both are promoted. We argue that professional reciprocity is important to achieve quality care and care workers’ job satisfaction.

Introduction

Feminist economists have identified reciprocity as a motivation for caring work. Across the disciplines reciprocity has received enduring attention as a social norm. In general terms reciprocity means people responding to each other in similar ways, either benevolently or hurtfully. Anthropologists regard reciprocity as a fundamental social norm and distinguish cultures by the relative emphasis on reciprocity as a principle of social organization compared to redistribution and markets. In particular, reciprocity has been argued to be critical to the survival and provisioning of hunter-gather societies (Sahlins 1972). Sociologists give reciprocity a central place in kinship ideology and argue such family ideologies are important in the provision of paid and unpaid care activities (see, for example Lisa Dodson & Zincavage 2007).

Reciprocity is receiving increasing attention in economics. An emerging body of work theorizing the role of reciprocity in human interactions and exchanges has emerged in institutional economics (see, for example Bowles & Gintis 2004, 2011) and game theory (see, for example Falk & Fischbacher 2006). This work points to the stability of reciprocal behavior, arguing that it has strong evolutionary roots and can generate outcomes radically different from the standard predictions of neoclassical economic theory. Experimental games consistently show that between 40 to 66 percent of players are reciprocators, while subjects who behave completely selfishly comprise between 20 to 30 percent (Fehr & Gächter 1998, 2000). Game theories also suggest that reciprocity is common and underpinned by social norms of fairness. Jon Elster (1998) in his critique of individual self-interest as the universal motivation argued that some people look at what others are doing and follow the majority. But under the norm of fairness, “one should do one’s share but only if others are doing theirs” (Elster 1998: 72). In their recent book, A Cooperative Species: Human Reciprocity and its Evolution (2011: Chapter 3)

1 In her typology of caring motivations Nancy Folbre (1995) identified reciprocity, altruism, and responsibility. These distinct but interrelated motivations, Folbre argued, reflect socially constructed norms, values, and preferences that go to the heart of the supply and valuation of caring labor (Folbre1995: 76-78). Nancy Folbre and Tom Weisskopf (1998) identified six motives for caring labour: altruism, a sense of responsibility, intrinsic enjoyment, expectation of an informal quid pro quo, a well-defined and contracted-for reward, and coercion.
Institutional economists, Samuel Bowles and Herbert Gintis provide a different framing of reciprocity with their concept of “strong reciprocity”. Strong reciprocators are people who have “other regarding” preferences (rather than self-regarding preferences) who sacrifice their own payoffs so that they can (1) cooperate with others (2) reward the cooperation of others and (3) punish free riders even when they do not expect to gain as a result of their actions. Strong reciprocators represent a departure from the neoclassical assumptions of game theory which allows for reciprocal altruism (otherwise known as enlightened self-interest), under-written by some payback. In other words, strong reciprocators will cooperate even when there are no mutual benefits or self-gain. Bowles and Gintis explain this by the existence of moral norms that are embodied in cultures and institutions that result in people acting according to social preferences of that society, rather than individual, self-interested preferences.

Similarly, feminist economic understandings of caring labor are marked by a departure from neoclassical economic assumptions. This is manifested in the feminist economic critique of the assumption of rational economic man and the positing of an alternative model of decision-making behavior of “individuals in relation” (Nelson, 2003). As Stella González-Arnal and Majella Kilkey described in their UK study of student carers participating in higher education, the rational individual “makes decisions while being firmly embedded in a net of relationships of care and dependency with others” (González-Arnal & Kilkey 2009: 101). As a result a space has emerged for investigating reciprocity and other relational dimensions as a motivation for caring labor.

However feminist economists have cautioned against transferring findings of experimental games to situations of caring labor. Nancy Folbre (2009: 316) warned that the impact of social norms of fairness and reciprocity has to be unpacked and may not imply positive outcomes for the treatment of caring labor. She cites the disapproval of public assistance to the unemployed in the USA and argues those who ignore the contributions of unpaid care work are not likely to count single mothers as among the “deserving poor”. Furthermore Maren Jochimsen (2003; 2010^2) argued that in the experimental laboratory subjects start on equal terms, do not know each other and interact anonymously when their behavior is observed to assess the willingness or not to take or forsake material payoffs. These are issues which distinguish experimental games from the empirical realities of caring work. Nevertheless, feminist economic conceptualizations of reciprocity, to some extent, maintain tensions between the more instrumental notions of the freely choosing reciprocal altruist of experimental games and attempts to move to a concept where preferences are based in socially determined norms which are internalized by groups and individuals, as exemplified by institutionalists such as Bowles and Gintis.

