Newer Dimensions of

PATIENT CARE

Part 3 Patients as People

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CHAPTER 8

"The secret of the care
of the patient is in
caring for the patient."

FRANCIS W. PEABODY, M.D.

Chapter 1

INTRODUCTION

EACH OF THE THREE MONOGRAPHS in this series on *Newer Dimensions of Patient Care* is concerned with how individualized attention to patients can be increased, particularly in large hospitals. Each focuses consideration upon a different facet of various possible solutions. Part I began by recalling patients' frequent complaints about anxiety, frustration, loneliness, boredom, and uselessness. It was suggested that changes, of an almost obvious kind, might be made in the physical and social environment of the wards that would reduce the sense of strangeness and the cold, impersonal atmosphere that exacerbate these discomforts. It was suggested specifically that hospitals attempt to reproduce, insofar as possible, symbols of normal home life, work, and recreation with which patients are familiar and from which they could draw comfort, distraction, and interest.

In the second monograph the discussion shifted from the use of the environment of the hospital as an instrumentality in direct patient care to consideration of the staff who provide such care. Staff were observed to be occupied largely in carrying out tasks that constituted small segments of patient care, without appreciable knowledge of the patients for whom the tasks were performed and often with little interest in them as persons. This functional division of work, together with the lack of institutional recognition and prestige accorded personnel at the bedside, was seen to retard "caring" for the patient, which Dr. Peabody characterized as "the secret of the care of the patient." It was concluded, therefore, that if staff are to make the emotional commitment necessary to provide total care, their psychological and social needs must be met quite as much as those of the patients.

The monograph attempted to define the psychosocial needs characteristic of most workers, and to suggest ways whereby these requirements might perhaps be met sufficiently to encourage increase of staff motivation and competence.

Part 3 is the concluding discussion of patient care as seen in social science perspective. Its purpose is to take a closer look at who those persons are that are designated as patients. Obviously patient care cannot be individualized or interest well maintained, particularly in the long-term patient, unless staff have some appreciable knowledge about the persons to whom care is given, as well as their medical conditions. Yet many physicians and nurses experience great difficulty in knowing how to acquire the information easily and expeditiously that is essential if patients' psychosocial needs are to be met, or how to use the knowledge once acquired.

For many years the social sciences have been attempting to develop ways of classifying people or of placing them within frames of reference, in order to be able to learn about, and thus predict, what their attitudes and behavior would probably be under various circumstances. These attempts have been sufficiently successful, we believe, to provide appreciable help to practitioners who want to have a more comprehensive understanding of their patients as persons. This monograph, therefore, describes ways of obtaining clues about how certain kinds of patients are likely to feel and react to their sickness and hospital experience, and of utilizing this information in the planning of individualized care.

"TOTAL PATIENT CARE" AS A MEDICAL NECESSITY

In the days when family physicians and private duty nurses cared for the bed patient in his home, it was fairly easy to pick up information about his life history and circumstances that was of great value in planning his treatment and management. Since patients have been coming to hospitals in vast numbers and from widely varied socioeconomic backgrounds, the obtaining of com-

parable information has become difficult indeed. The proliferation of categories of personnel has also intensified the problem of having information, once obtained, readily available to all who need it for use.

The trend in movement of patients from beds in their own homes to beds in hospitals coincided roughly, moreover, with the era of rapid advances in the application of the physical and biological sciences to medicine. So spectacular were the results of laboratory and clinical research that it must have seemed initially as if the key were about to be found in biochemistry, microbiology, and later in physics to the cause and cure of most diseases. Under such circumstances depersonalization of the patient was easy; it was reflected in such remarks as "that case of mitral stenosis in the second bed on the left."

Doctors and nurses were, nevertheless, admonished to relieve pain wherever possible, and to treat patients with respect, kindness, and compassion; many demonstrated great skill, often of an intuitive kind, in binding up emotional as well as physical wounds. Some of them certainly realized that "no man is a case of mitral stenosis or pneumonia or even of schizophrenia."[1] These labels are abstractions or hypotheses that are extremely helpful in treating disease, but, as Dr. Binger reminded medical students, "the reality is the suffering individual. It is he whom we must study to know."

With advances in biological research persons like Walter Cannon, Ivan Pavlov, Sigmund Freud, and, later, Harold G. Wolff demonstrated that body, mind, and emotions are not separate entities.[2] Instead, they are so interrelated that it is now recognized that the cause and treatment of a long list of diseases—bronchial asthma, peptic ulcer, colitis, arterial hypertension, migraine headache, and so on—can often be found only in a

[1] Dr. Carl Binger's *More About Psychiatry*, University of Chicago Press, 1949 (from page 5 of which these brief quotations have been taken), presents the nonspecialist with a most readable account of the development of psychosomatic medicine and psychiatry and its implications for comprehensive patient care.

[2] The very title of Dr. Cannon's classic volume, *Bodily Changes in Pain, Hunger, Fear and Rage*, first published in 1915 by D. Appleton-Century Co., New York, suggests the existing interrelationships.

prolonged study of the life history and personality of the patient.[1] Moreover, the growth of psychiatry and the behavioral sciences has resulted in directing consideration to the possible effect of unconscious motivation and of psychosocial and cultural factors upon health and sickness.

As a consequence of these developments, treatment of the total person is coming to be viewed as essential by members of all the medical and health professions. Such treatment, of necessity, demands a knowledge of the patient in his psychological and social, as well as his biological, aspects. No longer can medical attention and patient care rest so largely as in the past on casual judgment about who the patient-person is and what are his needs.

Recently the rehabilitation of persons with physical or mental handicaps, the prevention of disease, and the preservation of health have begun to receive increased attention within the hospital as well as in clinics and public health agencies. Success in these undertakings requires both knowledge and skills that have been utilized previously in patient care only to limited degrees. The rehabilitation of the severely handicapped demands not only knowledge about the person and the psychological meaning for him of his disability;[2] it also demands skill in inducing patient incentive, providing him with strong psychological support, and using his peer group to assist in achieving these ends. Attempts to encourage prevention of disease and preservation of health require an understanding of the beliefs or folkways regarding health and sickness held by various sectors of the population, as well as experience in changing attitudes and encouraging the development of new habit patterns.

EFFORTS TO BROADEN THE SCOPE OF PATIENT CARE

Although the importance of total patient care has already been well explored, documented, and accepted in principle, the intro-

[1] See Graham, David T., and Ian Stevenson, "Disease as Response to Life Stress" in *The Psychological Basis of Medical Practice*, edited by Drs. Harold I. Lief, Victor T. Lief, and Nina R. Lief, Harper and Row, Publishers, New York, 1963, pp. 115–153. This volume of papers presents recent research findings from biology, psychiatry, and behavioral science concerning psychosomatic disease and also the broader field of the psychological aspects of comprehensive medical care.

[2] For case illustrations, see *Facial Deformities and Plastic Surgery: A Psychosocial Study* by Frances Cooke Macgregor and others, Charles C Thomas, Springfield, Ill., 1953.

duction of such care into medical and nursing practice must often seem too difficult even to contemplate by persons trained in the treatment of disease and the procedural aspects of patient care. As a consequence, progress has been slow.

Various ways of meeting portions of this problem, however, have been instituted. During the past two decades an increasing number of schools of medicine and nursing have included in the curriculum consideration of concepts about human behavior developed by psychiatry and psychology. (Training for social work and clinical psychology has drawn heavily on these disciplines.) Now some schools are attempting to integrate concepts from sociology, social psychology, and anthropology into the curriculum much as those from psychiatry and psychology have been integrated. It may be assumed that greater use will be made of these social sciences as selected material becomes available that is more immediately applicable than are academic texts to the needs of the health professions.[1]

Another method that has been developed is to add new categories of personnel with specialized knowledge to the traditional doctor-nurse team. Thus medical and psychiatric social workers have been made participants in patient care, and are relied upon extensively as the repository of information about the patient in relation to his family and home, community, and work. On psychiatric services clinical psychologists are often considered almost indispensable in assisting to make personality assessments of patients, and perhaps in engaging in research of a behavioral nature.

Encouraging as are these developments, the learning of enough about attitudes and reactions to permit total patient care is in its infancy when compared with what has been learned about the recognition and treatment of disease. One probable reason learning does not proceed more rapidly is that, although practitioners depend heavily upon well-substantiated generalizations about the behavior of various kinds of disease, they have been trained

[1] As this report was being written, Stanley H. King's *Perceptions of Illness and Medical Practice* (Russell Sage Foundation, New York, 1962), and John and Elaine Cumming's *Ego and Milieu: Theory and Practice of Environmental Therapy* (Atherton Press, New York, 1962) had just been published, thus adding to the literature prepared expressly for the use of the health professions.

to work with each patient individually and to think of him as being very different from every other patient. This emphasis upon the individual and difference precludes their easy and ready acceptance of the fact that similarities in attitudes and behavior exist among various kinds of persons as well as of disease.

Many casual generalizations based on similarities—some of them probably erroneous because of the insufficient data on which they rest—are, of course, used daily in making assessments. Thus one hears statements such as: Men patients are less demanding than women patients; women tolerate pain much better than do men; or, patients of southern European ancestry are very noisy when they are in pain. But the importance of *systematic knowledge* of group similarities has received little conscious recognition as a tool useful in predicting how patients are likely to respond to their illness and hospitalization; in considering how patient care plans could be fashioned accordingly; and in foreseeing how staff might initiate interpersonal relations with fewer errors and perhaps more quickly and effectively. Because of this lack of recognition, attempts are too rarely made to scrutinize the validity of the generalizations used, or to explore what helpful data are available in the social sciences.

Public health nurses, for example, have laboriously collected information—individual family by individual family—about living and working conditions that bear upon health, as well as attitudes toward child rearing and health practices generally. In the course of time they have often become so well acquainted with a neighborhood that they were able to build up a substantial body of knowledge about the health assets and liabilities of its members, and predict with considerable accuracy what response to their counseling they would be likely to find in a particular kind of family. Some of these same nurses have recently discovered that behavioral science literature was available whereby they could have learned in a relatively brief period what had taken them months on a case-by-case basis. They had not known initially that under such seemingly formidable titles as *race and ethnicity*, *social class structure*, or *psychosocial and cultural determinants of human behavior* were facts and generalizations that could have been of incalculable help to them.

Nor did they know that they might also have obtained valuable clues about how to establish rapport with clients whose origin was very different from their own, and who in some instances had only a limited understanding of English. If they had had an opportunity to learn something in advance about the cultural background of Italian Americans, Puerto Ricans, Negroes, Old Yankees, or second-generation Jews, they could often have directed their conversation in ways that would have made their clients more immediately comfortable and responsive. Had they realized how it would have facilitated the establishing of a relationship, they might have learned at least to greet the client in his own language, or have informed themselves about the part of southern Italy, Puerto Rico, or Mexico from which any considerable number of their clients came.[1]

Patients in hospitals are as diverse as those visited by public health nurses, and staff do not even have the opportunity to see them in their home and community setting. One day as the head nurse ran over the names in the Kardex of the patients on a thirty-bed ward in a New York voluntary hospital, the visitor concluded that some ten or twelve nationalities chiefly of central and southern European origin were represented. So far as the head nurse knew, no patient had been asked where he came from or when he or his family arrived in the United States, in spite of the fact that such a question might have suggested to the patient that the staff were interested in *him*. Although some kinds of patients may have been far less able than others to assume the sick role, the staff prided themselves on "treating all patients alike."

On the same day, in the vast city hospital nearby, the situation would have been far more complex. Besides many of European background, there would have been a few of Oriental origin; large numbers of socially, economically, and educationally disadvantaged Negroes and Puerto Ricans; some individual patients from the dregs of the city who led lives of almost complete social

[1] In *Reality and Dream* (International Universities Press, New York, 1951), Dr. George Devereux, an anthropologist with psychoanalytic training, gives an interesting description of how he prepared himself to act as counselor to an American Plains Indian who was mentally ill, and of his success in winning the patient's responsiveness and cooperation.

or psychological disorganization; children not only physically sick but emotionally disturbed, mentally retarded, or perhaps born to unwed mothers; and many elderly persons in the last stages of physical and mental deterioration.

How can staff conceivably give total care to persons representing such diverse origins and life situations unless they have considerable social science knowledge at their disposal, as well as experience in using that knowledge? Even when physicians and nurses are exceptionally adept in providing patient care for those whose background is most like their own, their perceptiveness and sensitivity tend almost inevitably to decrease in proportion to the difference between their life situation and that of the patient.[1]

This tendency has been observed many times among staff working in outpatient departments, even when the variety of patients has been much less than in the city hospital to which reference has been made. In one study where a nurse interviewed each of the patients in the sample directly after his visit with the doctor, it was found that more than a third did not know why they were taking the medications prescribed.[2] This fact may have helped to explain why an equally large proportion were uncertain about whether the medications were benefiting them or not. (Nearly two-thirds did not know the names of their drugs, largely because the doctor referred to them by color.)

Several factors appear to contribute to the patient's lack of understanding about instructions generally: tension and anxiety, partial deafness, insufficient knowledge of the English language or inadequate educational background, and slow mental reactions resulting often from arteriosclerosis. But quite as important as these handicaps are the frequently negligible role played by the nursing staff in making the patients feel comfortable and in explaining the arrangements of the clinic, and the failure of the resident physicians and interns to try to make the patients understand. Often the doctors

[1] See the amusing but disturbing story, "Orientals Are Stoic," that André M. Tao-Kim-Hai, a Vietnamese on the staff of the United Nations, wrote about his American hospital experience. It appeared originally in *The New Yorker*, September 28, 1957; it was reprinted as the Appendix in Frances Cooke Macgregor's *Social Science in Nursing*, Russell Sage Foundation, New York, 1960.

[2] From a manuscript by Dorothy A. Vernstrom, "A Study of Nursing in the Out-Patient Department," 1958.

speak too rapidly or mumble their words without even facing the patient, or they use technical terms that no one with less than a high school education could be expected to know. Many times they appear bored or even annoyed that they should be obliged as part of their training to see patients whom they may characterize privately as "crocks."

Almost certainly these nurses and doctors have had no preparation as college undergraduates for interesting themselves in the wide spectrum of social groups that compose America; they apparently receive little supervisory assistance in the clinic in ways of handling nurse-patient and doctor-patient relationships; and no one has helped them realize that their attitudes alone might determine whether they could think of such small but important matters as clarity of speech and simply phrased explanations and directions.

THE IMPORTANCE OF "FACE-SHEET" DATA

Obviously the problem of how to provide total patient care is one of such magnitude and complexity that it deserves the best thought, for years to come, of many persons from varied disciplines who can contribute something toward its solution. What is perhaps most needed immediately is a broader and more inclusive frame of reference than psychiatry and psychology have supplied for thinking about patient-persons. Significant as have been their contributions, they have focused chiefly on the psychological functioning of the individual at the expense of neglecting many of those social and cultural elements that are also important determinants of behavior.

What is equally needed is a method for utilizing this frame of reference that is simple enough for doctors, nurses, social workers, and others to apply as a basis for making their initial assessment of who the patient-person is. If such a frame of reference and a method could be evolved and staff trained in their use, it might even be found later that many of the negative attitudes toward patients, such as the reference to "crocks" cited in the illustration above, would diminish. More knowledge about who patients are as persons would hopefully stimulate interest in them, while the greater security that staff would gain from training in directed talking and listening to patients might relieve the often seem-

ingly calloused attitudes that are probably rooted in discomfort as well as in disinterest.

Social Assessment as Developed by Personnel Departments

In considering what kinds of social data should be included within the frame of reference, it might be helpful to begin by examining the items that are used by another department of the hospital, whose function it is to make assessments for a specific purpose of those persons who come to it. We refer to the personnel department as it exists in almost all large hospitals or in other highly organized institutions. That department is required to form judgments in a relatively brief period of time about the suitability of persons of widely varied backgrounds for a broad range of positions. Hence it has been obliged to try to find questions specific enough and a method sufficiently simple but effective for it to obtain the most comprehensive information possible about the applicant within the allotted time period.

The questionnaires or application forms that have been developed often yield very considerable social data. They are likely to include most of the following items: name, present address and length of residence, sex, age, physical characteristics, place of birth, United States citizenship, father's occupation, father's and mother's education, number of brothers and sisters, marital status, number of children and ages, highest level of education attained, health record, work experience including compensation, race, and possibly recreational interests or use of leisure time. (In some places, several helpful items such as religion, race, and political affiliation have been proscribed by law because it was believed that they had been used by some institutions to discriminate against certain categories of applicants.)

The facts obtained provide a kind of shorthand summary of the person's life history. Each of the items is viewed as a clue to an important dimension of the human being. Sex, for instance, not only states a biological fact but suggests distinct differences that must be taken into account between men and women in work roles, social experiences, and attitudes. Age indicates not merely the number of years lived and whether the applicant is within the

"right" age range for the job, but also the potential opportunity thus far provided for the accumulation of experience and the development of judgment and skills.

When data concerning all these factors are examined *in their interrelationships*, a profile of the person emerges that is often sufficient for the interviewer to speak with confidence about the applicant's fitness in background, education, and experience for the position. The facility that many interviewers acquire in weighing the meaning of each statement and in correlating all the evidence is impressive indeed. Frequently, moreover, the written data requested are supplemented by the oral probings of the interviewer or the use of standardized tests, designed to obtain information about psychological factors such as attitudes, values, motivation, autonomy versus dependency, ability to cooperate with others, and so on.

Meagerness of Social Data Concerning Patients

No busy personnel office would know how to do its job without the assistance of some such questionnaire or form as has been described. The admitting office of the hospital also obtains routinely a few social data about each patient. These data for adults generally include: name, address and telephone number, sex, age, birth date, state or country of birth, marital status, religious preference, and name and address of a responsible relative or friend. A copy of these facts is usually sent to the appropriate nursing station to be attached to the patient's medical record. In addition, the admitting office obtains information about hospitalization insurance, the occupation of the patient, name and address of the employer, and length of employment. Similar questions are asked about the employment of the patient's spouse or guarantor. A bank reference and address are often requested for the patient and the spouse.

Beyond the very limited amount of information that is made available to the nursing station, the collecting of additional social facts is fortuitous. Physicians generally write notes about family members, particularly those of the preceding generation, but chiefly in reference to the possible transmission of or predisposi-

tion to disease. The psychosocial information that nurses acquire in the process of making a nursing care plan or of taking care of the patient may or may not be recorded, depending upon the practices of the institution and whether a datum is considered important to treatment. If recorded, the nursing notes are sometimes inserted as an integral part of the medical record and are thus available to all therapists; often they are kept separately and hence are used at best only by nurses. If a social worker is asked to interest herself in a particular patient, she frequently collects enough information so that one can begin to see the profile of a person. Her data may become part of the medical record; generally, however, she retains them in her office and perhaps presents them only upon request in oral form at a clinical conference.