The motivations for caring labor have mainly been discussed by feminist economists at a conceptual level. Reciprocity in feminist economics is conceptualized as a caring motivation as part of a twofold concept of caring labour where there is an instrumental and a communicative dimension (Folbre & Weisskopf 1998; Nelson 1998; Himmelweit 1999; Jochimsen 2003)^3. Instrumental care involves the tasks that are required to care for someone, such as giving them their medications or doing their wound dressing, and has been

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^3 The feminist economic twofold conceptualization of care aligns with work in other disciplines. For example see earlier work by political scientist, Joan C. Tronto, who argued that care is “both a practice and a disposition” (1993: 104).
conceptualized in the feminist economics literature as that part of care that is commodifiable. The communicative side of care is that part of the care given that results in a cared-for feeling and has been conceptualized as non-commodifiable\(^4\) (Maren A Jochimsen 2003: 49). When the instrumental caring service is performed with a caring motivation, it results in a “joint product”, which distinguishes real caring services from non-caring services (Folbre 1995; Folbre and Weisskopf 1998). This joint product results in the care recipient feeling “cared about” and the caregiver deriving satisfaction from knowing that they have provided the caring service well enough for the care recipient to feel cared about (Jochimsen 2003: 54).

Long-run expectation of a quid pro quo in the form of either tangible or emotional services is one of the motivations of caring labor in Folbre’s typology (1995: 76). She suggested that maintaining reciprocity in the provision of care activities is not inevitable and requires some nurturing. Both affection and a sense of responsibility will foster reciprocity, but it may tend to break down if the probability of payback declines (Folbre 1995: 76). A lack of appreciation and reciprocity can undermine the intrinsic satisfaction experienced by those providing care: “In personal relationships, we call it heart-break. In the caring professions, we call it burnout” (Folbre 2001: 51). While mutual giving and receiving underpins the concept of reciprocity in sociology (Karen V. Hansen 2005: 156), feminist economics positions reciprocity as more than a simple exchange. Paula England and Nancy Folbre (2003: 66) in their symbolically titled article “Contracting for Care” emphasized that care activities involve implicit as well as explicit contracts. They define an implicit contract as an agreement or understanding between parties about their mutual expectations and obligations. Such contracts are construed more broadly than those underpinning market exchanges and are enforced by norms of cooperation (Folbre 1995: 76). The giving and receiving is such that “the books don’t necessarily balance for every individual, as in voluntary market exchange” (Folbre 1995: 77). Furthermore, gender and age norms embody this version of exchange. England and Folbre (2003) argued that for men it is to provide income, while for women it is to provide care. An example of a norm of reciprocity based on age is the requirement of children to look after elderly parents (England & Folbre 2003: 66).

Feminist economists emphasize that dependency is a characteristic of the care relationship (Folbre & Nelson 2000; Jochimsen 2003; Eika 2009), which raises the question of whether reciprocity can be a feature of such relationships. Eika (2009), in her study of the quality of aged care services, has drawn attention to the economic effects of dependency such as lack of choice, inability to pursue their interests consistently, and limited care services arising from missing markets. Can reciprocity between the carer and caree ameliorate the lack of individual autonomy that is assumed to be present with dependency? Feminist economists have drawn on the work of Scandinavian sociologist Kari Waerness to distinguish between caring amongst healthy adults involved in equal give-and-take relationships “based on norms of balanced reciprocity in personal relations” (Waerness 1987: 210, emphasis in original),

\(^4\) The communicative side of care is comprised of emotional labour and whether it is commodifiable or not is a paradoxical issue. Arlie Russell Hochschild (1983) differentiated between emotional labour, which was sold for a wage and had exchange value, and emotion work, which referred to the same acts done in private where they have use value. Although Susan Himmelweit (1999: 36) maintained this distinction in discussing caring labour, it has not been upheld across the feminist economics literature as some authors use labour in relation to paid caring services while still acknowledging the non-commodified element in caring work (Nelson 1999; Meagher and Nelson 2004; Folbre 2006). The nursing literature discusses nurses being both “emotional jugglers” who present a variety of “faces” (Bolton 2001), as well as people who offer emotion work as a “gift” in the form of authentic caring behaviour (Bolton 2000).
compared to help and services provided to people who cannot perform these activities themselves. In these situations, typified by residential aged care, the receiver of the care is subordinate to the caregiver. Waerness (1987) offered the insight that people in this group are “dependent on those who feel an obligation or desire to care for others” (Waerness 1987: 210 & 211, emphasis in original). While residents in nursing homes clearly fit into Waerness’ subordinate category as they are dependent on the staff for care, Waerness inferred that reciprocity only occurs when there is a balance in the personal relationship involved. She did not include reciprocity in the subordinate relationship, nor did she offer an alternative explanation. Rather, the dependence of people being cared for due to their inability to care for themselves precludes the existence of reciprocity.

Susan Himmelweit (1999) noted that other writers do not find it helpful to view the relationship between the carer and caree as one of dependence in which the caree cannot reciprocate, or else as a mutually caring relationship in which reciprocity takes place on an equal basis. She drew on sociologist Claire Ungerson (1990: 21) to argue that strong feelings and personal attachments can exist in paid care relationships (Himmelweit 1999: 32). The authenticity of these two-way relationships enables nurses to build a rapport with residents that reduces the inequality between the carers and the care recipients. In short, the potential for reciprocity exists. Gabrielle Meagher offered a different perspective, arguing that unequal relationships embedded in reciprocity might help to explain the delivery of care. Utilizing Martha Nussbaum’s notion of compassion, Meagher likened the practice of compassion to a gift exchange, in which the caregiver provides the gift of compassion, and the care recipient is obligated to cooperate with the caregiver “to achieve the healing, growth, and/or dignity that is the goal of [the] care” (Meagher 2006: 42).

In summary feminist economic research has contributed a conceptual understanding of reciprocity as a motivation in caring labour. In doing so it has promoted an understanding of care beyond “homo economicus”. Sociologist Mignon Duffy described the contribution of feminist economists as using “the language of care to insert the lived experiences of love, obligation, and reciprocity into an economic theory that supposes those things not to exist” (2011: 13). In this paper we seek to extend the feminist economic understanding of reciprocity in caring labour through our empirical studies of nurses’ work in Australian residential aged care facilities. Analyses of our qualitative data provide support for positive, negative and generalized forms of reciprocity that feminist economics recognises are likely to be relevant for the quality of caring labour. We draw on the nursing literature to extend the feminist economic conceptualization of reciprocity with the notion of “professional reciprocity” and provide an empirical basis for its support. We argue that professional reciprocity has the capacity to generate therapeutic outcomes for the caree and greater job satisfaction for the carer. Furthermore professional reciprocity requires paid care workers to perform skilled relational work, and working conditions and training can either constrain or facilitate the creation of professional reciprocity.

The data

In this paper we seek to provide an empirical basis for understanding reciprocity in paid care work. We use nurses’ work in residential aged care facilities as a case study and draw on data and analysis of two qualitative research projects. In these studies we focussed on the relational aspects of paid caring labour by asking residential aged care staff to talk about the relationships they had with the frail, elderly residents they care for and why these relationships were important. The first data set was collected during 2002–2003 and involved 22 semi-structured one-hour interviews with a range of industry actors: registered nurses,
enrolled nurses, directors of nursing, and non-nursing managers. In this study we explored the development of two-way relationships between nurses and other staff with residents and their relatives. The data of the second study was collected in 2009 and involved semi-structured one-hour interviews with nine nurses caring for people with dementia from culturally and linguistically diverse backgrounds. We investigated how nurses understood their role in caring for residents with dementia which included a multi-faceted approach to communication that included reading body language and using non-verbal cues. The interviews were recorded and transcribed verbatim, and the data was analysed using software for qualitative research⁵.

We acknowledge that empirical investigations of care motivations are fraught with challenges, not the least because of the difficulties of directly observing such a multifaceted concept. However qualitative research has the capacity to uncover how people make sense of their situations and the frames they use to give voice to these understandings. We combine our analysis of interviews with aged care nurses with evidence from nursing research to build a picture of how these care workers understand reciprocity and how it motivates their work.