Rarely, except possibly in psychosomatic, psychiatric, and rehabilitation services, is enough social information customarily gathered or kept where it can be readily examined, to permit doctors and nurses to gain some sense of acquaintanceship with the patient's life pattern. But what is equally serious is that little concrete use is made in interpersonal relations with patients of such limited data as have been gathered. The chief purpose of the facts collected by the admitting office is to permit the hospital to assign the patient to the ward suitable for his age and sex as well as his medical condition; to get in touch with relatives as needed; to call for the assistance of an appropriate chaplain or minister, and make arrangements for religious food practices; to facilitate financial arrangements; to determine whether the services of a social worker are necessary; and to keep the necessary legal records. Such restricted face-sheet information as reaches the nursing station is so little used by ward staff in making an assessment of the needs of the patient-person that someone has well remarked that it is "the most seen and unseen item in the hospital record."

LACK OF STAFF INTEREST IN SOCIOLOGICAL DATA

As indication of how little attention is paid to face-sheet information, many nurses will recall an article in which Dr. Rena E. Boyle reported on what nursing students said when asked to

describe the patient they knew best. In regard to the patient's age some of them misjudged it by from ten to twenty years. "This was somewhat disconcerting," remarked Dr. Boyle, because age is an item recorded both on the chart and the patient assignment card. "Perhaps age is a concept," she commented, "which is relatively mysterious to young students since they would refer to patients in their thirties as being 'the older men' or, as one student said, 'You see, he's quite elderly. He's forty-nine.' "[1]

Probably no one had tried to help these students learn that age is not only an important biological fact that is roughly correlated with physiological changes, but also a frequently significant determinant of a person's interests and attitudes. Students still in late adolescence or their early twenties must find it extremely difficult to perceive how interests and attitudes are likely to alter from decade to decade during the life span of a human being. But the nursing literature witnesses to instances of irreparable harm done to subsequent interpersonal relations with a patient because some member of the nursing staff chatted inappropriately about personal interests or attitudes, characteristic of her age-group and background, instead of trying to concern herself with the psychological needs of the patient.

Lay persons who have had the opportunity to hear a medical case presentation in a hospital can almost always recall afterward the pattern of the first sentence, so suggestive is it of the biological base on which medicine has rested. In the clinical report that follows that first sentence, any reference to psychosocial data often seems to be considered an almost unnecessary if not frivolous intrusion. One of these presentations is reproduced here because it not only illustrates the above statement, but simultaneously demonstrates how essential is psychosocial information in understanding the medical patient under examination. The case is one "of a gross structural lesion intrinsically bound up with a man's personality and with the way he leads his life."[2]

[1] "How Well Do We Know the Patients We 'Know Best'?" *American Journal of Nursing*, vol. 58, November, 1958, p. 1542.

[2] Binger, Carl, *More About Psychiatry*. University of Chicago Press, 1949, p. 144. The following excerpt from pages 142–143 is presented with the permission of the publisher.

[The fourth-year medical student, who made the presentation to Dr. Binger, the psychiatrist, and a group of fellow-students, had had an hour in which to interview the patient besides studying the clinical record.] With his eye pretty constantly glued on the record for fear of forgetting any important facts, he begins according to stylized convention: "The patient is an unmarried white male of forty-nine." The instructor interrupts him: "Is the patient a man or a marsupial? Are you a white male, or a medical student?" He allows that he is a medical student and that the patient is a professor of Romance languages. The student goes on: "He came to the hospital for a bleeding duodenal ulcer. X-rays show deformity of the cap." But the instructor stops him again and says: "What university does the professor belong to?" The student then mentions one of the oldest and best known of the eastern universities. At this point the instructor inquires why a professor of one of our most famous universities is a patient on the public ward. Why not in a private or semiprivate room? The student does not know the answer but says that the patient was admitted through the accident ward, where he came for a minor injury. He hastens to add that that was merely coincidental; when they discovered in the accident ward that he had typical signs and symptoms of a duodenal ulcer, they sent him into the hospital for investigation. The student, like a hound picking up the scent, is off again on the subject of the deformity of the duodenal cap. The instructor, however, relentlessly pursues his Socratic way.

He inquires rather flatly: "Why was he brought to the accident ward?"

The student replies: "For a cut on his hand, but that had nothing to do with his admission to the hospital. He was *admitted* because of his bleeding ulcer."

Instructor: "How did he cut his hand?"

Student: "He fell out of bed."

Instructor: "Why does a forty-nine-year-old professor of Romance languages fall out of bed—especially if unmarried?"

Student: "He's very fat."

Instructor: "Do you mean he was too big for his bed and rolled out?"

Student: "Yes, that's it."

Instructor: "How can you cut your hand by falling out of bed?"

Student: "He fell on a milk bottle."

Instructor: "What was he doing with a milk bottle under his bed?"

Student: "I don't know."

The instructor continues: "Why is he so fat?"

Student: "From drinking cough syrup. He gained about sixty pounds in a year. He takes the cough syrup, which contains codeine, because of epigastric pain caused by his ulcer, and it's the ulcer that is responsible for his being in the hospital."

[Subsequently the patient was wheeled into the conference room. He was an enormous man with large limpid eyes and a small button of a mouth. Although the instructor tried to put him at ease, his volubility was obviously a cover for his defensiveness about codeine addiction. He explained that he took cough medicine for the excruciating pain he suffered chiefly at night. Because of his illness and addiction he had lost his teaching position and was faced with a serious financial problem. After the patient had been wheeled out, the instructor discussed the emotional aspects of the illness and the relationship, as revealed by physiological and psychiatric research, between the need for dependency and ulcer formation.]

Medical caseworkers, by virtue of the nature of their profession, are expected to inform themselves about many facets of the patient's family relationships and community ties. In spite of this fact they have been so indoctrinated with a dynamic explanation of behavior drawn from psychiatry that often they do not collect significant material dealing with sociological and anthropological determinants of behavior, or do not even make use of certain items in their face-sheet data. Some years ago Roger W. Little, a psychiatric social worker, remarked, "One dominant tendency in casework today is the failure to consider the individual as a person with a place in society, with a social status, social roles, and cultural traditions, except insofar as this behavior can be interpreted in dynamic terms." He inquired very pointedly how often caseworkers "referred to a man's class status, occupational role, or cultural tradition as the crucial element in his problem."[1]

Since this was written, some schools of social work have made appreciable efforts to broaden the theoretical frame of reference of their teaching and research. *Social Perspectives on Behavior*[2] is an example of a text of readings that was prepared expressly for this purpose to be used by "social work and related professions." It might be noted parenthetically that the book is quite as valuable

[1] "The Social Side of Casework," *Social Casework*, vol. 31, April, 1950, p. 162.

[2] Edited by Herman D. Stein and Richard A. Cloward, and published by the Free Press, New York, 1958.

for those physicians and nurses concerned with total patient care as it is for social workers.

As illustration of the too restricted frame of reference of which Little complained and which still characterizes much social work, let us look briefly at the records prepared by highly skilled social workers who were employed as counselors to the members of a medical care plan that was interested in preventing sickness and maintaining health. Examination of a sample of these case records revealed, either in the face-sheet data or in the running text, that the patients were predominantly American born; economically and socially they would be classified as in the lower middle class. Many of their parents had come from Europe and appeared to have clung staunchly to their native language and to the customs and values characteristic of many European peasants. Consequently, conflict clearly existed in several instances between the foreign-born parents and their children, who were now young adults with small children of their own. Conflict was especially sharp over questions of how these small children should be reared; the value systems of the grandparents and the parents were sometimes so antithetical that there was little common meeting ground for the resolution of conflict.

This kind of strife between generations is a common occurrence, particularly where two distinct culture patterns are involved, and it has been extensively documented and discussed in the social science literature. Yet in no casework record examined was there more than descriptive reference to these conflicts; no generalizations appeared about their potential destructiveness for the young parents and the children, and no indications of any effort to deal with them.

These social workers had been trained with great proficiency to make assessment of possible marital disharmony and sexual inadequacy, general emotional immaturity, child-rearing practices including over- or underprotectiveness, sibling rivalry, and so on. They had not been prepared to see the pathological implications for family life of sharp conflicts between generations even though they noted these conflicts in their case records. Had the meaning of such conflict been within their frame of reference, they would undoubtedly have used the therapeutic method in which they had been trained: helping their client to develop insight into his problem, and providing the psychological support necessary while he attempted to bring about some solution.[1]

[1] Helpful discussion, accompanied by extensive case illustrations of how the frame of reference of child therapy might be broadened, appears in *Social Science and Psychotherapy for Children*, and *Integrating Sociological and Psychoanalytic Concepts*, Russell Sage Foundation, New York, 1952 and 1956, respectively. Both books were the product of long collaboration between Dr. Otto Pollak, the sociologist-author, and the psychiatrically trained staff of a child-guidance agency.

Chapter 2

A PSYCHOSOCIAL AND CULTURAL FRAME OF REFERENCE

THE FOREGOING DISCUSSION has attempted to indicate the importance of expanding the scope of the information obtained about all patients. In this chapter, therefore, additional items will be suggested that should probably be included in the face-sheet data if staff are to be able even to begin an assessment of patients as persons. Factual information concerning most of these items could be acquired routinely by the admitting office merely by adding a few additional questions. Elaboration of this information would have to be obtained through conversation with and observation of patients and their visitors.

Quite as important, however, as the specific items of face-sheet data is enlargement of understanding about the *meaning* of the information acquired and the practical *use* to which it can be put. Consequently, the following chapters of this monograph will be devoted to exploring ways of looking at, and thinking about, the significance of some of these items separately and in their relation to each other, within the context of their applicability to direct patient care.

ADDITIONAL FACE-SHEET DATA

Patients' Family Ties

For many patients, besides children on pediatric floors, information about the parental family, or "family of orientation" in sociological terminology, would be exceedingly useful to staff. Where were the parents born, where have they lived most of their lives, what was the father's occupation and general level of

education, how many brothers and sisters has the patient had? Has the parental family remained a close-knit unit? Here are potential clues for introductory conversations with many a patient, and for considering the role of the relatives in the care program. Here also are clues to possible aspects of the socialization the patient underwent as a child that greatly influence his present attitudes and beliefs and even his medical condition.

More important is information concerning the adult patient's own family, the "family of procreation." The item currently used in hospitals, marital status, generally produces factual data only about the spouse. It reveals nothing as to whether there are children or grandchildren. Can one imagine a more immediate way to win the interest and liking of many persons than to give them an opportunity to talk about their children? This subject is a "natural" for helping to build or strengthen interpersonal relations, besides providing the information that in some instances may prove later to be of almost crucial importance.

Occupation and Recreational Interests

The frequent failure of the admitting office to provide staff with facts about the patient's occupation is symbolic of the heritage of the concept of the treatment of disease rather than of human beings. How much can doctors and nurses know about a person if they do not know how he spends half his waking hours?

Because one's occupation is a major source of self-identification for a large proportion of men and also for many women, hospitalized patients often feel that they have been torn loose from their moorings. Some testify to the fact that it would do them "a world of good" if the medical house staff would only make some reference to their work. They experience a sharp need to relate themselves, even through words, to their customary work ties.

Some persons identify themselves with their hobbies or recreational pursuits as much as with their work or perhaps more. Talking about their interests is a source of satisfaction; simultaneously it may permit staff to see another facet of their personality, or to be reminded of resources that can be employed to help them while away the time.

Education

Not to have data about this important item collected routinely is of the same order as failure to furnish staff with facts about occupation. Here is the essential key to what the patient will be likely to understand or not understand if technical terminology is used, and to methods of communication to be employed in health counseling and rehabilitation. Level and kind of education, furthermore, indicate something of the range of interests and outlook that the patient is likely to bring with him to the hospital. Thus they furnish staff with initial guidelines about how conversation can be directed, and aspects of the physical and social environment of the hospital used to evoke positive reactions.

Many doctors and nurses may take it for granted that they can tell all that is necessary about a patient's educational background from listening to the way he uses the English language and observing various personal habits. They sometimes forget that a country the size of the United States harbors considerable numbers of persons who are eccentric in language and behavior but who may be distinguished archaeologists, mining engineers, or night club entertainers, while other persons who "make a good appearance" are lacking in educational understanding.[1] They also forget that many large medical centers now serve persons from foreign countries who may be university graduates, but who speak English so badly or have habits so different from those of Americans that staff can mistake their identity much as the identity of the Vietnamese member of the United Nations Secretariat was mistaken.

Geographical Background

Place of birth and present residence, data almost always routinely collected, are valuable criteria for "placing" a patient, and they can often be put to a surprising variety of practical uses. A member of a hospital's personnel department was recently

[1] In its program of inservice training for new employees, a large chain of hotels has placed great emphasis on the fact that guests often cannot be safely identified by their appearance. It had been discovered that the patronage of leading industrialists or persons of wealth had been lost because some employee, in misinterpreting eccentricities of manner, had treated them as if they were penniless or ignorant.

heard deploring the fact that place of birth is no longer permitted by statute on application forms for employment in her state. "Had I only known," said she, "that a somewhat shy or anxious applicant was born in China as was I [both are Anglo-Saxon Americans] just think how I could have used that information to make the woman feel comfortable and to talk more readily while I had a better opportunity to assess her qualifications."

In a country where so large a proportion of people have recently moved from rural areas to cities or from urban homes to suburbs, the face-sheet data could well be supplemented with further information about the patient's geographical background. It will be seen later that facts about where the patient has grown up or spent an appreciable part of his life sometimes explain interests, habits, or values that otherwise appear unimportant or strange to staff who have had a different environmental background. Placing the patient geographically, furthermore, may suggest leads for comfortable conversation that has meaning for him, and that may result in his revealing feelings about his physical condition or his care that he would otherwise suppress.

Ethnic Background

Two exceedingly important determinants of human behavior, which have generally been omitted in any explicit form from the face-sheet data, concern the patient's ethnic or nationality background and his socioeconomic status.[1] If a patient differs appreciably in physical characteristics from the American norm, as do most Negroes, American Indians, Japanese Americans, Chinese

[1] Ethnicity refers to the cultural values and ways of behavior that the members of a group have learned and transmit to their children, and which serve to tie them together. We may speak of the populations of Norway, Sweden, and Denmark as representing three ethnic groups. Because of a broadly similar value and behavior system, however, we may also speak of the Scandinavians as composing one ethnic group when compared, for example, with the people of Latin Europe. Because of the large similarity not only in language but in general outlook found within some countries, the term "nationality background" has often been used as a rough equivalent for ethnic background. In those countries composed of many ethnic strains, such as the United States, reference to present nationality has limited practical usefulness.

Americans, and many persons of Latin American ancestry, staff make a mental note of that fact, and sometimes record it on the medical record unless a question about "race" has been included on the admission sheet. Doctors and nurses generally assume that there will also be cultural and socioeconomic variations from the norm, but they often have insufficiently broad or reliable knowledge about the nature, extent, and meaning of these variations to make positive use of such knowledge.

For patients who "look like Americans" questions about their ethnic background are rarely raised, although many of these persons may have preserved essential attitudes and values characteristic of the specific European area and social group from which their parents or grandparents came. Thus staff are not alerted to the possibility that in a particular hospital patients of fairly recent North German, Irish, Italian, and English ancestry, let us say, may react differently to the physical environment, the treatment regime, or even their own bodily discomfort. Because of reasons that will be discussed later, nurses particularly have been reluctant to ask patients about their country of origin. By not feeling free to get and use such information, even though it is generally known that most persons like to recall their childhood, they have lost invaluable opportunities to convince a patient that they were concerned about him and his welfare. They may perhaps have closed the door to obtaining further information requisite to meeting his psychosocial needs. Besides, they have lost the unexcelled opportunity provided them for gradually developing some understanding of how and why individuals come to be what they are.

So uncomfortable do many staff members find it to inquire about patients' social background or so difficult to visualize the potential importance of this procedure, that the following illustration is inserted here. It demonstrates how an occasional simple question can sometimes elicit extensive information, provide comfort and pleasure for the patient, and create satisfaction and intellectual stimulation for the listener.

A man sociologist about thirty years old, who was taking a course in fundamentals of nursing in order to understand more about the

role of the staff nurse, was assigned to give a bed bath to a patient of eighty. He greeted the old man by name and then asked with unmistakable interest if the name was Armenian. The question called forth a long story of where the patient had been born, what his childhood had been like under Turkish rule, how that portion of Armenia was now part of the Soviet Union, how Armenians had been Christians for many centuries, what his religion meant to him in his old age.

Both patient and sociologist were engrossed in the conversation, so engrossed in fact that the "nurse" was able to give his first bath to a person with broken-down tissue without the acute discomfort that many inexperienced nursing students suffer. As the sociologist was about to leave he asked the old man to bless him. With great dignity and depth of feeling, the elderly patient raised his gnarled right hand and in the Armenian language blessed the young sociologist who, in fact, was not a Christian but a Jew.

The old man temporarily had received total patient care of the highest order. Would he ever forget that nice young man who had given him a chance to recall his long life and had even asked him for a blessing! The sociologist was so elated from having been able to reach out with warmth and understanding to a stranger old enough to be his grandfather that he rushed to tell his nurse colleagues what had happened, and to report that he intended to visit that "wonderful old" man even if he were not assigned for further nursing duties.

Socioeconomic Status

Staff show a similar reluctance to place the patient explicitly within a socioeconomic frame of reference, even though they often place him quite correctly by inference in their informal conversations with colleagues. If the term "social class," which is much used by social scientists, is substituted for socioeconomic background, the reluctance increases. Race, ethnicity, and social class are frequently viewed as the "dirty secrets" of sociology, comparable to the dirty secrets of sex and aggression that psychoanalytic theory has emphasized.[1] It has been learned that there can be no profound understanding of personality without a willingness to consider the roles played by sex and aggression. Likewise, it will probably be learned that there can be no large understanding of human behavior unless there is willingness to

[1] Seeley, John R., "The Americanization of the Unconscious," *The Atlantic*, vol. 208, July, 1961, p. 7.

examine a cluster of determining factors generally characterized by the term "socioeconomic" or "social class."

Indication of a growing willingness to foster such examination appeared recently in an article in *Nursing Outlook* by Patricia E. Kariel.[1] In it she spoke very positively about the help that public health personnel could obtain in promoting desirable health practices from a knowledge of the psychosocial determinants of human behavior. Although all the determinants were important, she had discovered that socioeconomic status was particularly emphasized in several of the nineteen recent social science studies of health attitudes and practices that she had examined.

We hope to be able to demonstrate later in some detail that the application of knowledge about socioeconomic status can be as useful to the staffs of hospitals as to public health practitioners. It will suffice to note here that the social and economic style of life to which a person is accustomed decides in large measure his tastes, whether in food, clothes, home furnishings, or conversation; his work and recreational preferences; his choice of friends; perhaps even the denomination of the Protestant church or the branch of Judaism to which he belongs. To the degree that the service provided by the hospital is in congruence with his life pattern, the chances are greatly enhanced that he will be able to adapt himself to it with the minimum of psychological discomfort.

Patients who have been accustomed to many amenities experience strain and unhappiness if they find themselves in a hospital room that is sunless and drab in appearance, where privacy is lacking, and where staff may seem unmindful or even rude. On the other hand, if patient care is planned predominantly in conformity with the life pattern of the upper middle class, those large numbers of patients who have been socially and economically disadvantaged may discover that they are in an environment where almost everything, including the language used, is unfamiliar and stressful. To meet even the most immediate language, as well as psychological, needs of such patients poses a problem for staff who have been socialized into middle-class

[1] "The Dynamics of Behavior in Relation to Health," *Nursing Outlook*, vol. 10, June, 1962, pp. 402–405.

value systems. Doctors and nurses are frequently unable to perceive why some patients are upset, difficult, or do not recover as readily as they should, while others are overcompliant, too appreciative, and too uncomplaining.

A PROFILE OF THE PATIENT

The preceding section has noted six items of additional information that could profitably supplement the social data now generally available to ward staffs. Almost all of this information, in its bare outline, could be obtained readily by the admitting office. Even socioeconomic status, which has been listed as a separate item to emphasize its importance, can be determined easily with very considerable accuracy. As will be seen in a later chapter, it is only a composite index, generally obtained by combining the facts about occupation, education, income, and area of residence.[1] If these several items are added to those ordinarily appearing on the patient's chart, we shall have some such outline as the following:

Psychosocial and Cultural Frame of Reference

1. Age
2. Sex

} In their psychosocial, as well as their biological, aspects

3. Patient's parental family, or other relatives, or sponsor
4. Patient's own family, including spouse, children, and grandchildren
5. Occupation and income
6. Recreational interests
7. Education
8. Geographical background, beginning with place of birth and including present residence
9. Religion, including Protestant denomination or branch of Judaism
10. Ethnic background
11. Socioeconomic background

[1] The social service department of a mental hospital informs us that its staff are now expected to note the socioeconomic status of each family on its reports of home investigations. To determine status, information is obtained only about the occupation and educational level of the head of the household. Rough as is this assessment, the department declares that it has been of surprising value in emphasizing the importance of selecting foster homes that resemble the patient's background.

Even the merest facts about each of these items will, when combined into a composite whole, provide the physician, nurse, or social worker with an appreciable profile of the patient as a person and of his relationships with groups of other persons who are likely to play a significant part in his life. This information is sufficient to give the doctor or nurse the feeling that he is not meeting a total stranger for the first time; in fact, he knows a good deal about the person just admitted whom he is to see. With the greater self-confidence that comes from such knowledge, it should be much easier to initiate meaningful conversation with the patient, and to take a positive first step toward establishing a comforting and supporting relationship. Having succeeded with this first step, it should become progressively easier for both patient and staff to engage in the kind of talking and listening that provides relief for the patient and essential further information for staff use, and that permits later health counseling and rehabilitative measures a larger chance of patient acceptance.

EXPERIMENTAL USE OF OUTLINE FOR PATIENT ASSESSMENT

In the last chapter of this monograph, after having further explored the meaning of some of the items listed above, we shall attempt to say something more about how the outline can be used as a guide in providing care that includes attention to psychosocial factors. We must note here, however, lest readers think it a far too complex and time-consuming instrument for patient assessment, that it has evoked considerable affirmative interest as tried in the writer's workshops with nurses in administrative, supervisory, and teaching positions.

In recent years the writer has spent part of several classroom sessions discussing these nonbiological determinants of human behavior in their applicability to sick persons. Then she has asked each member of the seminar to visit a medical or surgical patient in some neighboring hospital or its outpatient service, and attempt to see how much could be learned about him that could be organized around these several items. The prospective visitor has been requested not to appear, if possible, to be conducting

a formal interview. Some thirty to forty minutes has been suggested as an appropriate length of time for this initial visit, unless the patient's condition or his interest in extended conversation indicated otherwise.

Without having the authority of their position in the home-hospital to support them, the most difficult part of the assignment for these nurses has been to visualize how to find a patient to whom they could pay a visit, and how to assume the role of a nurse-visitor without appearing in uniform. In some instances, anxiety has run high prior to the visit, and an occasional nurse has felt obliged to appear in a white coat at the nursing station where she consulted the head nurse about a patient she might see. This anxiety has undoubtedly prevented some nurses from using the allotted time to the best advantage. Many, however, have thought of simple, convincing, and gracious ways of introducing themselves to the selected individual whereby the stage has been set for easy flow of conversation.

On the day following the visit, those who felt that they had had an experience valuable to themselves or the patient have been asked to present a profile of the person to the members of the workshop. Generally about half the group have wanted to present their "case," and two or three have scarcely been able to wait for an opportunity to tell about the amazing experience they had had. In making their presentations many of the reporters found it almost impossible to describe the person first, before becoming involved in his medical condition and care; others discovered that they had forgotten at least one important item in the outline, or had not known how to direct the conversation to obtain the information. When these problems occurred it was difficult for listeners to see essential parts of the profile of the individual clearly, and the reporters were often interrupted by requests for further details.

Although the nurses were attempting this procedure for the first time, the visits have generally produced a surprising amount of useful information. Always there have been a few persons who have obtained data that both in quantity and quality elicited great interest and even astonishment from the group; obviously

this kind of knowledge about a patient went well beyond anything in their previous experience. Always some patient has been encountered who had such a need to talk that he poured out much of his life's history; one nun-nurse found herself unable to leave the bedside for two hours. In several instances, the visitors became so interested in "their patients" that they frequently returned to see them until the close of the seminar.

Because the writer has been unable as yet to pursue this experiment beyond its initial stage, no assessment can be made of what would have been accomplished had it been continued longer with each group. Several individual nurses have reported that they had had a taste of an enlarged way of becoming acquainted with patients, but that they needed considerable practice in the method, accompanied by classroom discussion and clarification.

Perhaps the most affirmative response has come from the members of a Protestant denomination that has long operated hospitals for disadvantaged groups in the United States as well as in technically underdeveloped countries. In several workshops, representatives of this denomination have asked for supplementary lists of readings about determinants of human behavior, and have commented, "Why haven't we had this kind of content before? It is just what we need to learn how to understand the people with whom we work."

TEACHING OF PSYCHOSOCIAL AND CULTURAL FACTORS IN PROFESSIONAL SCHOOLS

The plan for psychosocial and cultural assessment of patients that is presented here is focused at the point of clinical practice; and such testing as the writer has been able to give it has primarily involved nurses associated with the administrative and supervisory aspects of clinical practice.

What is quite as important as any attempt to interest practitioners in the use of this kind of behavioral science knowledge is the orientation of students to the psychosocial and cultural components of comprehensive patient care. Reference was made in the Introduction to the fact that a small but increasing amount

of social science is being taught in medical and nursing schools. However, sociology, social psychology, and anthropology are so broad in scope that many relevant subjects can be chosen for teaching purposes without necessarily emphasizing the factors under discussion here.

We wish, therefore, to refer to specific undertakings in three places, illustrative probably of others, where students are being given orientation to these factors. These undertakings suggest a possible trend that seems likely to increase as selected teaching materials are published. Consequently, within the next few years physicians and nurses may begin to come to the clinical situation with a sociocultural frame of reference more nearly comparable to the psychological orientation that they have already begun to bring.

Persons who have read Professor Frances C. Macgregor's *Social Science in Nursing: Applications for the Improvement of Patient Care*, have already had an opportunity to become acquainted with the way she developed the course offered at Cornell University-New York Hospital School of Nursing, and with a sample of the content.[1] Because of the close association she has maintained between the classroom and the clinical practice areas of the Hospital, she is able to show the interrelationships that have been effected between concepts presented in lectures and the students' clinical experiences.

For five years at Baylor University College of Medicine, Dr. Samuel W. Bloom presented a series of sociological lectures within the greatly broadened freshman course in Basic Psychiatry. His lectures focused considerable attention on the theory of culture and the practical applicability of knowledge about ethnic and social class factors to medicine. Dr. Bloom, who is now associated with the State University of New York College of Medicine, Downstate Medical Center, prepared his teaching materials for publication by Russell Sage Foundation and the volume was issued in 1963 under the title, *The Doctor and His Patient.*

[1] Russell Sage Foundation, New York, 1960.

At the new University of Kentucky Medical Center a department of behavioral science has been created for the express purpose of teaching students in the several health professions and of conducting research connected with medical and health problems. Recently, Dr. Robert Straus, chairman of the department, presented a paper that noted some of the assumptions on which the instruction rests. Readers may be interested in comparing the items listed by Dr. Straus within his theoretical frame of reference with the psychosocial and cultural factors that we have noted as determinants of the patient's profile.

> Man is a social creature and many of his needs are met through his interaction with other human beings. High in the hierarchy of sociological determinants of behavior one would list the behavior of his reference groups: his family, his age peers, those of the same sex, those belonging to the same social stratification group as identified by a cluster of social and economic variables, the residents of his neighborhood, the members of his church, his fellow employees or those engaged in the same occupation, and finally those persons who share a common cultural heritage as defined by ethnic or regional criteria.[1]

Obviously the frame of reference that is emphasized here—an exceedingly important one for all persons who work directly with other persons—is interaction between human beings. What one misses is reference to interaction with "things" as well as with human beings. In Part I of *Newer Dimensions of Patient Care* emphasis was placed on the fact that many individuals develop affection for and gain satisfaction from a long and varied list of things, whether pet animals, machines, personal possessions, or selected fragments of landscape. "To commune with nature," a phrase familiar to readers of nineteenth-century poetry, suggests something of the possible quality of nonhuman relationship.[2] There are persons for whom such relations may be scarcely less rewarding than are contacts with other persons. This is likely to

[1] "Sociological Determinants of Health Beliefs and Behavior," *American Journal of Public Health*, vol. 51, October, 1961, p. 1548.

[2] "All my life I have suffered from 'geographical emotions.' Places are almost as real to me as people." From Bryher, *The Heart to Artemis: A Writer's Memoirs*, Harcourt, Brace and World, 1962, p. 22.

be particularly true in the early and late years of life when there are associations with few persons except the family, or when those with former friends and relatives have been broken by separation and death.

Because the behavioral scientists have made so little examination of the nature and extent of relationships with "things," no body of theory or organized knowledge is available that would emphasize the importance of finding out what the meaning of things may be for the hospitalized patient. It should be taken for granted, however, that when a social assessment of the patient is being made and in later conversations with him, information needs to be sought about his entire supporting environment, both the human and nonhuman. The hospital may consequently permit or provide certain things, at least in symbolic form, that are particularly meaningful for him; often he will gain comfort and pleasure merely from talking about them.

Chapter 3

CULTURE, THE DESIGN FOR LIVING

AN INTERNATIONAL HEALTH EDUCATION team, sponsored by the World Health Organization, was attempting a demonstration of how malaria might be eradicated in one of the countries of southeast Asia. It decided to make a simple film strip that could be shown widely. Hence it sketched the story of a boy of fourteen who runs to the doctor's office, reports that his little sister is sick, and escorts the doctor to the home. There the boy asks many questions about his sister's malady; the doctor explains in language an adolescent would understand the cause and treatment of malaria, and how it can be prevented.

Once the sketch had been written in French or English, the native translators were asked to put it into the language of the particular country. Nothing happened. Repeatedly the health educators inquired what the difficulty was. Certainly the translators knew how an adolescent boy would talk, said the Westerners. Certainly they knew what vocabulary was needed to make the doctor's explanation understandable to persons with little education. Still nothing was begun and no reason was given.

The particular country is one where persons have been trained from childhood never to appear to criticize or make suggestions to persons in positions of authority. Therefore, it was only with the utmost difficulty that the health team succeeded in persuading the native translators to reveal the problem. Said they: "The script is not right. No doctor ever goes to a patient's house." With some impatience because of the delay over what seemed so small a matter, the health educators suggested that the situation could be easily remedied: the brother would escort his little sister to the doctor's office, where the conversation would occur. But

again there was no action and even greater reluctance to say what was wrong. At last under considerable pressure, one of the translators revealed the truth. No boy of fourteen would ever ask questions of a doctor; there would never be informal conversation between two persons so different in age and status. If the film strip were to be shown, said the speaker, it would not teach the people anything about malaria. What they would see in it was that Westerners were trying to make "nasty children" out of their boys!

A health educator from the Secretariat of the World Health Organization happened to be visiting this project when the incident occurred. He commented later to the writer that he had long held anthropology in the highest respect, and had learned much from reading about the concept of cultural differences. But he never expected to witness a scene that so reinforced his judgment that anthropology was not only important but indispensable. "Think of the irreparable harm that might innocently have been done," said he, "if that film had been made as originally planned and shown throughout the country."

CULTURAL PERCEPTIONS ABOUT HOSPITALIZATION

Let us turn now from this remarkable illustration of how peoples who have experienced different kinds of socialization may variously interpret the same evidence, to a consideration of how perceptions may differ about the desirability of hospitalization. Then we shall be in a better position to examine the theory of culture, and to explore its potential usefulness for persons engaged in the cure and the care of the ill.

In large parts of the world it has been taken for granted by the great majority of the population that the appropriate place to be when ill is in one's own home surrounded by the comforting love and attention of members of the family. To think of going to an unfamiliar environment to receive attention from strangers is scarcely tenable. As hospitals have been opened in such areas, this attitude has often been reinforced by the discovery that these institutions engage in practices that run counter to the com-

munity's well-established ways of doing things. Hence, were it not for pain, which forces persons into action that they would otherwise be reluctant to take, these hospitals might have had difficulty in recruiting patients.

Many of them, on the other hand, have attempted to modify their practices to conform to some of the local folkways and hence to patients' expectations. Thus they have often appeared more like a resident outpatient service than the inservice pattern familiar to us. Members of the family have been allowed to stay with the patient and to provide his food and his personal care. In countries where the population is so used to sleeping on the hard floor that beds cause great discomfort, patients have often been permitted to lie on mats or to sit cross-legged on the bed.

To Westerners, accustomed to the hospital as a place that emphasizes the values of great cleanliness, orderliness, and quietness, it must seem hardly believable that families and even patients should be allowed to sit and sleep on mats on the floor and perhaps cook in little pots on the earth just outside the patient's room. Many doctors, nurses, and laymen alike who have seen the film of Dr. Albert Schweitzer's hospital in Lambaréné, have been quick to comment on how unsanitary, disorderly, and primitive conditions appear. With time, money, and native labor it has often been possible, without destroying the value system of the community, for the hospital to ameliorate some of the more undesirable conditions by such simple expedients as constructing, on its grounds, cooking houses and places where families can stay.

However, the hospital model of the Western World, with its vast equipment for diagnosis and treatment and its concepts of efficient organization and management, is rapidly being extended around the globe by international agencies. Physicians and nurses from the technically underdeveloped countries who receive training in Europe and North America, moreover, frequently return with the desire to reproduce what they have seen in the "advanced" countries, regardless of whether it will most nearly meet the needs of their particular area. So greatly socialized into Western values have they become that they often

testify to the revulsion experienced upon their return when they see "dirty, unkempt" families everywhere. As a consequence, the trend is likely to be toward the displacement of families and the introduction of trained personnel (strangers) for providing patient care. This is occurring at the very time when some American hospitals are beginning to discuss the possible psychological value of the family-centered institution, and are struggling with initial reforms that would permit the family to play a somewhat larger role in the therapeutic program.

Cultural Efforts to Change Attitudes of American Indians

American Indians have had a dislike and often dread of hospitals similar to those experienced by the peoples we have been describing. The long separation from their families, which was formerly a result of hospitalization for the widely prevalent tuberculosis, exacerbated the dislike. Thanks to the recent increasingly successful use of drugs administered by clinics, the potential success of inoculation of children against tuberculosis, and the permission for hospitalized patients to spend more weekends at home, this situation is being improved. In addition, the United States Public Health Service, which is responsible for the operation of hospitals on the reservations, has been attempting to learn how to work within the cultural patterns of the American Indians, in the hope that the perceptions and emotional reactions of their clients might undergo change. Two efforts, as reported and interpreted by Professor Lyle Saunders, merit retelling.

> An important part of the opening ceremony [of the new hospital for Navajos at Tuba City, Arizona] was an Indian religious ritual in which corn pollen was liberally sprinkled throughout the hospital, where it remained for seven days—probably to the annoyance of all the non-Navajos on the staff. Permitting an Indian ceremony such as this in a hospital dedicated to modern medicine may have been soft-headed pandering to ignorant superstition. On the other hand, it may have been the most important single action of preventive medicine carried out on the Navajo reservation during the entire year. Corn pollen must seem an improbable therapeutic agent to most of us. But so might yeast-mold seem to a Navajo, although we

know that some yeast-mold products, when used under certain circumstances, are effective remedies. In the case of this corn pollen, however, the important thing was not its intrinsic properties, but its symbolic meaning as one element in a sacred ceremony. And its value lay not in what it did in the hospital, but in what its presence did in the way the Navajos viewed the hospital. This building might easily have become a place to avoid, an alien place of lurking danger that few Navajos would willingly enter. Instead, as a result of the ceremonial, it started off at least as a neutral place with an opportunity to prove its worth empirically.[1]

* * * *

One day last year, so I am told, lightning struck a tree close to an Indian Service sanitarium in Arizona. Very soon thereafter, the patients—all of them Navajos—began to leave the sanitarium against medical advice. The reason was a simple but compelling one. A place where lightning has struck is to Navajos a dangerous place, and the fear created by the proximity of such danger was enough to outweigh the threat to the patients' health and that of other people that might result from their leaving the sanitarium. The exodus was stopped before it reached serious proportions by an equally simple procedure. A Navajo "singer" flown from Window Rock in a chartered plane to help handle what was rapidly becoming a medical emergency, conducted a "sing" over the public address system of the sanitarium. This ritual action counteracted the evil influences released by the lightning stroke and by rendering the institution psychically sterile made it again a safe place for Navajos to be.[2]

Importance of Cultural Knowledge for Maternity Services

A hospital's maternity service provides illustration in many places of how specific procedures are engaged in that run counter to the established folkways of the community, and thus alarm if not alienate prospective patients. Its concepts and practices based on scientific medicine are often in sharp contrast to the complex patterns of beliefs, evolved over the centuries, that regulate innumerable aspects of pregnancy, childbirth, and the subsequent care of mother and child. Perhaps no part of ethnography makes

[1] "Relationships Between the Culture of the Patient and Nursing Care," *Bulletin of the California State Nurses' Association*, vol. 52, November, 1956, p. 323.