**Positive reciprocity**

Experimental games in economics reveal the presence of positive and negative quid pro quo practiced by participants with positive reciprocity defined as the impulse to be kind to those who are kind to us (Fehr & Gächter 1998, 2000; Falk & Fischbacher 2002). Research conducted in Canada and the US provides evidence that patients often reciprocate the care they receive from nurses by giving gifts which can either be tangible or intangible. Janice M. Morse’s study involving 40 Canadian nurses found that intangible acts that nurses perceived as a gift were patients helping them by watching over a confused patient, assisting with meal trays, thanking staff for their care, or, in the case of a catatonic patient, choosing to get well (Morse 1989: 35). Tangible gifts from patients in hospital were usually bought from a store but in community nursing they were often homemade or home grown. Sharing a cup of tea or coffee with the nurse at the end of her visit was an essential aspect of reciprocity experienced in community nursing (Morse 1989: 35 & 36). If nurses were given individual gifts it was because the nurse was seen to have “made a difference” or “gone an extra mile” for the patient (Morse 1992: 239). Morse argued that nurses’ acceptance of gifts was important for the patient’s recovery process and that the “act of reciprocation must balance the perceived debt and compensate the individual to whom the debt is owed” (1992: 255). Other nursing researchers have found that nursing home residents in the US saw reciprocity as evidence of good relationships and therefore of good quality care. Residents reported doing things for themselves to “save the girls time” and saw themselves taking action as an opportunity to demonstrate reciprocity, which these residents viewed as rewarding (Bowers, Fibich & Jacobsen 2001: 543).

In our research conducted in Australian residential aged care facilities there was also evidence of positive reciprocity. One nurse described how small tangible gifts of chocolate from an elderly resident contributed to building an environment of positive reciprocity:

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⁵ NUD*IST (an acronym for Non-numerical, Unstructured Data; Indexing, Searching and Theorizing) version N6 was used for the 2008 study and NVivo 7 for the 2009 study. Both software packages are supplied by QSR International.
I give them the pills late at night and they say, “Don’t forget to take your usual.” Cause they leave a little pot of chocolates on the side there.

Q: So they know you like chocolates?

A: They know I love chocolate, yeah. I’m OK if I’ve got chocolate. (laughs) (Sandra, registered nurse)

Sandra’s cheerful account indicates that some mentally alert residents deliberately seek to reciprocate by having chocolates ready and waiting for her. They make a point of giving something back to a nurse they like. Nurses often relate to small incidences of reciprocity as evidence of having a rapport with the care recipient:

Every time I walk into the room and the person has no idea who I am, but loves my smile. I’m the person with the really nice smile but doesn’t remember, the only thing they remembers is the smile. (laughing)

Q: And they do remember your smile?

A: Mmm.

Q: Okay, so when you smile at them, how do they react?

A: They smile back. (Matilda, registered nurse)

In this situation the nurse understands the resident as looking to give something back to the carer – the smile is the focus of the connection between them. As this resident has dementia and does not ever remember the nurse’s name, the fact that this resident continually identifies the nurse as the person with the nice smile and returns the smile is evidence of a reciprocal link that is operating over time in the presence of a memory deficit. Although only a simple thing, these smiles are providing an ongoing reciprocal connection that the resident enjoys, providing a frail, elderly person with ongoing pleasure that contributes positively to that person’s quality of life and provides the nurse with ongoing job satisfaction because she is able to communicate and maintain a positive connection with this resident despite cognitive impairment. These examples of smiles and chocolates reflect a reciprocal exchange between nurses and their care recipients that have the capacity to contribute to mutual behaviors and nurse-resident relationships that enhance the quality of care given and received.

Negative reciprocity

Retaliatory acts have been termed “negative reciprocity” by game theorists (Fehr & Gächter 1998; 2000: 160; Falk & Fischbacher 2002: 207), which has been described as the principle of “an eye for an eye and a tooth for a tooth” (Fehr & Gächter 1998: 845). Negative reciprocity can extend from a refusal to cooperate with others who are being uncooperative to a willingness to sacrifice something to hurt others who are being unfair (Rabin 1998: 22). This could have relevance to neglect or abuse which sometimes occurs in caring situations, potentially perpetrated by either care providers or care recipients. While feminist economics have noted the existence of abuse and neglect in care relationships (Nelson 1999: 49; Folbre & Nelson 2000: 131), the links between negative reciprocity and caring labour have not been explored.
Janice M. Morse (1992: 243) found evidence of a two-way exchange in paid care work, with patients engaging in retaliative acts, the ultimate being the right to sue a nurse for incompetence. It was more common however for patients to refuse to comply with treatments and become “difficult patients” or to write letters of complaint to the hospital administration in response to the care received. Abuse and neglect has been discussed in the feminist economics literature, centring on abuse of the care recipient by the caregiver. Kari H. Eika (2009: 114) cited research that showed in 1998–1999 some 25–33 percent of US nursing homes were characterized by poor quality care including harming residents. However it is less well acknowledged that the care workers are also subject to verbal and physical aggression by residents. Moreover, reduced care to care recipients can occur as reciprocal acts. Although feminist economics discussions have not linked low quality care with negative reciprocity this approach potentially offers better understandings of abuse and neglect and the quality of care generally.