[2] *Ibid.*, p. 316.

more interesting reading than do these beliefs; little appears more steeped in superstition to educated persons without anthropological orientation to the world of benevolent or frequently malevolent superhuman powers or spirits. These powers seem always ready to bestow good fortune or destruction according to the faithfulness with which ritualistic observances of recognition, gratitude, or propitiation are practiced.

To suggest how detailed are beliefs and observances, we quote what the anthropologist Oscar Lewis has to say concerning only one small aspect of childbirth in a Mexican village. "When the afterbirth is expelled it is buried under the hearth. If it is carelessly disposed of or is eaten by a dog, the mother may die and the child's face may swell. . . . The dried cord of a first-born son is believed to be an effective cure for certain eye diseases. A child born in a caul is destined to become rich and the caul is saved for good luck."[1] When one realizes that such beliefs are numerous enough to fill many pages and, moreover, differ to some degree from village to village in the same country, the question may well be asked whether a hospital maternity service can hope to win the trust and confidence of an uneducated community.

Some years ago Dr. Isabel Kelly, an anthropologist working in Mexico under the Institute of Inter-American Affairs, prepared for discussion a memorandum suggesting various relatively simple procedures. She believed that hospitals might profitably undertake these procedures if they wished to gain the goodwill of pregnant women and particularly of the midwives who had long exercised almost complete control over counseling and deliveries. She began by referring to the importance of the disposition of the placenta, and to the practice of "some far-sighted hospital administrators" who, upon request, deliver it to the families to do with as they see fit. She concluded that this practice might well be adopted throughout the country. Her memorandum continued:

> Two problems relate to the umbilical cord. Sometimes, one finds a firm conviction that the ultimate size of an individual's genitals

[1] *Tepotzlán: Village in Mexico.* Holt, Rinehart and Winston, New York, 1960, p. 70.

depends on the length of umbilical cord left attached to the navel. The family is consulted by the midwife as to desired length, or there is an established measure, which, incidentally, seems considerably greater than that customary in normal hospital practice. When a delivery takes place in a hospital, clearly the family loses control of a matter that is believed to be of vital import to the newborn, once he or she attains adulthood. Particularly for a female, larger genitals are considered desirable to avoid difficulty in giving birth. Assuredly, in zones where this belief concerning the umbilical cord is current, it would not inconvenience the hospital unduly to allow the parents to stipulate the length of cord or to follow the measure dictated by local tradition.

In some instances, disposition of the stump may be a matter of considerable moment. Some groups believe it should be buried in a spot that fulfills certain conditions; or it may be exposed in a tree to rot. It may be carried by the father to some remote spot; if he throws it away at the home base, the infant will turn out to be timid. In one zone the cord is treasured, later to be used as a home remedy; should it be lost, the child will grow up to be improvident. In an area where disposal is a matter of concern, the hospital might be persuaded to turn the stump over to the family, provided it is sloughed off before the mother and child leave the institution.

The postpartal diet of a woman is rigidly prescribed by local custom. If she eats beans, the umbilicus will not heal; if she consumes certain foods, she will suffer from cramps. Some foods are considered injurious to both mother and child. The varied diet generally offered in hospitals often is not culturally acceptable. Such conflict may destroy the patient's peace of mind and for that reason actually cause physical upset. Foods, judiciously selected to accord with local beliefs, might make hospitalization seem less grim. [Dr. Kelly added in a footnote that in many hospitals diet presumably presents no problems, for the family supplies the patient's food.]

A second example of avoidance of conflict with culture patterns concerns the postpartal bath. In many parts of Mexico, special interest and significance surround it. Generally it takes place a stipulated number of days following birth; perhaps in a sweathouse or makeshift substitute; with specially prepared water, to which herbs have been added. Often it is believed that the patient will not regain full health until she has undergone the prescribed bath treatment, and the debilitating effect of a vapor bath probably is more than offset by the psychological aspect. In any event, as long as it is not demonstrated that the baths in question are actually harmful, it would seem eminently sound diplomacy not to attempt to change

the popular bath regimen. The midwives would be alarmed and their confidence shaken, and the populace assuredly would respond in negative form.[1]

Some readers will probably conclude that, interesting though these "foreign" customs may be, they have no relevance for patient care in this country except on the Indian reservations. Hence we wish to close this discussion of hospitalization as seen within a cultural context with an illustration by Dr. Margaret Mead of a representative American situation.

Margaret Huger, a nurse who was teaching the care of the patient "as an individual," realized (perhaps because she had been in the South Pacific during the war) that cultural differences might be important in understanding patients. So she went to the American Museum of Natural History to get a "chart of racial differences" which would explain, in one lecture, all that was necessary to know about different patients' backgrounds. She stayed to make an intensive study of what the hospital situation means to Italian Americans. It turned out to be a most exacting piece of anthropological field work. She went back to ward nursing. It took many months to accumulate enough Italian patients in the various hospital services, and all her interviewing and recording had to be done while she was carrying a heavy nursing load in a large understaffed hospital. But, because she did this, we were provided with a first model of what sorts of things had to be looked for. Now we can ask the necessary cultural questions and translate them into materials appropriate for nursing education or for the orientation of senior nurses going into new cultural situations, either in our own country or abroad.

The strains and anxieties that Margaret Huger found, varied from the Italian woman's sense of exposure if there was an uncurtained window on the tenth floor facing the sky (whereas "old Americans" worry about an uncurtained window only if someone can see in), to the terrible feeling of loneliness of the Italian woman who lost a baby and then had to face alone the possibility that she might never bear a living child. In the ordinary American scene today, where the answer to the question, "What will you do if you can't have children?" is "Adopt some, of course," we are not prepared for the agony of a woman to whom child-bearing is an absolute essential of

[1] Kelly, Isabel, "An Anthropological Approach to Midwifery Training in Mexico." Institute of Inter-American Affairs, Mexico, D.F., 1954, pp. 4–5. Mimeographed.

marriage, and to whom even temporary separation from the family is itself a trauma.[1]

THE CONCEPT OF CULTURE

The foregoing sketches have been presented to illustrate several generalizations that form part of the theory of culture, and thus to lay some foundation for a broader understanding of the cultural aspects of those factors appearing under the "frame of reference" described in Chapter 2. First, it must be obvious from these cases that there are "right" and "wrong" ways of thinking, believing, and acting, but that rightness and wrongness are not absolutes. Ideas about them differ sharply in various parts of the world. The group that holds to a particular way of doing something may be as large as a nation or even several nations. Often, however, it is only a small subgroup within the larger unit: "Fifth Avenue" versus the "Lower East Side" in New York City, or "Nob Hill" versus "Mission Street" in San Francisco are shorthand expressions for sharp variations in the life-ways of subgroups within the same city.

Second, most persons have been socialized from birth to take for granted that the way in which their own group thinks, believes, and acts is the right way. Hence they view differences in folkways or customs with a critical eye if not with aversion or repugnance. The Fifth Avenues of the world tend to dislike, ignore, feel uncomfortable with, or be sorry for the people who live "on the other side of the tracks," while the latter reciprocate, sometimes with profane scorn and hostility.

Third, unless the fact of cultural differences is accepted and an attempt made to learn about and view sympathetically the beliefs and customs of other groups, great damage to intergroup relations may result. Recognition that the customs of other peoples may have served their needs well in adjusting to and solving the problems of living, often permits the cultivation of positive interrelationships that are basic to successful therapy.

[1] Macgregor, Frances Cooke, *Social Science in Nursing*. Russell Sage Foundation, New York, 1960, pp. 82–83.

Such recognition and acceptance, however, are often very hard to achieve. Perhaps because of the seeming naturalness and "rightness" of the ways in which the members of a particular group have grown up and reached maturity, it frequently appears to be psychologically threatening to come face to face with representatives of other and unknown kinds of background. Hence the tendency is widespread to reject all differences with the statement that people are "pretty much alike underneath." Over and again on hospital wards this phrase is reiterated whenever there is the hint of a suggestion that individualization of care, based on a knowledge of the particular patient's cultural pattern, might be indicated. The opinion that all people are basically alike is heard even more frequently than the statement mentioned earlier that every patient differs so much from every other patient that no generalizations are possible.

The story told the writer by a pediatrician illustrates how alarming initially he found the behavior of men whose upbringing had been completely unlike his own, but how valuable to him later was the experience he had had. He had been reared in a home and sent to private schools and a distinguished private college where emphasis was placed on being a "gentleman," where aggression was channeled into competitive sports or other "acceptable" outlets, where intellectual and artistic interests were cultivated, and urbanity accompanied by independence of thought and judgment was encouraged. During World War II, before he was ready to enter medical school, he was drafted into the Army and sent to a training camp. For the first time he encountered a cross section of young American men. He spent at least three months, said he, simply attempting to "protect his skin." He found it necessary to learn a totally different behavior pattern as rapidly as possible. His customary way of saying at the table, "Please pass me the potatoes," was sufficient to produce loud jeers because of his Boston accent and his politeness that the men interpreted as "sissiness" or worse. He discovered that one grabbed for the potato dish, and if it was beyond reach, one demanded it emphatically perhaps with the help of a little profanity. Although he was handsome and well-proportioned, the fact that he was somewhat below average height contributed to his vulnerability to physical as well as verbal attack.

The degree of aggression and overt hostility of these men, but simultaneously their psychological dependency upon the "buddy

system" and upon the authority figures against whom they continuously griped; the lack of social amenities and of interest in ideas; the poverty-stricken vocabulary and the endless talk about "women" and sex—all these were startling and shocking to him. On the other hand, he came to see that he must appear to them widely deviant from their image of what constituted appropriate masculinity, and that their very aggressiveness had probably been an asset in their social environments.

Years later when he found himself an intern and then resident in the outpatient department or on the wards of hospitals that served a cross section of a city's population, he discovered that he knew how to talk with ease to patients like the men in service. He maintained that had he not had the earlier experience, many of these patients would have been unable to "hear" him, because his politeness, well-modulated voice, and relaxed manner would have signified to them weakness and indecision if not effeminacy. Hence, as pediatrician, he made a great point of telling fathers (in families where the man is the authority figure) in a somewhat loud, aggressive tone and in the vernacular exactly what he wanted done for a sick child. These fathers could not only hear and understand him, but he believed they gained comfort and support because "that doctor" knew "what was what."

As the foregoing example suggests, great gulfs to mutual understanding often separate human beings, and consequently far more than token efforts have to be made to bridge these gulfs.[1] Anthropologists see in the concept of culture a possibly helpful means for building such psychological bridges, thus reducing the tendency to fall back on the rationalization that beneath the exterior people are much alike. They also see in it a means for formulating generalizations broadly applicable to groups of persons, so that the therapist does not have to assume that each patient is quite unlike every other patient.

The theory of culture was initially developed by anthropologists as the result of study of the life patterns of peoples around the world; it has been adopted by the other behavioral sciences, greatly elaborated, and viewed by them as having large practical usefulness in explaining why various groups behave as they do in "advanced" as well as in "primitive" societies. Some years ago

[1] Hall, Edward T., Jr., "Orientation and Training in Government for Work Overseas," *Human Organization*, Spring, 1956, p. 9.

when Stuart Chase, an economist by training, wrote *The Proper Study of Mankind*, which attempted a popular interpretation of what social scientists had learned about human relations, he designated the "culture concept" as "the cornerstone of the study of behavior,"[1] devoting several chapters to it.

Many social scientists have sought to define this concept briefly and simply. For example, culture may be thought of as "the total way of life of a people, the social legacy the individual acquires from his group. Or culture can be regarded as that part of the environment that is the creation of man."[2] One can conceive of culture in its long historical perspective. As such, it is everything that man has come to know and has transmitted to others from the time he discovered how to make fire and use language; to the time when he learned to plant seeds for food, improve his weapons, and create the wheel; to the present when he is able to build vast cities, develop an elaborate technology and economy, fashion complex political, educational, and religious institutions, and run hospitals capable of caring for a thousand patients under one roof. One can also conceive of specific geographic cultures, such as French, American, Chilean, or Chinese, some of which differ in little more than language and relatively minor ways of thinking and acting, while others are almost incomprehensible to one another.

For practical purposes of patient care, it is not enough to think only of a national culture pattern; it is essential to recognize that many and significant variations exist within any country that is heterogeneous in population. Regardless of the fact that advanced forms of transportation and communication have done much to break down isolation and dissimilarities in the United States, people who live in the sparsely settled mountain areas and those who live in the larger cities of the Eastern Seaboard may have appreciably different interests, subjects of conversation, work habits, and leisure-time activities, values concerning what is important and unimportant, and even attitudes about sickness

[1] Harper and Bros., New York, 1956.

[2] Kluckhohn, Clyde, *Mirror for Man*. Fawcett Publications, Greenwich, Conn., 1957, p. 20.

and its treatment. Such variations may require differential methods of patient care if therapy is to be of maximum effectiveness. Similarly, variations among ethnic and racial groups, the several social classes, and some of the religious subgroups are much too important to be ignored.

Culture as a Blueprint of Group Living

The culture pattern of any group of people is a kind of blueprint of all its life activities. The individual learns this blueprint, largely unconsciously, through his childhood experiences in the family and progressively through his contacts with teachers, playmates, members of his church and other community organizations, his fellow workers, and persons of the opposite sex. As Dr. Andie L. Knutson has written:

> Present knowledge concerning the role of heredity and environment in human development leads to an unequivocal rejection of instinct explanations for social motivation, social beliefs, social attitudes, or social behaviors. The child is not born with a set of values, nor with a pattern of goals, nor with a set of rules of human conduct, nor with a sense of love, affection, or trust for other human beings. These are man-made things that are imparted to him in early childhood. Children learn to be clean or to be dirty, to be active or sloven, to be cooperative or competitive, to be submissive or aggressive, to be tender or cruel. They learn to love and to hate, to share and to steal, to run or to fight. Their health behaviors, no less than other behaviors, are acquired.[1]

By the time the individual reaches adulthood he has a vast amount of detailed knowledge about how he should act or refrain from acting in situations similar to those in which he has grown up. He has also a system of values by which he judges what is pleasant, desirable, appropriate, right, or the reverse.[2] From the plant and animal life available he will know what is good to eat.

[1] "Psychological Basis of Human Behavior," *American Journal of Public Health*, vol. 51, November, 1961, p. 1704.

[2] "It is almost as if our minds, own personalities, became a forum in which the influences, the behavior, the ideas and attitudes of various people with whom we have been somehow in close contact were again and again acted out and relived." From *A Study of Interpersonal Relations*, edited by Patrick Mullahy, Hermitage Press, New York, 1949, p. xx.

If he is an American, he will scorn snails; if he is French, he will consider them a great delicacy. Without even thinking, he will know how to handle many tools and gadgets. Only if he is left-handed and hence obliged to struggle with how appliances work, will he perhaps discover that he lives in a right-handed culture. He will have learned how to talk to men of his own age, to those younger and older, and to women of various ages and backgrounds. He will reflect the attitudes of his group about what is suitable masculine behavior, about the importance or lack of importance of privacy, and whether he feels free to admit, if able to stand on his feet, that he is sick. Probably his culture will even define for him whether he should take patent medicines or home remedies, consult a druggist, or go to a doctor; it will have presented him with an image of what physicians and nurses are like and how he should behave in their presence.

The student of society never fails to marvel at how complete is the blueprint offered the members of a group.[1] All of its details are so interwoven, moreover, that the resulting pattern has been characterized as the seamless web.

Consequently persons experienced in thinking in terms of cultural blueprints, if told a few key details, can often reconstruct a relatively accurate picture of the life pattern of the particular group. These blueprints have the greatest utility, since they generally represent the codified solution of innumerable problems. Were it not for them, a person would spend his time from morning until night trying to make hundreds of minor decisions that he now makes automatically, thus freeing him for supposedly more important matters. On the other hand, if a person has been thoroughly socialized into the cultural pattern of his group, he often experiences great difficulty in breaking the stranglehold on him of even minor details of the blueprint.

Some years ago, for example, several leading financiers from one of the Wall Streets of America decided that they would discard their

[1] In 1906 Ginn and Company, Boston, published William Graham Sumner's *Folkways* which has never been out of print and since 1960 has also been available as a Mentor Book. This great classic of folkways and mores around the world has had a profound influence upon the thinking of the educated laity, as well as upon anthropological theory and field research.

white collars and wear more comfortable and cooler clothing during the hot summer; they would, in fact, come to their offices in dressing gowns. Although their robes were becoming, with the fine tailoring and the beautiful material, and the men had the psychological support of each other, some of the wearers were unable to outlast the stares of the crowd for even one day. No one came to his office thus dressed a second day.

If learned ways of thinking and acting can be so firmly embedded, the important question arises of how change is achieved. People have found it relatively easy to accept new technological developments—such as the gramophone, radio, and now television—the value of which can be objectively tested and verified. These developments often bring other changes in their train. Thus the automobile has broken down the isolation of rural areas, permitted urban dwellers to become suburban, encouraged wide-roaming vacations, and largely replaced the living-room as a desirable place for "dating." As a consequence of technological developments and their concomitant results, change appears in many places to be extensive and rapid. Americans, in fact, think of themselves and are thought of by other nations as liking and promoting change.

We cannot afford, however, to be deceived by these aspects of change. It is far more difficult and slower to alter attitudes and values that are strongly rooted and less readily verifiable about religion, marriage and the family, the two-party political system, or health habits and medical scientific knowledge. Regardless of extensive educational campaigns, some groups still "know" from their cultural blueprints that cancer and tuberculosis are inherited; that it is folly to assume that fluoridation of the water supply is not only harmless but reduces dental caries. In some groups, enuresis among children, obesity among middle-aged women, and alcoholism among men are considered more or less normal. In others, they are viewed as the manifestation of an underlying personality disorder that warrants medical attention.

Both the diversity of these cultural blueprints and the resistance to change of some of their component parts present severe problems for persons in the health professions. The therapeutic

role demands, first, that practitioners, if they seek to be more than technicians, try to understand their patients; it demands, second, that they frequently try to produce attitudinal changes in those under their charge. In similar fashion public health personnel need to learn the value systems of entire communities in which they are working if they even hope to gain acceptance for their programs. Yet professional schools have thus far given students little help in examining the theory of culture and its practical usefulness. Except in those few medical, nursing, public health, and social work schools where fairly extensive work in the behavioral sciences has been introduced during the past decade, the observations of a sociologist concerning one relatively progressive medical school may be considered typical.

> The concept of culture was generally restricted in its application to persons with beliefs and practices that would seem unusual to the majority of medical students and doctors. Preceptors used cultural interpretations most often to explain the behavior and attitudes of persons belonging to minority groups, such as migrants from the South, Negroes, and Japanese. The concept was hardly ever applied to explain the dynamics of thinking of medical students, of the medical profession, or of a hospital.[1]

THE DOMINANT PATTERN OF AMERICAN CULTURE

So pervasive is the impression that culture is "something other people have" and so overweighted were illustrations at the beginning of the chapter with just such a picture, that some brief consideration must be given in this closing section to the dominant cultural pattern of the United States. It is the pattern into which a considerable proportion of health practitioners and of the American population have been socialized. Because it is the dominant one, many persons and groups, whose own original value systems did not differ radically, have attempted to incor-

[1] Eaton, Joseph W., "The Social Science Content of a Medical Curriculum," *American Sociological Review*, vol. 21, October, 1956, p. 615.

Parts 1 and 2 of the writer's *Newer Dimensions of Patient Care* may be viewed as a description of some aspects of the cultural pattern of the general hospital in the United States, and of the attitudes and behavior of its practitioners that are the result of the kind of socialization they have received.

porate it in part or in full. Moreover, it has consistently furnished a baseline against which variations or deviations from it are almost always measured.

The dominant or norm-making pattern has been set, though far less incisively now than at one time, by the white, Anglo-Saxon, Protestant middle class. An extensive social science literature has been devoted to a description of its characteristics. Here we shall note important items that were selected from this literature, without regard for order, to give students in a sociology course at the Columbia University-Presbyterian Hospital School of Nursing some picture of these characteristics.[1]

Occupational success and achievement
Hard work and stable employment
Thrift, piety, punctuality, respectability
Monogamous marriage, marital fidelity, family support and concern
Educational achievement
Respect for law and order
Concern for private property, home ownership
Protestant church affiliation
Membership in voluntary associations, such as clubs, committees, lodges, etc.
White skin color
Cleanliness and order
Love of country

At the Harvard University School of Public Health, Dr. Benjamin D. Paul, an anthropologist, devoted attention in lectures for several years to the dominant system of American values. In his presentation he placed less emphasis upon the ethnic group that was the original important norm-maker and more upon the system that evolved, which has been subscribed to, altered, and reinforced by other groups as well. Some of the ideas in the following paragraphs have been taken from the paper he prepared for his students under the title, "Values in American Culture."

Obviously many of the characteristics of the dominant culture pattern result from the early history of this country. They reflect

[1] Reproduced from the mimeographed course materials prepared by the instructors.

the heritage of the people who came from northern Europe to the New World; the incentives and struggles of life on the frontier that was forever being pushed farther westward; the social adjustments that were made to vast immigration (both forced and voluntary), to the desire for horizontal and also vertical social mobility, and to the innovations prerequisite to achievement. The "Protestant Ethic" in which most of the early settlers had been socialized appears to have emphasized the desirability not only of piety, but of thrift, hard work, private property, and achievement.[1] Life on the shifting frontier promoted strong individualism, distrust of public authority, continued movement, and the nuclear family of procreation rather than the extended family characteristic of many older countries. Neighborliness and, later, membership in a burgeoning array of fraternal, social, and philanthropic organizations provided diversion, mutual help, and companionship to replace some of the assets of the extended family.

Individualism or the supposed right to shape one's own destiny was extended even to the concept of romantic love. Instead of marriages arranged by parents or other persons, it was generally believed that everyone was entitled to fall in love with and marry whom he pleased. The conspicuous strain toward social conformity, however, that has also characterized the middle class in America, has effectively kept apart many young people

[1] In his paper, "Child Rearing, Culture, and the Natural World," published in *Psychiatry*, vol. 15, August, 1952, pp. 267–270, Dr. Jules Henry sought to demonstrate that mothers' child-rearing practices, even while in the hospital, reflected some of the values of the dominant culture. In the maternity service under study, regular feeding periods of forty-five minutes were prescribed for each infant; babies could not leave the hospital until they had regained their birth weight. This regime emphasized efficient feeding in regard both to expeditiousness and to amount of intake.

Nearly 500 utterances of mothers to their babies were recorded, of which 32 per cent contained "Come on," the characteristic American expression for urging a person to do or achieve. ("Come on, wake up"; "Come on, you've got to drink more than an ounce"; "Come on, open your mouth"; "Come on, show off for the lady.") Twenty-seven per cent of the utterances, often accompanied by patting, pulling, or pinching the baby, were concerned with keeping him awake in order to suck. They contained "Wake up" or some related phrase, reminiscent of the dominant culture pattern in which people to be successful are expected to be "wide awake." ("O.K. Let's get going. Wake up, quit going to sleep, hey.") In decreasing order of frequency were other utterances pertaining to quantity or speed; utterances in which adult wishes were opposed to the baby's wishes; and utterances pertaining to achievement, work, failure, or success of the baby or the mother.

from different socioeconomic or ethnic backgrounds who might otherwise have thought that they were "meant for each other."

So great has been this strain toward conformity, in fact, that psychiatrists and clinical psychologists frequently encounter persons who are worried because they are *not enough like* other people, while many comparable Europeans would probably be worried because they were not more different from others.

Closely related to the desire for being, or at least appearing, successful has been a continuing belief in progress strong enough even to attempt to "harness nature"; optimism that everything was bound to come out well in the end if not at the moment; and an interest in *doing* something if only for the sake of action.

Chapter 4

ETHNIC BACKGROUND

A Polish-American patient, who was suffering intractable pain, had taken it for granted that if he were very sick he would be given massive doses of individualized attention, including a nurse's hand on his forehead or an arm around his shoulder. (Although he was born in the United States, this expectation was apparently in accord with practices in the part of the country from which his parents had come.) When he received no such attention in the particular hospital, he concluded that all the staff disliked him. As a result, said he to the social scientist interviewing him, he knew his discomfort was much worse than it would have been otherwise. When the interviewer reported what he had learned, the doctors and nurses were amazed and distressed. They decided they did not know how to give the kind of care the patient wanted, and hence had him transferred to the psychiatric service in the hope that the staff there would be able to do better. For this patient, who already felt rejected, the transferral must have seemed like the final act of rejection!

The foregoing illustration points to the dilemma encountered by many members of the health professions who, regardless of potential interest, are unable to individualize care for some of their patients because they rely for guidance upon the blueprint provided them by the dominant cultural group into which they have been socialized. However, large numbers of patients—even the majority in some of the public hospitals and health agencies—may have had other kinds of blueprints of appropriate or expected behavior as their heritage.

Consequently, this chapter must give at least brief attention to some portions of the population who immigrated to the United States from geographical and social settings that were quite different from those of the early settlers, and who generally arrived

after the dominant pattern had already been set. The purpose of the initial descriptive sections is to recall to the reader who these groups were and the nature of the economic and social problems they discovered upon arrival. Such a description may help to make more understandable some of the psychological problems that the newcomers and also the dominant group experienced in the process of social interaction, and many of which, at least in residual form, still continue to plague both groups.

Only as these problems are understood, intellectually and emotionally, are persons who provide patient care or plan health services in a strategic position to individualize care or to offer services that are most readily acceptable to their clients. Thus this chapter on Ethnic Background, like the following one on Socioeconomic Background, is intended as an introduction to the subsequent discussion of current social science studies that demonstrate how important are these psychocultural factors in determining the kind of health services available and patients' reactions to them.

GROUPS FROM EUROPEAN BACKGROUNDS

In *The Uprooted: The Epic Story of the Great Migrations That Made the American People*, Oscar Handlin, son of Russian immigrant parents and now professor of history at Harvard University, writes about emigration as the central experience in the lives of millions of persons who arrived in the United States before the Congressional Act of 1924 almost closed the door to further entrance of eastern and southern Europeans.[1] As in a dramatic prose poem, Dr. Handlin describes the broken homes, interruptions of a familiar life, and separation from known surroundings; what it meant to become a foreigner, to cease to belong to a closely knit village community, and to see one's American-born children grow up often resentful of paternal authority and long-established family customs.

[1] Little, Brown and Co., Boston, 1951; also available in Grosset's Universal Library paperback edition. This book is particularly recommended because it focuses upon the meaning of uprootedness for the immigrant rather than upon the more customary theme, the impact of the immigrant upon American society.

The groups whom the author describes were peasants stretching all the way across Europe to Russia and southward to the Mediterranean. They were the Irish, Poles, Lithuanians, Czechs, Slovaks, Greeks, Croatians, southern Italians including Sicilians, and many others. For centuries they had been the backbone of a continent, and regardless of radical political and social upheavals they had remained almost unchanged. Although they would have been called small farmers or sharecroppers in this country, they lived in villages of which every family was an integral part and where many families were interrelated by marriage. The village's largest and most important building was the Church, often Catholic rather than Protestant.

The unexpected, vast increase in population subsequent to 1750 and the resulting stark poverty, finally forced these peasants to leave their homes and villages and start the hard trek to America. Here, they huddled for years in ghettos of eastern cities where steamships disgorged them from the steerage, or in the expanding mining and industrial communities of Pennsylvania, West Virginia, and the Great Lakes. Almost always they settled where they could live with members of their own ethnic background, perhaps even of their village, who had preceded them.

Besides the peasants there was another large group that came from Europe, namely, the Jews. They were not a nationality group, since they were found in varying numbers in almost every country. They could be characterized as an ethnic group to the extent that they had preserved a remarkable amount of their own ancient heritage, but they had also taken on many aspects of the culture of the particular country in which they lived. Unlike these other immigrants they were not people who worked the land. In eastern Europe especially, many of them lived in largely self-contained villages and city ghettos where they were engaged as craftsmen and small shopkeepers, and where their religion as set down in rules in the Torah regulated almost every aspect of their lives. So great was the anti-Semitism in Poland and Russia that uncontrolled attacks on Jews were frequent. After each of the "pogroms" of the late nineteenth and early twentieth centuries large numbers from those countries migrated to the United

States where they initially experienced much the same hardships as the peasants.

In western Europe where by the nineteenth century there was little overt persecution but varying amounts of discrimination against them, Jews tended to live in the large urban areas. Frequently they occupied important positions in business and industry, the professions, and university teaching and research. Many relinquished their ties with orthodox Judaism but not necessarily with other aspects of Jewish culture, such as preservation of their psychological and social identities as Jews, placing a high valuation on educational and intellectual pursuits and on achievement generally; maintaining a strongly knit family and kinship system; and having a marked sense of obligation to the elderly, sick, and less fortunate among themselves and even among other groups.

Migration of such Jews was small until the 1930's when national socialism turned virulently against all members of "the Jewish race,"[1] including those in Germany and Austria where they had become more completely assimilated into the life of the larger society than elsewhere in Europe. As a consequence, the United States suddenly experienced a considerable influx of Jews and some few non-Jewish political exiles from the Nazi-dominated countries. Among them were outstanding physicists, chemists, and mathematicians; physicians, jurists, and architects; playwrights, composers, novelists, and theater producers. Because of their educational background and general sophistication, these persons were able to make a rapid and often highly successful adjustment to life in a new country. As a consequence, they present few special problems for the health services, and some of them are even contributing notably to the expansion of these services.

THE SPANISH-SPEAKING GROUP

Persons characterized as Spanish-speaking constitute another group of appreciable size in some parts of this country. Although

[1] There is, scientifically, of course, no such thing as a "Jewish race."

their roots were originally in Europe, relatively few have come directly from Spain. Instead, the Spanish went to Latin America where they intermarried with the "indigenous" Indians. More than three hundred years ago a few of them began to settle in parts of Mexico that were later annexed to the United States. Their descendants are the some half-million Spanish Americans, living mostly in New Mexico and Colorado, who view themselves as "old stock" Americans and are not to be confused with the relatively recent Mexican-American immigrants. The latter are those, or their descendants, that came predominantly between 1900 and 1930; their number is approximately 2,000,000 and they live chiefly in Texas, Arizona, and California where many of them still find their social and economic condition precarious. In addition, are the Mexicans, primarily in the industrialized agricultural areas of Texas and California, who enter the United States either under contract arrangements or illegally as migrant laborers and supposedly return to Mexico at the close of the harvesting.[1]

The other large branch of the Spanish-speaking are the Puerto Ricans. Country laborers, who lacked land and could find neither employment nor places to live in the cities of Puerto Rico, began coming to continental United States in the hope of bettering their lot. During World War II there was such demand for labor that their numbers greatly increased, and since the initiation of cheap air transportation have been further augmented. Inasmuch as they are American citizens they are free to enter and leave as they see fit, and movement back and forth between the island and the mainland is extensive. Although governmental efforts have encouraged a considerable segment to settle in agrarian areas of several states, New York City has always had

[1] For an excellent discussion of these three groups of Spanish-speaking people, their ways of living, their attitudes toward disease and its cure, and the problems they pose for "Anglo" physicians, nurses, and social workers, see Lyle Saunders' *Cultural Difference and Medical Care*, Russell Sage Foundation, New York, 1954. For a detailed study of the social forces contributing to health and sickness in one California community, see Margaret Clark's *Health in the Mexican-American Culture*, University of California Press, Berkeley, 1959. Persons interested in obtaining a picture of representative family life in rural and urban Mexico will find highly readable, *Five Families* and *Children of Sanchez*, both written by the anthropologist Oscar Lewis, and published by Basic Books and Random House, New York, 1959 and 1961, respectively.

by far the largest proportion, probably now about three-quarters of a million.

In spite of the greater amount of official and private assistance available, adjustment to a new life has perhaps been almost as difficult for the Puerto Ricans as for the earlier peasant immigrants from Europe. The latter were white in color and, although little educated, were often closer to the European tradition on which this country was built. The great majority of the Puerto Rican arrivals are unprepared for urban living, have few usable skills, speak English badly, and have varying admixtures of Negro and Indian blood. Hence they find themselves obliged to take undesirable and poorly paid jobs, and they live in crowded, dilapidated, and bleak tenements in rundown sections of the city, except for those who have been provided with apartments in the extensive public housing developments.

Poverty and the conditions of economic adjustment have distorted their family value system. Frequently the women find it easier to secure jobs than do men. For a woman to become a wage-earner while her husband is idle puts a severe strain on the Spanish concept of the man's role as head of the family.[1] Households are often divided; either the husband or the wife may come to New York according to reports of availability of work, while the other remains in Puerto Rico.

Although counted by the Bureau of the Census as white, the darker skinned individuals meet with many of the same discriminations as do the Negroes in finding desirable housing, employment, and recreational centers. Because of their color and language difficulties, they frequently do not feel at home even in the Catholic parishes and parochial schools, and they have been unable to find a comfortable place for themselves in the Negro churches that are predominantly Protestant, or in the Negro social centers.

Many of these generalizations would be equally applicable to the Mexican Americans of the Southwest. It should be noted

[1] The psychopathology resulting from reversal of sex roles, as found in a sample of Puerto Rican families, is described in Marvin K. Opler's "Ethnic and Class Subcultures and Child Care," *Social Problems*, vol. 3, July, 1955, p. 14.

emphatically, however, that a wide range of concerted efforts is being made by public and private agencies to resolve some of the difficulties encountered by the Puerto Ricans and Mexican Americans. Probably the single most important agency continues to be the public schools that attempt to provide all children (and some adults) with the necessary language tool and also with a working knowledge of cultural norms.[1]

GROUPS FROM NON-EUROPEAN BACKGROUNDS

Except for the Spanish-speaking, the groups thus far described are of European origin, and are popularly referred to as members of the white or Caucasian race when comparing them with persons from different biological backgrounds. We must now turn to groups within the United States who stem from a completely non-European background, and whose color of skin and other physical characteristics bespeak their origins in Asia or Africa. They include chiefly the American Indians, "Orientals" from Asia and the Pacific Islands, and Negroes. By biological inheritance these groups are designated as members of the Mongoloid or Negroid races. The terms are not very helpful, however, since mixture of races has been extensive and since social and cultural learning appears more important in determining ability to adjust to life conditions than do such inherited group characteristics as science thus far has been able to isolate for examination.[2]

American Indians

The Indians whom the Europeans found upon their arrival are probably not indigenous to the New World, but migrated at some early period from what is today known as Asia. Before the

[1] For an interesting description, based on extensive anthropological field work, of the ways of life and changing culture of Puerto Ricans in a New York slum, including a chapter on "Health and Life Stress," see Elena Padilla's *Up From Puerto Rico*, Columbia University Press, New York, 1958; for a picture of how sickness and health are related to the cultural, physical, and emotional facets of the environment of this slum area, see Dr. B. B. Berle's *Eighty Puerto Rican Families in New York City: Health and Disease Studied in Context*, Columbia University Press, New York, 1958.

[2] For a brief discussion of the problems encountered in the concept of race, see Gordon W. Allport's *The Nature of Prejudice*, Doubleday Anchor Books, Garden City, New York, 1958, pp. 106–111.

United States government set aside land for their use, many of them had died as the results of wars, hardships, and disease. Popular thinking has so identified the Indians with living on reservations that many persons fail to realize that large numbers of individuals have become assimilated into the national life until they are scarcely recognizable as members of a separate cultural group. Surprise is often expressed when one discovers that much of the steel construction of New York skyscrapers is done by them, or when one encounters them in an urban setting, such as the San Francisco Bay Area with its perhaps 10,000 Indians, where their clothes and behavior suggest that they may never have seen a reservation.

It is those who choose to continue to preserve their identity and distinguishing ways of life as Indians that live in pueblos in isolated parts of New Mexico and Arizona or on the often desolate land that was made available to them. Although now increasing in numbers, they constitute an insignificant fraction of the country's population. Yet they have long attracted attention out of all proportion to their numerical size: some white persons still cling to the earlier romantic notions of the "noble savage"; others have frank curiosity about ways of living, thinking, and acting that seem very strange but fascinating to them; while still others feel in conscience bound to try to redress the often sorry record of the white man's dealing with them.