In our research there was evidence of residential aged care nurses having to cope with verbal and physical aggression and there have been reports for over a decade that nurses working in aged care are often the hidden victims of violence (Hudson 1995)\(^6\). Although negative reciprocity cannot explain all the verbal and physical aggression to which nurses are subjected, it may contribute to a better understanding of care work. This is demonstrated in an account from Felicity, an enrolled nurse:

> With people with dementia, if you do their ADLs [activities of daily living] or something like that, you need to be careful, or give medication, you don’t just push it in, you say hello, here’s the medication for you, something, you don’t force them to put it in their mouth or otherwise they will give you a big slap.

In this account, if the nurse or caregiver does not take the time to approach residents and gain their cooperation, they may resist or become aggressive. This can be described as negative reciprocity because someone is doing something to them that they do not like and their response is to retaliate. As many residents in aged care facilities have dementia and hence a high level of cognitive impairment, they often will not understand the care that is being given. It is possible that there is some part of the care they do not like or that they become tired of someone “doing things” to them and “lash out.”

Not only are these situations in paid care potentially harmful to the caring staff, there can also be a negative impact on the care provided:

> The ones that are likely to swear at you and use four letter words or hit at you, you tend to sort of just do what you have to do and say “Goodbye, see you later” and move on, one is not meant to do that but it’s human nature.

(laughs) (Estelle, enrolled nurse)

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\(^6\) The International Council of Nursing views nurses as experiencing more workplace violence than other industries and has issued a position statement on the topic (International Council of Nurses (ICN) 2000). In Australia, there is still seen to be a “culture of silence” in nursing resulting in an under-reporting of violent incidents (Natalie Dragon 2006: 22). That a degree of silence exists has important ramifications because the problem continues to be understated and largely hidden, similar to the situation of domestic violence within families.
Estelle’s account makes it clear that if a resident is difficult to manage then the amount of time that staff spent caring for them may be less than with more cooperative residents. It is also possible that some difficult residents may have more time spent with them because it takes staff longer to give the care due to the challenging behaviors. The higher level of emotional labor and time involved in caring for verbally or physically aggressive residents can result in a lower quantum or quality of care.

**Generalized reciprocity**

Caring labor does not always require direct reciprocity between the care provider and care recipient because such responsibilities are socially constructed and rely on generalized reciprocity. Nursing researchers Anne Neufield and Margaret Harrison (1998: 962) describe generalized reciprocity as “an expectation that assistance received will be returned to an individual other than the original provider of support.” They gave the example of a grandson who valued his role of caregiver to his grandmother as a model for his children so that they would understand the importance of contributing to others. Anthropologist Marshall Sahlins in his widely cited book, *Stone Age Economics* (1972: 194) argues that generalized reciprocity is neither defined by time, quantity or quality, nor conditional on what was given by the donor, but based on what the recipient can afford and when.

Edwina Uehara (1995) argued that her research with urban African-American women found that they operated within a support network in which assistance was provided through an informal system of “needs-based reciprocation” in which participants did not keep track of the details. Women who received support did not feel “overbenefited” because they would in turn provide future support for others (Uehara 1995: 495). In other words, communities of African-American women operate on a norm of generalized reciprocity rather than the “tit-for-tat” form of reciprocity. Similarly, feminist economist Irene van Staveren (1999: 46) argues that such “gift” giving is the primary allocative mechanism is what she terms the “domain of care”. These gifts are not always pure gifts where there is no expectation of a future return or benefit of any kind. Generalized reciprocity is evident in her example of nurses who face budgets cuts but continue to provide good quality care to patients as a gift “beyond the contract” in their everyday work (Staveren 2001: 48). In a nursing study it was found that the most satisfying health care relationship reported by chronically ill patients was reciprocal trust. “In other words, trust from health care professionals fosters trust in health care professionals” (Thorne & Robinson 1988: 786). This is akin to Putman’s notion of social capital characterized by networks that foster “sturdy norms of generalized reciprocity” (Putnam 1995: 67). Lesley, a registered nurse in this study, expressed a form of generalized reciprocity:

> Well because you’re looking after frail, elderly people. A lot of them have lost their independence and their health is failing. You’ve got to really be there to care for them and make sure their needs are met and I always think you would like your elderly parents to be looked after well by someone caring.