The significant contribution of the Indians to World War II, whether on the fighting fronts or in essential industries, has given many of the men now in middle life a wider knowledge of other cultures and the desire for appreciable modernization of the economy and the educational, health, and welfare services of the reservations.[1] Simultaneously, increasingly larger segments of the federal service and of private organizations concerned with Indian affairs are attempting to understand the aspirations of this group and to encourage developments that are acceptable to its members.

[1] One of the 31 persons upon whom the late President Kennedy conferred the new Medal of Freedom is the exceptional Annie Wauneka, who has worked assiduously to improve health conditions on the Navajo Reservation and is chairman of the Navajo Tribal Health Committee.

How difficult such understanding may be for Caucasians to achieve was suggested by the two incidents, reported in the previous chapter, where efforts were made to allay the Navajos' fear of hospitals. It can perhaps be glimpsed from a mere statement such as the following: In Indian eyes being sick means that the person is out of sorts with his environment, whether that environment be an animal, a tree, or another human being.[1] Fortunately, health personnel who go to the reservations to work now have at their disposal a large, useful literature that was unavailable until recently, which deals not only with the patterns of thought and action of the various Indian tribes,[2] but with the development of more insightful health programs.[3]

Peoples of Oriental Ancestry

Although the number of persons in the United States popularly spoken of as members of the yellow or brown race is small, the experience of the Chinese and Japanese who constitute relatively large groups is particularly instructive. It illustrates so incisively the kinds of problems that could be encountered by people of non-European culture and physical appearance in gaining acceptance and a stable foothold in America that more space must be given to a description of that experience than would otherwise be justified. Even the briefest record demonstrates that the Chinese and Japanese have not only had to face the prejudice of local individuals and organizations but official restrictions imposed by federal or state governments; the record demonstrates also that the dominant American culture has at times been

[1] Cross, Jeri, "The Doctors' Wax," *The Indian Progress* (Boulder, Colorado), July 23, 1962, p. 3.

[2] As illustration of this kind of literature, see *Children of the People: The Navajo Individual and His Development* by Dorothea Leighton, M.D. and Clyde Kluckhohn, Ph.D., Harvard University Press, Cambridge, 1948; also *Sun Chief: The Autobiography of a Hopi Indian*, edited by the anthropologist Leo W. Simmons, Yale University Press, New Haven, 1942.

[3] See Bernice W. Loughlin and Ellen Mansell's "Training Health Workers on the Navajo Reservation" in *Nursing Times* (London), vol. 55, January 30, 1959; also articles currently appearing in medical and public health journals on the recent experimental program of the medical clinic at Many Farms, Arizona, operated under the supervision of Dr. Walsh McDermott, head of Department of Preventive Medicine and Public Health, Cornell University Medical School, and with the assistance of Dr. John Adair, senior anthropologist.

sharply torn by dissensions about appropriate policy and forms of action. Finally, note must be made of social science studies now beginning to appear that indicate the probability that the process of acculturation has produced problems particularly of an attitudinal and emotional nature among the Chinese and Japanese Americans of which the health professions need to be cognizant.

Shortly after the discovery of gold in 1848 in California, some thousands of Chinese men fled from the famine and political chaos of their country to work in the gold fields. It was their intention to earn modest fortunes and then return to their wives and children at home. When the country that had welcomed their arrival later deprived them of the right to mine gold or own land, more of them than formerly worked as cheap contract labor in building railroads and clearing forests. Subsequently when they were laid off the railroad gangs, they met the racial hostility by dispersion and by adopting occupations for which there was little competition. Thus in the larger cities throughout the United States they opened restaurants and laundries, and small sections of several cities became almost completely Chinese.

After 1892, congressional legislation denied naturalization to all Chinese and prohibited further immigration of laborers. As a result, numbers declined because many returned to China or died. The exclusion provision of the Immigration Act of 1924 was still more harsh in preventing men laborers from bringing their wives to this country. However, it opened immigration to Chinese merchants and students and their families. The birth rate began to increase and since the repeal of the Exclusion Act and the establishment of a quota for Chinese who may enter annually, even though that quota is only 105, the number of births has grown until there are now three native-born Chinese for every two foreign-born. The Chinese population at present is close to 120,000, of whom half live in California.

As a consequence of these historical events, the United States presently has three distinct groups of Chinese.[1] One is composed

[1] For an authoritative study by a Chinese-American sociologist of many aspects of the Chinese experience in this country, see Rose Lee's *The Chinese in the United States of America*, Oxford University Press, New York, 1960.

largely of aging men who are still almost completely oriented toward China and many of whom would return if they could. They are sometimes spoken of as the sojourners because they have always thought of themselves as being here only on a temporary basis. They live, frequently dormitory style, in an overcrowded Chinese section, or return to it on Sunday. They speak little English and have maintained their peasant culture to such a degree that they are unacquainted with, or are even suspicious of, health and welfare facilities available to them.

The next and now largest group is composed of the Chinese Americans, who wish to be thought of first as Americans and second as of Chinese ancestry. To an even greater degree, perhaps, than many other groups from recent immigrant backgrounds, they find themselves torn between respect for the values of their parents and the desire to break with old ways. Often they are acutely conscious of the social distance that exists between them and Caucasian Americans.

The third group consists of those persons and their children who had entered the United States on a temporary basis as students, intellectuals, and businessmen, but because of the fall of the Chinese government were unable to return home. Many now occupy important positions in the professions, scholarly undertakings, and the business world. In their interests and way of life they are more nearly identified with the larger American community, among whom they live, than with the other two groups.

One can readily see that utilization of health services presents many problems for the first group. Its members have placed their reliance largely in their own folk medicine and the treatment of herbalists, although western doctors are thought to be needed for surgery and the treatment of tuberculosis and venereal disease. The hospital is viewed by many only as a place of last resort in which to die if necessary. Fear of it is "reinforced by the belief that one should die in familiar surroundings so that one's ghost will not get lost or wander about."[1] As a consequence, entering a

[1] Cattell, Stuart H., *Health, Welfare and Social Organization in Chinatown, New York City*, Community Service Society of New York, 1962, p. 80. This report, prepared

hospital is delayed until the latest possible moment. If a man lives in a "company" house, his dormitory roommates may force him to go to the hospital in order not to have a death on their hands.

For the group of American-born Chinese many of these problems do not exist. It is knowledgeable about the appropriate use to be made of western medical and nursing facilities, and is generally able to pay for them. According to Cattell's report, however, the incidence of mental illness among this group and the foreign-born brides is very high. He attributes this fact to the severe conflict between cultures that second-generation Chinese experience. "They have an expression for this which loosely translated means 'legs straddling two boats,' an apt description of a precarious existence."[1]

Attitudes encountered by the Japanese, who did not begin coming to the United States until near the end of the nineteenth century, have been similar. The romantic view that Americans had of Japan served to give the newcomers a favorable welcome initially. They filled a useful role in agriculture, particularly since they brought highly developed skills; they worked hard, were thrifty, created many organizations to help them in their adjustment including mutual aid societies, sent their children to the public schools, and were eager to conform to most American ways. Because they wanted to hold to their own language and religion, they built afternoon Japanese schools and Buddhist temples.

Suddenly a wave of anti-Japanese sentiment spread like wildfire along the Pacific Coast and then eastward. Great pressure was brought to bear on President Theodore Roosevelt to exclude "the Nipponese invaders," who were "not our kind, and will not merge." As a result the Gentlemen's Agreement of 1907 was effected, whereby Japan was to prevent emigration to the United

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by an anthropologist for the Chinatown Public Health Nursing Demonstration, presents valuable information about the social structure of America's second largest Chinatown, growing social disorganization, and health attitudes and practices. Included is an excellent general bibliography. The report is available in mimeographed form at $1.50 through the Society at 105 East 22d Street, New York 10010.

[1] *Ibid.*, p. 58.

States of laborers. California, however, was not satisfied and enacted legislation prohibiting Japanese from owning land in the state; the exclusion clause of the federal Immigration Act of 1924 was designed primarily to keep the Japanese from entering this country.

To a group much like the Jews in their eagerness to take advantage of all the educational and social as well as economic advantages of their new homeland, rejection came as a profound shock. It only forced them to turn inward, and to rely upon their family solidarity and their organizations for mutual aid. In spite of their great efforts and the general amelioration of their condition, large sectors of employment (and even nurses' training in some hospital schools) were not open to Japanese in California as late as 1940.

Then came Pearl Harbor and shortly afterward the official order that some 100,000 Japanese be evacuated from the Pacific Coast. Before many of them had even had time to make needed business and financial arrangements, thousands of American citizens as well as noncitizens were in War Relocation Camps, more generally called concentration camps. Throughout the United States there was quick revulsion against, what Handlin calls, "the most shameful episode in recent American history."[1] Liberal opinion mobilized to support the Japanese, and the federal relocation authority assisted them sympathetically. Many of the young Japanese-American women were later removed from the camps and resettled for the duration of the war in jobs in Chicago and New York, many of the young men served with distinction in the armed forces.

So greatly was the conscience of America troubled that postwar federal legislation permitted the Japanese, as well as the Chinese, to seek American citizenship if they wished, and opened the door to the entrance of a few immigrants annually. The Japanese were free at last to own land and become eligible for those social welfare benefits and types of employment for which citizenship is a

[1] Much of this description of the Japanese in the United States has been taken from Oscar Handlin's *The American People in the Twentieth Century*, Harvard University Press, Cambridge, Mass., 1954. The quotation is from p. 214.

prerequisite. Job opportunities have been greatly expanded, the universities count the Japanese Americans among their best students, and the Nisei and Sansei (second and third) generations appear to be demonstrating extraordinary success in adapting themselves to the middle-class standards of a Caucasian society.[1]

It cannot be assumed, however, that these adjustments are being made without considerable psychological strain. The first-generation Japanese family has emphasized, even though in modified form, the traditional values of the authority of the father and elderly persons, the subordinate position of women, the duties and responsibilities of children, and the suppression of emotion in many situations other than recreational pursuits. These characteristics, so divergent from those of the American cultural norm, can scarcely fail to produce anxiety in the second and even third generations, which are trying to establish their self-identity in reference both to their Japanese relatives and to the non-Japanese community. In connection with the case histories presented in *Clinical Studies in Culture Conflict*, Dr. Georgene Seward comments on the "pervasive depression" running through them. She views these depressive reactions as a means for expressing resentment for which direct expression is not permitted. Hence, "hostility is consistently turned in on the self in the face-saving devices of depression and somatic illness."[2]

Negroes

Some 10 per cent of the population of the United States is composed of Negroes who were originally brought directly or indirectly from Africa as indentured servants or slaves. Until the time of the Revolutionary War it might have been supposed that this group would move toward freedom as did many other indentured servants rather than becoming the victims of institutionalized slavery. With the patenting of the cotton gin, however, agriculture became highly profitable. The belief in slavery began to revive in the cotton-growing areas of the country, and with it

[1] Devos, George A., "Watch the Sansei Generation: Cultural Traditions and the Acculturation Process of Japanese-Americans," *Pacific Citizen* (Los Angeles), December 23, 1960.

[2] Ronald Press Co., New York, p. 450.

the belief in white superiority and Negro inferiority.[1] Although the Civil War ended institutional slavery, the political, economic, and psychological problems engendered by it and the era of Reconstruction, as well as the practice of racial segregation and the educational and economic disability of Negroes, kept this segment of the population from gaining any large or true freedom.

Perhaps for the very reason that Negroes were so forcibly torn from their own roots that American culture is almost their only frame of reference and English their only language, they have exhibited great eagerness to become full participants in American society and to share in a common culture. In this respect they have differed from many of the immigrant groups that often wished to preserve a knowledge of their language, practice their own religion, and maintain many of their customary folkways connected with family life and community organizations. Because Negroes differ sharply from the norms of the dominant culture both in physical characteristics and in their background as a depressed group educationally, economically, and socially, they have had an exceedingly difficult time in becoming integrated into the national life.

Since World War I, however, many forces have been at work that have resulted in noticeable modification of the Negro's position. Extensive migration from the South to the large industrial centers elsewhere has broadened educational and employment opportunities; the progressive industrialization and prosperity of the South have caused appreciable change in attitudes there and larger expenditure of funds for Negro schools and social services, while the efforts of many organizations and influential persons as well as the federal government have greatly enlarged facilities and opportunities. Simultaneously the success of individual Negroes as writers, musicians, actors, dancers, and participants in professional sports of all kinds has heightened Negro self-respect and has given members of the dominant culture a changed perception of the potentialities of this minority group. In addition, a large body of social science research, some

[1] Simpson, George Eaton, and J. Milton Yinger, *Racial and Cultural Minorities*. Harper and Bros., New York, 1958, pp. 123–124.

of it stemming from southern universities, has provided carefully documented examination of the nature of "the Negro problem."

In spite of such noteworthy gains, Negroes have continued to find themselves largely confined to segregated living wherever they have gone, even when there was no statutory legislation supporting it. Because they could rarely rent apartments or buy houses in areas where white persons lived, the neighborhood schools to which their children were sent tended to be primarily Negro and often inferior in quality. Few churches, clubs, or other social organizations with a white membership freely welcomed them; even many of the labor unions resisted accepting them, particularly for apprenticeship training whereby they could have improved their industrial skills. Except in work situations that were predominantly of the unskilled and semi-skilled kind or on some college campuses and in occasional business and professional settings, Negroes and members of the dominant culture have had no opportunity to know each other on anything approaching a basis of equality.

This continuing pattern of segregation has resulted in recent years in the greatly increased demand by Negroes that they be accorded "first-class citizenship." In the current struggle, which has reached the proportions of a social revolution, such powerful official and unofficial forces are supporting the Negro position that the legal outcome can be scarcely in doubt. But the long heritage of misunderstanding, tension, and hostility over the "Negro problem" (or the "white problem," as defined by some writers) cannot fail to have significant consequences both for Negroes and for whites, including those who provide therapy and patient care or who plan and administer health services.

ETHNIC FACTORS IN PATIENT CARE

Fragmentary as are the foregoing pages, they nevertheless suggest how numerous and diverse have been the ethnic groups that have entered the United States; how difficult economically and socially have been the early years for most of them; and how hard it still is for some to gain full social acceptance. This historical

record needs continuously to be kept in mind; otherwise members of the dominant culture can easily assume that for those of European origin, at least, acculturation is so largely completed that the past is almost forgotten or sentimentalized, while attitudes, behavior, and degree of psychological security are more or less uniform.

What makes this assumption readily plausible is the fact that the United States long had an official policy, based on the philosophy of the "melting pot," which not only permitted but encouraged vast numbers of people to enter the country. According to this philosophy, all newcomers could and should be quickly and successfully assimilated into the national culture, which was, of course, primarily the culture of the dominant group. An exception was made, however, of persons representing other than the "white race."

Viewed in its external aspects, this philosophy has met with marked success. Thanks to the great need for manpower in the development of the country, the wealth of natural resources, and the eagerness of the newcomers to make a better life for themselves, as well as official insistence upon a common language and compulsory schooling, assimilation of those of European peasant origin appears to have been achieved to an amazing degree. Visitors to the United States, especially from countries like Switzerland that support a philosophy of cultural pluralism rather than assimilation,[1] comment on the extent to which there is participation in common goals and even adoption of some of the customs of the various groups.

The assumption that the acculturation of European immigrants is largely finished has been strengthened, moreover, by the

[1] Many countries officially permit groups with distinctly different cultural patterns to perpetuate these differences. Thus publicly supported schools, as well as churches, theaters, shops, and restaurants, provide a particular group in its own language with customary means for living. Governmental agencies and nationwide businesses use interpreters and translators extensively to transcend language barriers; rules and regulations and even street signs may appear in two or more languages. A remarkable degree of accommodation to practical difficulties develops under a system of cultural pluralism, but relatively little social contact is likely to exist between groups except as required for economic and governmental purposes. Each group, moreover, tends to be concerned with its own interests, even at the expense of perhaps urgently needed common planning and promotion of national goals.

very fact that the extensive sociological and anthropological literature dealing with "minority groups" or the subject of prejudice is now confined primarily to groups of non-European background. Their problems have been, and those of the Negro remain, so acute that this emphasis is understandable. Recently, however, behavioral scientists, particularly those working in the field of social psychiatry, have begun studies of the effect of environment upon personality.[1] The results suggest that the process of acculturation is less complete than most doctors and nurses, as well as others, would have assumed. Conflicts between two systems of values or expectations exist in the second and third generations, as already noted in the instances of the Italian woman who suffered great despair because of her inability to bear a child and the Polish man who expected a kind of nursing care rarely given in American hospitals. The studies suggest, furthermore, that the process of acculturation has been accompanied by varying degrees of psychological stress, which has often left enough scars to make comfortable interpersonal relations between the newer and the more securely placed older groups difficult to achieve.

The *meaning* of these scars for their bearers may be hard for members of the dominant culture to perceive, particularly when the overt causes seem relatively unimportant. Consequently, the fact that they could affect the therapeutic situation may not even come to mind. Until far more research findings are available, little help can be given members of the health professions in predicting how representatives of various groups are likely to react when faced with the ministrations of members of the dominant culture who are in positions of authority, or when faced with specific life events such as sickness, acute pain, hospitalization, death. But it is possible to suggest enough of the possible meaning of the acculturation process to alert hospital staffs, community social workers, and public health nurses to the necessity for watchful attention to ethnic factors even in patients who speak English with no accent or errors in grammar.

[1] Reference is made to several of these studies in Chapter 6.

Since this chapter began with the description of a cultural problem presented by a Polish-American patient, let us turn for illustration of the meaning of acculturation to some further consideration of this group. In many industrial cities in the East and Middle West people who immigrated from Poland are still popularly characterized as "Polacks" and the section of the city in which they are concentrated is often known as "Polack Town." These terms have been used so pervasively that when the writer once asked an intelligent appearing taxicab driver where the Poles lived in a city heavily populated with them, he showed complete ignorance. Five minutes later, however, he announced, in a tone that indicated how inferior he thought them to be, that we were driving through the "Polack" section.

The continued use of this word recalls the disparagement faced by Polish Americans.[1] Because their language seemed formidable, their names unpronounceable, and their customs strange, they provided the longer established ethnic groups from northern Europe with an opportunity for expressing insecurity, hostility, or merely dislike of cultural differences. The following conversation suggests the unhappy circumstance of growing up a Polish American only a few years ago in one of the cities on the Great Lakes, and the probability that such prejudice has kept many members of this group from moving more easily and rapidly into educational and economically successful circles.