This nurse’s idea of care is clearly focused on a notion of generalized reciprocity. She is making a point of caring for other people’s elderly relatives well because she wants her family members to be cared for well when they are elderly. It has been argued in the nursing literature that rural nurses may contribute to social capital because they are immersed or embedded in the social networks that make up the fabric of rural life (Lauder et al. 2006). Generalized reciprocity is
therefore a much broader type of reciprocity than the positive and negative reciprocity described in experimental games which were based on a “tit-for-tat” dynamic where people gave to people who gave to them and were mean to those who were mean to them. Generalized reciprocity operates without an immediate payback and circulates throughout a network of people who accept this norm. Caregivers operating on a norm of generalized reciprocity give good care because they believe good care is important and it is what they want for themselves and their family members whenever they have a need for care.

Professional reciprocity

We draw on the nursing literature to identify another form of reciprocity which we term “professional reciprocity.” The nursing literature refers to reciprocity as an important element of the nurse–patient relationship that contributes to the therapeutic process. The focus on nurse–patient relationships developed as nursing moved from the Nightingale era of “impersonality and efficiency,” which was centred on nurses following doctors’ orders, task allocation, and performing routine work, to a “professionalizing occupation” (May 1991: 553). In 1973 the International Council of Nurses’ Code for Nurses shifted nurses’ primary responsibility away from doctors to patients or those in need of nursing care (Kuhse 1997: 32). Importantly, nursing education expanded to include interpersonal aspects of nursing (Travelbee 1971). This new focus positioned the nurse as patient advocate, requiring assertiveness and courage, and “marked a revolutionary shift in the self-perception of nurses and their role” (Kuhse 1997: 36). Over time the mode of contract between nurses and patients changed and building good interpersonal relationships became part of nursing skills and knowledge. A study of experienced staff nurses working in medical and surgical wards in a Scottish general hospital found that nurse–patient relationships organized around a combination of reciprocity, knowledge, and investment had positive and beneficial effects for the patient and the nurse (May 1991).

However, for reciprocity to occur, the patient/resident/client must respond and participate in a partnership involving the caregiver and the care recipient. In a Canadian study in a long-term care facility, nurses and health care aides defined reciprocity as “a mutual togetherness” and as “making things work in the day-to-day” (McGilton & Boscart 2007: 2152). Further, it has been theorized in the nursing literature that interactions between the nurse and patient are reciprocal to the extent that a “reciprocal spiral” develops in which these individuals continue to interact or withdraw from the situation. What results is a mutuality or interdependence in which both achieve goals (King 1981: 84).

Meryl, a director of care of a residential aged care facility, described the type of relationship that she believed her staff needed to build to provide good quality care to elderly residents:

They’ve got to approach each person as an individual. They’ve got to know the person. They’ve got to actually care about the person to want to get good outcomes for them. They can’t be approaching things in a task-orientated way because it’s just horrific for the resident if they do that. They’ve got to be able to relate well to them and have a joke, have a laugh, build a warm sort of relationship. I think all those things add up to a caring, you know, the caring sort of therapeutic model. And also a lot of the work that’s done is to make people feel better about themselves.
Meryl sees the nurses and carers as responsible for initiating reciprocal exchanges with the residents. Building mutually warm and friendly relationships with the residents is part of providing good quality aged care.

Patricia Marck (1990) in a review of the nursing literature on reciprocity identified therapeutic reciprocity as a distinct form of reciprocity in care relationships. She proposed four antecedents before therapeutic reciprocity can exist. These strict criteria prevented this notion of therapeutic reciprocity becoming widely used in the nursing literature (Nolan & Grant 1993). Our data shows that some reciprocal exchanges do suggest that a range of therapeutic objectives and outcomes are sought. For this reason, we argue that reciprocity actively instigated by paid care staff for the purpose of therapeutic benefits is “professional reciprocity.” But the nurses had to be instrumental in cultivating these exchanges:

You would just spend a bit of time talking to them, reassuring them, using a calm voice and, you know, touching their hand and trying to be very gentle with them. That’s what they respond to the most. (Polly, clinical nurse)

The evidence is that this type of reciprocal relationship can and does exist when people have dementia as Jennifer, another director of care explains:

It’s a lot of human contact, and I think you’re helping people that are vulnerable. You’re helping people that need you. And just doing that, by giving part of yourself to these people, you get something back from them, just as much. It doesn’t have to be gratitude, like wow, you’re wonderful, but just an acceptance and a sort of communication.