> In response to an anthropologist's remark that he could not "place" the name of a young psychiatrist, the latter said with a slightly embarrassed laugh that it couldn't be placed because he had changed it. Then he told how intolerable adolescent Polish Americans found the jeers of their schoolmates about the *ski* on the end of their last names and their always being "Polacks." Consequently, the future psychiatrist and his cousins decided that when they were legally eligible they would change their name. The process was simple, the final *i* was only transferred to the middle of the word. As they went on to college and professional schools in other places, no

[1] In *The Edge of Sadness* (Little, Brown and Co., Boston, 1961) Edwin O'Connor subtly indicates through his portrayal of the "Polish comedian" curate, Father Danowski from "Polack Town," how the Irish Americans of Boston look on this younger immigrant group as brash upstarts who sorely try the patience even of the Irish priests.

one thought of them as different; they had "passed" from the ranks of a minority group into the majority. "But," said the psychiatrist, "I now have some guilt about what I did. My sister did not change her name. She became a distinguished musician who has probably made many Polish Americans proud of their background. Although I, as a psychiatrist, would never be so well known to my nationality group, I should like to do something to strengthen its self-respect."

When this conversation was reported to a law professor who has devoted himself to the enlargement of civil liberties, he replied—exactly as would many other persons—that he could scarcely believe such destructive ridicule still survived. Yet in 1956 Doctors Hunter, Schaffer, and Sheps, in their study of community health organization in Salem, Massachusetts, commented on the hostility found there between the "Yankees" and the Poles, who constituted a quarter of the population.[1] The Yankees characterized the Poles as "aggressive and tight knit," rarely met them socially, and were apparently reluctant to ask them to participate in communitywide activities. The Poles responded with the familiar use of stereotypes that were applied to all Yankees: "They are dying out, so why should we pay any attention to them"; "They have all the money"; or "They are nothing but a sleepy group."

Let us return now for a minute to the Polish-American patient who brought with him to the hospital a culturally determined but highly unrealistic expectation concerning the nursing care that would be provided. In the light of the foregoing discussion, the question must be raised of whether he did not come accompanied as well by feelings of insecurity or inferiority, which also tended to strengthen his conviction that the staff did not like him. Had they been sensitized in advance to what the patient revealed to the interviewer and to the likelihood that he had great need for social acceptance, we believe that both nurses and doctors would have made a concerted effort to establish a warm supporting environment. They would have realized that, had they been successful, he would have been relieved of his sense of rejection

[1] *Community Organization: Action and Inaction.* University of North Carolina Press, Chapel Hill, 1956, pp. 65–69.

and some of the agony of intractable pain would have been lightened.

The detailed knowledge needed about specific ethnic groups is, as already noted, not available; even if it were, hospital staffs would have the time to acquaint themselves with only a little of it. But this fact need not lead to the assumption that under the circumstances there is nothing they can do. They can first of all be alert to the realization that many patients will enter the hospital with perceptions and psychological needs unlike their own. They can recognize that an essential and early step in individualized care is to get acquainted with the patient as a person and transmit to him a sense of welcome; that a continuing effort must be made to encourage him to talk about himself and how he feels about the hospital and the care he is receiving; that one of their important contributions as therapists is to watch and listen for every possible clue to his reactions at the same time they are attempting to provide an atmosphere of acceptance that will encourage him to express his feelings.

PREJUDICE AS A DETERRENT TO PATIENT CARE

It was noted early in this monograph that sensitivity to others tends to decrease in proportion to the distance between the life patterns of the persons or groups involved. In the preceding section we were concerned with patients of European origin who are well along but still in the process of finding a comfortable and secure place for themselves within American society. Attention has been paid them for the reason that health personnel often seem lacking in the sensitivity needed to recognize that there continue to be psychocultural differences with possible accompanying stresses that require attention. Their life situation, however, has come to differ only to such a relatively small extent from that of members of the health professions that greater sensitivity and hence more comprehensive patient care should be relatively easy to cultivate.

When we turn to those sectors of the population who appear to be of non-European origin and who are now generally designated

as the "minority groups," the problem becomes more difficult. Repeated reference has been made to the broadly applicable generalization that distinctive differences in physical appearance or in forms of behavior create psychological road blocks that obstruct spontaneity and competence in interpersonal relationships. Difference in and of itself is capable of creating such barriers because of the almost universal tendency to dislike or be suspicious of what one does not understand. But what makes the problem particularly troublesome is that a web of prejudice, or perverted truth, often develops around groups who exhibit differences. This web of prejudice distorts perception and the ability to exercise objective judgment, both in those who are prejudiced and in those who are its victims. It is particularly insidious and dangerous in its consequences because a person is rarely able to detect prejudice in himself although he can often detect it in others. Hence only as one can gain insight into his own motivation is he in a position to make possible correction of harmful attitudes and thus permit unbiased thinking, observation, and imagination more freedom for constructive use.

Causes of Prejudice

For the very reason that prejudice operates largely below the level of consciousness but may be an important determinant of the quantity and quality of the health services and patient care provided entire groups as well as individuals, some further exploration of its causes and nature is indicated.[1] Anthropologists and social psychologists are convinced that the socialization that children undergo is responsible for no inconsiderable amount of prejudice. In the home, school, and from playmates, children learn what groups they should like and dislike and how they should behave to each, exactly as they learn to like or dislike certain kinds of food and to be afraid of snakes but love dogs.

[1] For particularly helpful discussions of prejudice and review of the research done on the subject, the reader is referred to two books already cited: *The Nature of Prejudice* by Gordon W. Allport, and *Racial and Cultural Minorities* by George Eaton Simpson and J. Milton Yinger. Both have been used, particularly the latter, in preparing these pages.

The following incident illustrates how early and complete that learning may be.

> Before the recent struggle that has ended segregated seating in local transportation in places, the writer was riding in a bus through the finest residential section of a southern city. She saw a Negro man hurrying toward the bus, accompanied by a beautifully dressed white child who was dancing along beside him happily holding his hand. He was probably the butler or gardener in her home and she was permitted to accompany him to the bus and then run home alone. As he started to step on the bus, the child called in a high pitched voice that had unmistakable anxiety in it, "You know you go to the back to sit down." Already at five years of age she knew where her good friend was expected to sit, but she was afraid he wouldn't remember.

Experimental and clinical evidence collected by psychologists and psychiatrists has provided several significant theories about other probable causes of prejudice. One of these, spoken of as the frustration-aggression concept, suggests that frustrations are so pervasive a part of everyone's life that the consequent blocking of achievement of desired goals is likely to create hostile impulses. The individual therefore seeks a scapegoat on which to vent his hostility. Frequently he makes the members of some minority group that scapegoat. Then he seeks to justify his action. By pointing to certain aspects of their behavior that he finds reprehensible (aspects that often are a reflection of his own unconscious fears, anger, and lust) and by failing to observe other aspects, he concludes that they well deserve the treatment accorded them.

A second theory attributes prejudice to personal insecurity. Large numbers of persons apparently suffer from inadequate self-respect or from feelings of isolation and powerlessness. One means used to relieve this acute discomfort is to express hostility toward disadvantaged groups, or to support fascistic types of totalitarian movements, such as those that have shown themselves to be anti-Negro, anti-Semitic, anti-Catholic, or anti-Mexican, according to the particular circumstances. In some

forms of mental illness persons display an almost violent hatred of a selected group; this behavior has been interpreted as an effort by the individual to displace self-destroying trends in his personality.

Still another and related cause of prejudice appears to lie in the attempt of many persons to enhance their self-esteem or remove a threat to it. So great is their desire for social approval that they conform to the attitudes of acquaintances and others with whom they identify themselves. Even when they may recognize and deplore the prejudices exhibited, they maintain a discreet silence for fear of losing social acceptance.

In addition to these several causes of prejudice, which all individuals are likely to employ to some degree to serve their personal needs, sociologists have explored causes that originate in its usefulness as an instrument of political, social, or economic control. For example, where one group, perhaps a nation, wants to maintain rule over another group, it almost always develops an image of itself as so distinctly superior that it is fully justified in exercising control over the "inferior" group. Similarly, when individuals or organizations in the United States have seen economic advantage to be gained from taking land away from the Indians or the Japanese or from exploiting factory and migrant labor, highly distorted pictures have come readily to mind of the specific groups as lazy, ignorant, worthless, or potentially disloyal.

Nature of Prejudice

When we turn to a consideration of how prejudice is manifested, we note first of all that it is not static but is often unpredictable. Although most immigrant groups have been subjected to it, prejudice toward those of European origin has tended, as we have seen, to diminish greatly if not to disappear in the course of two or three generations. Change has been the result of various interacting factors: the particular groups have lost many of their distinguishing characteristics and more "visible" groups have appeared to take their place, while new or dynamic economic and

political forces and broadened educational experiences have been destructive to traditional forms of prejudice.

For the very reason that attitudes toward particular groups vary with time, place, and circumstances and may change rapidly, outbreaks of prejudice cannot always be foreseen.[1] Thus German Americans experienced so much unpleasantness and even overt hostility during World War I that they feared a repetition of it subsequent to 1939. Instead, prejudice was directed almost exclusively toward the Japanese and Japanese Americans, who now find themselves, less than twenty years after the close of the war, in a more favorable position than at any time since shortly after their arrival in the United States. On the other hand, the Spanish-speaking groups are still severely disadvantaged socially in spite of many efforts in their behalf, while the Negroes in their current effort to gain first-class citizenship are being subjected to some of the bitterest manifestations of prejudice as well as some of the strongest support they have received since the Proclamation of Emancipation.

Another aspect of the nature of prejudice lies in the tendency for the attitudes of the dominant culture to be reflected by the various ethnic groups in their feelings and behavior toward one another and even toward themselves. If it were not for the unconscious nature of prejudice and its usefulness in meeting a variety of needs, one would suppose that a group that had suffered discrimination would exercise great care not to view the behavior of other groups in stereotypes. But the pattern of prejudice repeats itself, as illustrated by a simple test administered a few years ago to the wealthy Irish Americans in San Bernardino, California. Vicious descriptions of Irish immigrants published in the Boston newspapers of the late 1880's were copied and read to them as reports about a "people." The reports were particularly malicious in their generalizations concerning dirtiness, intemperance, "breeding habits," impulsiveness, and hot temper. Without question the Irish took them as descriptions of the Mexican

[1] For a summary of how attitude tests have been employed since 1928 to measure prejudice, what changes have occurred since then in attitudes toward various groups, and the use made of stereotypes by popular magazines, see Eaton and Yinger's *Racial and Cultural Minorities*, pp. 157–165.

Americans whose arrival in San Bernardino they so greatly disliked.[1]

Because of the probable need to project onto others the social opprobrium or psychological insecurity from which one is suffering or has suffered, Mexicans may show hostility toward Negroes; German Jews may indicate how distinctly superior they feel to Jews from eastern Europe; and American-born Negroes may consider Negroes from the British West Indies as inferior to themselves. Even members of the dominant culture, particularly in the more static areas where they are declining in relative if not in actual economic, social, and political influence, may be discovered developing hostility for progressively successful groups that they believe are robbing them of what is rightfully theirs.

But not all hostility is thus displaced by a process of projection. A minority group may come to accept the attitudes expressed toward it as true, at least of its more unsuccessful members, and hence may engage in disparagement of or hostility toward segments of itself. When considerable anti-Semitism was prevalent, behavioral studies showed that some Jews were also anti-Semitic. Negroes frequently exhibit pronounced dislike of other Negroes: those who have advanced into the middle class can be heard sharply deploring the way in which poor, ignorant sharecroppers move to the industrial cities and thus supposedly create an unfavorable image of all Negroes in the minds of white people. The dominant group may speak disparagingly of those "poor whites" or "hillbillies" who have also migrated to the large cities, but it does not view itself as being placed in an unfavorable light as a consequence.

The final tragedy for people subjected to prejudice is that they may turn the hatred expressed toward them in on themselves as individuals, to fester in the darkness of the unconscious mind. When this occurs, potentially productive energy is wasted, ability to meet members of the dominant culture without undue subservience, withdrawal, or aggression is further decreased, and serious intrapsychic trauma is produced. In such assessments of

[1] Opler, Marvin K., "The Influence of Ethnic and Class Subcultures on Child Care," *Social Problems*, vol. 3, July, 1955, p. 18.

personality as psychiatrists and psychologists have been able to make of representative Negroes, the corrosive nature of the self-hatred found is, to use Dr. Kardiner's phrase, a "mark of oppression."[1]

Implications for the Health Services

Obviously the suffering caused by social discrimination in its many forms has significant implications for all the professions that serve a cross section of the population in a helping capacity. The health professions are no exception. For the very reasons that the relation between emotional and psychosomatic states is so close and the success of therapy depends so much upon the patient's faith and trust in those providing care, it is particularly important that clinicians exercise insight into the nature of this social problem.

In Chapter 6 we shall return to some aspects of this subject when we review a sample of the behavioral science studies that have inquired into the extent to which ethnic and socioeconomic factors play a part in the planning and providing of health services. Many studies that are greatly needed, however, have not been undertaken or are not available in published form. In this concluding section, therefore, we must refer specifically to what is currently of especial importance, namely, the psychosocial aspects of patient care of Negroes.

For more than a decade hospitals, health agencies, and professional associations have been faced with the necessity of making policy determinations about provisions both for Negro patients and for Negro members of the health professions. When the federal hospitals undertook integration of all patients and staff, regardless of race, the step appeared extremely radical to those parts of the country that had maintained segregation. Great change has occurred since. Provision for more or better medical and health care for Negroes has been instituted, and considerable

[1] See Kardiner, Abram, "Explorations in Negro Personality" in *Culture and Mental Health*, edited by Marvin K. Opler, Macmillan Co., New York, 1959, pp. 413–424; and Seward, Georgene, *Clinical Studies in Culture Conflict*, Ronald Press Co., New York, 1958, pp. 41–150.

numbers of hospitals that formerly did not admit Negroes as patients or only on a basis of segregation have been reorganized.

Nursing particularly has had spectacular success in opening many of its schools to all qualified applicants, in utilizing both Negro and white nurses to care for patients without distinction to race, and in ending the necessity for a national Negro membership organization. Although medical and psychiatric social work is small numerically, it is part of a profession that has long taken vigorous action in attempting to break down racial barriers. The medical profession has not yet matched the accomplishments of these two groups, and much remains to be done particularly in giving Negro doctors more adequate opportunity for specialized clinical and research training and for appointments to the staffs of voluntary hospitals to which they may admit their patients. Throughout the health services, however, change has been distinctive enough to indicate that present trends are almost certain to be continued.

The problem, therefore, that concerns us here deals with the psychosocial aspects of patient care for that segment of the population that has been so seriously disadvantaged emotionally as well as economically that knowledge, sympathetic understanding, and skill in interpersonal relations are essential. In some hospitals and clinics brought to our attention, initial efforts at least are being made to examine what forms of direct patient care would best meet the needs of Negroes with varied kinds of life experience. Unfortunately, few of these efforts have reached the stage of publication in professional journals, although the general literature on the Negro is very large.

One important article, which has appeared under the title of "Cultural Influences on Patient Behavior," is concerned with the reactions to hospitalization of Negroes from rural areas of North Carolina.[1] In it Grace S. McCabe tells how patients frequently chanted, prayed, sang hymns, preached, and encouraged each other "to trust in the Lord." Some of these communications to God, as well as the joking in which patients also engaged, were interpreted by Mrs. McCabe as requests for help from staff, made

[1] *American Journal of Nursing*, vol. 60, August, 1960, pp. 1101–1104.

in the only way psychologically oppressed Negroes knew how to ask for aid. She found, however, that staff generally lost the cues because they either resented the behavior or they viewed the humor as interesting or "cute."

An article such as this brings the sharp realization that segregation has been so pervasive that few white and Negro persons are acquainted with each other except in superficial ways. Until recently southerners went on the assumption that they knew and understood Negroes. Now it has to be universally admitted that white persons know little at first hand about the family and community life, the values and aspirations of the different socioeconomic groups.[1] Negroes know appreciably more about white persons because large numbers have been employed in the homes, on farms, and in small businesses owned by the latter. Besides, members of minority groups generally find it important to observe carefully the behavior of majority groups. However, a large proportion of that small sector of the Negro population that has been able to advance into the middle class, lives separated from meaningful contacts with white persons. Thus those best able by education to exercise leadership in attempting to enlarge social interaction between the minority and majority groups have frequently been the ones with the fewest contacts.

Recognition of this lack of, but need for more, acquaintanceship comes out clearly in the interviews that a special correspondent for one of Italy's most distinguished newspapers had recently with Negro students in Alabama. When he inquired why the students preferred going to Atlanta University, a private institution for Negroes, rather than to a nonsegregated institution, they replied: "We do not know the world of white students. Therefore we prefer to live with our own group. . . . Integration in the schools should begin with the kindergarten."[2] When one of the two Negro students enrolled in the University of Alabama was asked why she wanted to enter a white university,

[1] Antonovsky, Aaron, and Melvin J. Lerner, "Occupational Aspirations of Lower Class Negro and White Youth," *Social Problems*, vol. 7, Fall, 1959, pp. 132–138; Frazier, Franklin E., "The Negro Middle-Class and Desegregation," *Social Problems*, vol. 4, April, 1957, pp. 291–302.

[2] *Corriere della Sera*, Milan, October 13, 1963, p. 7.

she said in effect: I think that if the American society of tomorrow —or even a tomorrow far in the distance—is to be integrated, all of us should try to live as much as possible in the environment and atmosphere of the whites.[1]

Because of this lack of acquaintanceship as well as the deeper sense of frustration, guilt, and fear, to which the psychiatrists point, that may exist in both groups, there is perhaps no more urgent problem in exploring the individualization of patient care than examination of its psychosocial aspects in reference to Negroes. Psychiatry would maintain that all persons acting in a therapeutic capacity need insight first of all into their own attitudes. Like other minority groups, the Negro has great capacity to *feel* when he is being rejected or treated patronizingly even though white persons may be quite convinced that they are free of prejudice.

Also, the therapeutic role requires attempted analysis of the meaning and significance *for the patient* of the care being provided. Many come to the clinic or inpatient service with fear of machines, procedures, and the institution, of persons in authority, and of what the diagnosis may reveal. Perhaps almost all dread how they will be received as persons. Consequently, acts of commission or omission can often be interpreted by them as slights, when none was intended.