Not only does professional reciprocity facilitate better care, it also increases the job satisfaction of nurses. A US study of nurse clinicians involved in medical-surgical nursing found that nurses who had a cognitive connection with their patients described it as “an extremely active and intentional process for the nurse” (Ramos 1992: 503). The outcome of such relationships was described as overwhelmingly positive for these nurses and they consistently said that their relationships with patients were central to their professional satisfaction and health (Ramos 1992: 504). Another American study of nurse practitioners from a variety of specialties and practice settings found that the relationships with patients, which flourish within an ongoing reciprocal process of collaborative engagement with the

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7 Patricia Marck (1990: 53–4) argued that the four antecedents for therapeutic reciprocity were that it could arise in any situation in which a nurse and a client were interacting with each other and exchanged meaningful thoughts, feelings and behaviour; interfering factors such as noise and cultural differences must be less potent than the meaning of the exchange occurring between the carer and caree; the carers’ skills in facilitating reciprocation must exceed the interfering factors in the environment; and the nurse or carer must participate in the relationship from the philosophic premise that human existence has multiple meanings and some personal meanings can be shared, amongst other things. She went on to argue that therapeutic reciprocity is not constituted by the care given but manifests itself in the shared meanings between nurse and client. In the case of a nurse caring for a patient post-abortion, Marck analysed the mutual exchange of meaningful thoughts, feelings, and behaviour – therapeutic reciprocity – using several sources of information including silences, tone of voice, disclosures, and shared humour. She argued that, by arriving at shared meaning about the client’s experience, the nurse and the client enhance their mutual understanding, which informs their approach to the situation.
patient’s health-related concerns, were the basis of nurses valuing their nursing experiences (Kleiman 2004: 268). There was also evidence in our research that aged care nurses derive their job satisfaction from the relationships they have with the residents for whom they care:

I think, and it’s from personal experience, I get a lot out of looking after these people as well. They give back to you. And it’s really funny, because people that have dementia have this really uncanny sense of knowing how you feel, which is weird. I mean, I don’t want to sound like a freak or anything, you know what I’m saying, but I notice often that, you know, and I’ve heard other nurses talk about exactly the same thing, you’re not feeling good but you’re still at work, but you’re not feeling good – sad, whatever, you know – and often a person that has dementia will sort of know that, somehow.

Q: And what would they do?

A: Oh come and sit with you, or they touch you. Yeah. (Jennifer, director of care)

And

Um (pause) I think that most of it is what residents actually give me themselves. I feel that you see that little glimmer in their eye, you see there’s a smile comes on their face, you know, because you’ve done something, because you’ve been there. (Sandra, registered nurse)

The capacity of nurses to facilitate reciprocity however is severely limited if they are working in time-starved “industrialized” work environments “in which ‘care’ degrades to merely a series of coldly executed, standardized tasks” (Adams & Nelson 2009: 15). For professional reciprocity to be a routine part of nursing care, as nurses themselves desire it to be, requires both appropriate education and a supportive working environment.

Why do residential aged care nurses seek to foster reciprocity?

George Akerlof described labour contracts as partial gift exchanges where firms paying higher wages results in their employees working in excess of the minimum work standard (Akerlof 1982: 544). Nurses working in Australian residential aged care facilities are not so fortunate. One study found that 53 percent of nurses from the aged care sector believed their pay rate was extremely or quite poor. Respondents also noted that other similarly educated and accountable professions such as teaching are paid at a higher rate than nurses (Hegney, Plank & Parker 2006: 277). Nurses working in both public and private residential aged care considered their jobs to be poorly remunerated with a heavy workload that they find physically demanding, emotionally challenging, and stressful. The nurses reported that they could not complete their work to their satisfaction and were critical about their workload, staff numbers, and staff skills mix (Eley et al. 2007: 869). Another study found that “a very real issue … was thus simply coping with the everyday, relentless demands being placed on them and which showed, in their opinion, no signs of abating” (Jones, Cheek & Ballantyne 2002: 231).
An American study of nursing home residents’ perceptions of good quality care found that some residents who grew tired of waiting for assistance took “matters into their own hands” even though this at times placed them in some physical jeopardy (Bowers et al. 2001a: 542). Another study on nurses’ work in two US nursing homes found that time was an important factor in all nurses’ work. It affected how nurses worked, how they felt about their work, and how their work affected resident outcomes. Having too little time was the main source of job dissatisfaction for these nurses (Bowers, Lauring & Jacobson 2001b: 485). In a Canadian study of care provider–resident relationships in long-term care, both the care providers and the residents identified inadequate staffing as a barrier to nurses having enough time to spend with residents (McGilton & Boscart 2007: 2155).

The evidence from both the nursing literature and our research is that nurses’ job satisfaction is enhanced by professional reciprocity. This reciprocal exchange between the nurse and the recipient of her/his care not only increases nurses’ job satisfaction but also results in a higher level of quality care for the care recipient though promoting therapeutic outcomes. Since nursing moved from that Nightingale era into evidence-based practice, nursing texts have emphasized the importance of the nurse–patient relationship and that interactions between the nurse and patient are reciprocal (Travelbee 1971: 153; King 1981: 84; Spradley 1990: 275).

There is also some evidence in our research that when people providing care do not understand the importance of developing mutually positive relationships with their care recipients, this has an adverse impact on the person receiving that care. Katherine, a clinical nurse consultant, recounted both an example of professional reciprocity and a problem with the behavior of a carer who does not yet understand how to develop therapeutic relationships with residents:

We look after him, and a lot of the staff can joke and he feels comfortable, and he’ll joke back and his eyes light up when he sees them and they speak to him. One member of staff who teases him and, now I’ve been working on that, he won’t go near the house when she’s working in his house, and he’ll be anywhere in the facility but in his house.

The inappropriate behavior of this carer had an adverse effect on this elderly resident to the extent that he went out of his way to avoid that person. In a Swedish study of five care providers who were particularly successful at communicating with patients who had communication difficulties, the researchers described how the successful communication process worked as a “caring communion” which was a creative act involving a reciprocal “understanding and being understood” (Sundin & Jansson 2003: 114).

Conclusion

Analysis of interviews with residential aged care nurses indicates that reciprocity is an important and multifaceted motivation in paid care work, as theorized in feminist economics and other literatures. In addition to positive, negative and generalized forms of reciprocity being at play in paid care work we argue that a more instrumental approach to reciprocity also motivates nurses, which we term professional reciprocity. Deliberately initiated by professional caregivers to build relationships with their care recipients with the view to promote therapeutic outcomes, professional reciprocity potentially enhances the care recipient’s autonomy. It can still operate, at least to some degree, in the presence of cognitive impairment. Professional reciprocity initiates a mutual relationship and increases nurses’ job
satisfaction, which also has the capacity to enhance the quality of care provided. Professional reciprocity partly reflects the nature of trained nurses’ relationships with their patients and it can be enhanced with appropriate training and working conditions. Also, by focusing on training, pay, job satisfaction, and working conditions as a means of improving the quality of care, the concept of professional reciprocity could strengthen feminist claims to make care work more visible and valued.

Professional reciprocity is part of a complex array of factors that have the capacity to increase the quality of paid care and possibly the willingness of nurses to supply care. The work of feminist economist Jochimsen (2003: 236 & 237) offers some ideas on how to understand the way in which professional reciprocity contributes to meeting a society’s caring needs. She hypothesizes that the achievement of caring activities to meet caring needs depends on the combination of motivation to care, the work to establish and maintain the caring relationship, and the resources (material and time) to provide for and sustain the caring relationship. The effectiveness of a caring situation that incorporates professional reciprocity as a motivation has been shown to require integration with the work and resource aspects. Our analysis indicates that nurses actively engender rapport and reciprocity with their aged care residents with a view to promote quality care and therapeutic outcomes. This two-way exchange supports the ongoing work of providing care, as cooperation makes providing care easier and results in better care provided to the care recipients and heightened job satisfaction for the carers. Being adequately resourced (materially including training and in time) supports nurses to engender professional reciprocity while being under-resourced lessens their ability to build relationships that positively contribute to providing good quality care.
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