Reactions to hospitalization, however, will vary conspicuously according to the life experience that the several subgroups of Negroes have had. Behavior such as that of the rural Negroes, which may also characterize a comparable group of white persons, would be entirely foreign to educated Negroes. On the other hand, members of the latter group may be so sensitive to their membership in a minority that staff think them unduly insistent about their "rights" or lacking in appreciation.

Some psychiatric and psychosomatic services devote considerable staff discussion, under the leadership of a psychiatrist, to the feelings of staff toward individual patients, including Negroes, and to verbal reconstruction of the social interaction that has supposedly taken place. Those in attendance sometimes comment

[1] *Ibid.*, October 10, 1963, p. 3.

later on the usefulness of the discussions in helping them clarify their own attitudes and facilitate their work with particular patients. Such sessions are capable of relieving unconscious prejudices and providing members of the staff with valuable psychological support. In addition, they may furnish data about the perceptions and behavior of an individual Negro patient that are perhaps applicable to his subgroup as a whole.

But needed particularly are far more systematic data of this kind, which have been carefully correlated with educational and socioeconomic background. The information obtained would be comparable in nature to that of social science studies of other aspects of the beliefs, expectations, and behavior of Negroes. Until this information is at hand, observations like those made by Mrs. McCabe might well provide guidelines for experimenting with various approaches to the psychosocial components of patient care. Two or three interested staff members, for instance, might engage in observations on a selected ward, carefully noting in writing what they had seen and heard and their reactions and interpretations. These notes could then become the basis for discussion in ward meetings of their probable general validity and for planning what kinds of action to institute. Evaluation of the results of the action undertaken could, in turn, become the subject for further discussion. Finally, what was learned could be transmitted to other wards of the hospital, or to a wider audience through preparation of articles for publication in professional journals.

Chapter 5

SOCIOECONOMIC BACKGROUND

IN THIS CHAPTER we turn from our discussion of the diverse ethnic groups that comprise America to a consideration of the diverse socioeconomic backgrounds to be found within the population. Thus further opportunity is provided to think about diversity—but again diversity within group regularities that can be fairly readily recognized and thus utilized for practical purposes. Because references to "patients" in a generic sense, as if they were all primarily alike, are so frequent, repeated emphasis has to be placed on the fact that various groups of patients, like the groups in the population at large from which they come, tend to perceive and react to life situations in appreciably different ways.

The usefulness of knowledge about ethnic background, moreover, is greatly reduced unless that knowledge, as suggested in the preceding chapter, is correlated with facts about the socioeconomic status of the people under discussion. Everyone is aware that all Irish Americans, Old Yankees, Jews, Chinese Americans, or Negroes are not alike in life experience; that each ethnic group is composed of subgroups that differ from one another occupationally, educationally, in amount of income, and in their aspirations. Yet it is exceedingly easy, as we have seen, to categorize or stereotype an entire ethnic group. Two recurring statements heard in hospitals and clinics will illustrate how inaccurate and even unfortunate such stereotypes may be if one is striving for greater discrimination in patient care.

When an Italian patient is found to be over weight, the cause is often said to lie in the supposition that "Italians" eat quantities of spaghetti and rich sauces prepared with olive oil. Visitors to Italy discover that northern Italians eat relatively little

spaghetti, and the middle and upper classes pride themselves on their diet-controlled slimness. Spaghetti with sauce is characteristic of Naples and southern Italy. It is, however, far too expensive a food for large segments of the impoverished population, and hence is eaten by them only on special occasions. For persons in more comfortable economic circumstances, the use of spaghetti and a degree of corpulence may be the visible symbols of relative prosperity.

Another generalization is that hospitalized "patients from Mediterranean countries make a great deal of noise" when uncomfortable. The inference seems to be that the complaints, moaning, and laments are a spontaneous reaction that is "natural" to these peoples and hence, although disturbing to staff and other patients, must often be tolerated. It does not imply that such patients should receive more attention than others on the ward, or attention of a different kind. How "natural" is this behavior must be questioned. The writer recalls a visit to a maternity hospital in Athens where the director explained in advance that patients on the private and semiprivate floors would be quiet but those on the wards would be extremely "noisy." The visitor assumed that the difference could be explained by the use of sedatives in the more favored parts of the hospital. She was told, however, that analgesics were not used in connection with any normal deliveries.

Were the pronounced differences in behavior the result of the fact that middle- and upper-class Greeks had been conditioned from childhood to suppress physical manifestations of discomfort, and perhaps to have less fear of hospitals and of childbirth? Had the generalizations heard in American hospitals resulted from the possible fact that patients, recognized as coming from Mediterranean countries, were predominantly from peasant stock who brought with them fear of the hospital and anxiety about their illness as well as spontaneous reactions to pain? Although we do not know the answers, these questions at least provide clues for experimenting with various kinds of individualized care that might prove helpful to such patients. And in the process of experimentation, answers might be found.

SOCIAL CLASSES

Following his arrival in the United States, a European anthropologist was asked, "After all the class-ridden countries on the Continent where you have lived, isn't it good to get here where there are no social classes?" The anthropologist was so surprised that he thought his imperfect English had caused him to hear incorrectly; hence he asked twice that the question be repeated. Finally, he replied that it was his impression that awareness of social class status played a more important role here than in those European countries with which he was acquainted, but that opportunity for social mobility in the United States was generally large and reinforced by the dominant attitudes. As a result, upward movement from one class to another was much easier than in many parts of Europe. The questioner showed no interest in this opinion, but reiterated that social classes were nonexistent in America.

The latter only reflected a point of view that has been so pervasive that even educated persons frequently refuse to accept the concept of a social class structure.[1] Has not this country been opposed since its founding, say they, to the idea of aristocracy or other special privileges? Do not Christian teaching and the Constitution emphasize that all men are equal? Equality certainly exists insofar as all men are human beings who experience the universal processes of birth, life, and death. Beyond that, equality is largely an ideal, so great are the individual differences in mental and physical potentialities, childhood socialization, and opportunity for educational and job advancement.

However, the dominant culture has placed great emphasis on the fact, as we have seen earlier, that everyone should try to "succeed." Success, moreover, has been defined largely in terms of money, power, prestige, and economic security, rather than in terms of more subtle qualities such as intellectual, emotional, or spiritual growth. Thus sharp competitiveness and a tendency to "conspicuous consumption" (or sometimes conspicuous underconsumption) have been favored.

[1] For an excellent discussion of why Americans have historically refused to recognize the existence of classes, see the first chapter of Leonard Reissman's *Class in American Society*, Free Press, New York, 1957.

For the members of some groups "getting ahead" has been relatively simple. They have been born into families that were already favored socially and economically; where the values of the family and of the dominant culture were so congruent that these values could be easily internalized; and where the expectation was unmistakable that the success already achieved would be maintained and enlarged by the next generation. In such instances it has been almost assumed, to quote Dr. Max Lerner, "that the child will 'do well'—that he will be part of the main currents of play in the nursery or early primary grades, and not stay on the margin; that he will be a 'success' at his job or career and in gathering his portion of the world's goods; that when he gets into emotional difficulty he must become 'adjusted'; and, most of all, that he will strive to be 'happy'."[1]

For those groups described in the preceding chapter achievement has been much more difficult. We have already noted that initially they were not only socially and economically disadvantaged but were frequently subjected to humiliation and discrimination. Even the public school system often reflected discrimination by providing fewer facilities and less experienced teachers to neighborhoods that most needed enrichment.[2] Yet among these groups no strong political labor movement comparable to that in many European countries has appeared, and except for sporadic small movements such as the current Black Muslims there has been little embittered, self-imposed isolation. Instead, there has generally been the hope that one's children would be able to advance well beyond the level of the parents. This attitude has prevailed to such a degree that it has often been almost taken for granted that each generation would progress at least one step toward middle-class status.

Members of groups that have not yet attained this status may even classify themselves as predominantly middle class when asked, for example, to which one of several designated classes

[1] *America as a Civilization: Life and Thought in the United States Today.* Simon and Schuster, New York, 1957, p. 547.

[2] Warner, W. L., R. J. Havighurst, and M. Loeb, *Who Shall Be Educated: The Challenge of Unequal Opportunities*, Harper and Bros., New York, 1944. For contrast, see Chapter 7, "The Best We Can Do" in Martin Mayer's *The Schools*, Harper and Bros., New York, 1961.

they think they belong. By contrast some individual persons well above the median line of the middle class feel self-conscious about admitting, upon being questioned, that they are relatively favored in the position they occupy in the community and hence may even downgrade themselves. But describe to these same persons salient characteristics about representatives of various groups and they will almost always classify the representatives much as would the social scientist. For instance, a taxicab driver in a city of half a million population, who has completed only two years of high school, earns about $90 a week, and pays $70 a month for five small rooms in a drab neighborhood, will probably be designated as well below the top of the working class. By comparison, a lawyer graduated from Princeton University and Harvard Law School, who has a remunerative legal practice, sends his children to expensive private schools, and lives at one of the "best addresses" in the city, will be said to be "well off" or "on top."

Scale of Social Classes

In spite of lip service given to a classless or to a middle-class society, everyone is well aware of the fact that vast differences in behavior, attitudes, and values exist between various socioeconomic groups in the population. It is for the purpose of classifying and analyzing these differences that behavioral scientists have evolved a diagram known as a scale of social classes or of social stratification.[1] Because the middle class represents the dominant

[1] In the extensive literature on this subject, various criteria have been used to define and differentiate the social classes and for determining in what class individuals or families belong. Some of the criteria that have been commonly employed are level and source of income, occupation, education, type of dwelling and place of residence, family background, ethnic background, religion, and "power" position. The anthropologist W. Lloyd Warner and the sociologist August B. Hollingshead have extensively studied how to determine the class position of persons in any given community. Warner concluded that a maximum degree of social class prediction could be achieved by using only four but differently weighted criteria: occupation, source of income, house type, and dwelling area. Hollingshead has more recently reduced the criteria to three: residential address, occupational position of the head of the household, and number of years of school the head has completed. Readers interested in the methodology developed by these authors are referred to Warner, Meeker, and Eells' *Social Class in America: A Manual of Procedure for the Measurement of Social Status*, Science Research Associates, Inc., Chicago, 1949, and Hollingshead and Redlich's *Social Class and Mental Illness: A Community Study*, John Wiley and Sons, New York, 1958.

group with which all other groups tend to be compared, sociologists usually begin by noting that class on their diagram. So great has been its growth and the differentiation that has gone on within it, the middle class is portrayed as divided into an upper and a lower middle class.

The upper middle class in general is composed of professional persons including university teachers, scientists, and other technical experts; those holding responsible positions in middle management in business, industry, and government; and managers of large industrialized farms. The lower middle class roughly is composed of schoolteachers, salespeople, office workers, technicians, advertisers, middlemen, persons operating small shops and businesses, and all others popularly designated as belonging to the "white-collar" group.

Other classes are noted on the diagram in their relationship to the middle class as *upper* or *lower*. The number of classes portrayed depends upon the size and complexity of the community under examination. In a large and dynamic city and its affluent suburbs there will be an appreciable upper class, consisting of such persons as leading bankers, judges, university presidents, and chief business and industrial executives. Their incomes from salary and investments put them in a high tax bracket. In some long-established communities there is still another but numerically very small group, designated as the upper-upper class, that commands a leading position in Society through being descended from families of social distinction and having generally inherited wealth.

Below the white-collar or lower middle class, according to the traditional scale, is the numerically large "blue-collar" working class that has also undergone such differentiation that it must be subdivided. In the upper portion are the skilled workers who are now employed predominantly within an industrial form of organization, whether they be connected with the extraction and production of basic materials, the construction of buildings, roads, machines, airplanes or ships, or the making of consumer goods. Thanks to technological improvements that have permitted greatly increased productivity, the wages, hours of work, and social welfare benefits of this group have deen raised until they

are often comparable to or exceed those of persons in the lower middle class. Also included in the upper portion of the working class are the owners of self-operated farms, a rapidly decreasing segment of the population.

In the lower portion of this class are the unskilled workers whose duties are routine and require little education or on-the-job training. Unless they are members of aggressively successful labor unions, their wages are often little more than the minimum required by law. Included are such persons as factory machine operators, sanitation workers, porters and assistants to skilled workers, cleaning men and women, maids, and farmers who cultivate land owned by others. This is the category where the great majority of immigrants have begun their new life in America, and a disproportionate percentage of Negroes still find themselves.

Last on the scale is the segment, spoken of as the lower (or lowest) class, that does not have regular work or is chronically unemployed, ekes out a marginal existence economically, and is generally characterized by great instability of family life. As a whole this class makes heavy demands on tax-supported services, whether those of public assistance including home relief, public hospitalization, or custodial and remedial care in institutions. Some of its members are migrants in search of work, warm sunshine, more adequate welfare checks, or a chance to "get away from it all."[1] Many never "got a start" in life, chiefly because of lack of education or deprivations stemming from family insecurity, whereby they could have maintained themselves as part of the working class. Others have seen more prosperous days but have dropped down the social scale because of economic depression, technological developments, continued sickness, old age, alcoholism, drug addiction, or other misfortune.[2]

[1] See Albert N. Votaw's "The Hillbillies Invade Chicago" in *Harper's Magazine*, February, 1958, pp. 64–68.

[2] Those unacquainted with George Orwell's *Down and Out in Paris and London* (Harcourt, Brace and Co., 1933, and Berkley Edition, 1959) will find in this classic, written from personal experience, a realistic but witty and humorous picture of what life was like "at the bottom" in two world capitals during the depression of the 1930's. John Steinbeck's widely read *The Grapes of Wrath* (Viking Press, New York, 1939) deals with the agrarian counterpart of Orwell's "down and outers": "Okies" who were obliged to migrate from the dust bowl and their bank foreclosed farms. See also Nelson Algren's *A Walk on the Wild Side*, Farrar, Straus and Cudahy, New York, 1956.

In recapitulation, we might say that for a highly developed urban area the social class scale would appear as follows:[1]

Upper-Upper Class
Upper Class
Upper Middle Class
Median Line of Middle Class
Lower Middle Class
Skilled Working Class
Unskilled Working Class
Lower Class

Except for remnants of the old plantation culture and some towns dating from colonial days where class distinctions are still held to tenaciously, social differentiation has generally progressed less far in small cities, rural areas, some of the newer parts of the nation, and many of the communities that have sprung up since the close of World War II. As a consequence, the number of classes tends to be fewer in such places; the lines of demarcation between the two parts of the middle class and of the working class may be less sharp; and an upper or a lower class may be very small or even nonexistent.

Before leaving this portion of the discussion a word must be said about the terms "upper" and "lower" that many persons find objectionable. It should be reiterated that in many of the studies they are used only to describe where the various groups stand in relation to the dominant middle class; they are semantic devices and are *not* intended to imply value judgments concerning the superiority of the pattern of behavior and attitudes of one group as compared with another. The very terminology, however, lends itself to much misinterpretation. Perhaps the semantic problem could have been largely avoided if the scale had been portrayed horizontally rather than vertically. Thus some of the social classes would have been represented at varying distances to

[1] Behavioral scientists often use slightly differing terminology to describe some of the social classes. Thus the "skilled working class" is designated on some scales as the *lower class*, while the last two groups on our scale are combined under the designation of *lower-lower class*. Although the middle class also works, the term "working" has been employed here as descriptive of a cultural pattern of living where behavior, values, and attitudes differ in many respects from those of the middle class.

the east or right of the median line, and the others to the west or left of the line.

What causes the major difficulty, however, is not the words themselves so much as the fact that those words *do* portray popularly held attitudes and values of appreciable segments of the population concerning success or failure in the achievement of social status. In the studies made by W. Lloyd Warner and his colleagues, these very terms were employed expressly to designate the kind of ratings members of a community gave each other.[1] The ratings served to demonstrate that there is a strong tendency, even by persons who reject the concept of social class or who view their own behavior as morally reprehensible, to look with favor, heightened interest, and often envy at those groups above the median line.

This tendency, moreover, is accompanied by the intellectual and psychological difficulty that most persons have in extending themselves far beyond the pattern of living and thinking into which they have been socialized. Hence writers, who are generally members of the upper middle class, have paid insufficient attention to the working and lower-class groups whose behavior patterns may appear uninteresting, strange, or sharply deviant if not disgusting. Even social scientists have sometimes admitted that they were psychologically threatened, as well as overwhelmed by the practical problems encountered, in attempting to make studies of groups appreciably different from themselves. As a consequence, greatly needed research and perceptive fiction about unskilled workers and particularly the lower class have lagged, and persons connected with health, educational, and welfare services have had difficulty in formulating programs designed to meet the needs of groups most unlike themselves.

Further reference will be made later to the implications of this problem for the individualization of patient care in hospitals and clinics. As illustration of the difficulty that professional persons in

[1] For an excellent description of "The Warner Approach to Social Stratification" and the various controversial issues created by his assumptions and research methods, see Ruth Rosner Kornhauser's article bearing that title reproduced in *Social Perspectives on Behavior*, edited by Herman D. Stein and Richard A. Cloward, Free Press, New York, 1958, pp. 363–394.

general may encounter in working with those at the bottom of the social class scale, we wish to note the remark of a perceptive, highly motivated, and experienced social worker whose clinical practice we had an opportunity to observe. It was his task to interview young men upon their admission to a medium security prison, and discuss with them individualized plans for educational and vocational training. Probe as he would, this social worker was unable to elicit from a twenty-year-old Mexican American any positive interest in possible choices of program or any aspirations for the future. As the prisoner left the office the social worker commented, half to himself, that he was so culture-bound by his own middle-class values that he suffered a feeling of complete frustration when he could not get a spark of interest from a man who was being given a chance to improve his life situation.

CHANGES IN THE SOCIAL CLASS SYSTEM

The foregoing section portrays in rudimentary form a picture of the social class system in the United States as it has emerged from social science studies. This picture has been very helpful in explaining many otherwise inexplicable aspects of American society, and has had appreciable usefulness in its recent application to problems of patient care and public health, as will be seen in the next chapter. There has been criticism, however, that the studies from which broad generalizations have been drawn (not unlike the earlier studies of rural communities undertaken by sociology departments in land-grant colleges) were too frequently of relatively small places that had already passed the stage of vigorous growth.[1] About declining communities, particularly those in New England and the Deep South, it could be argued that the number of classes was greater and the distinctions

[1] As examples of these studies, see Robert and Helen Lynd's *Middletown*, Harcourt, Brace and Co., New York, 1929, and *Middletown in Transition*, 1936; John Dollard's *Caste and Class in a Southern Town*, Yale University Press, New Haven, 1937; Allison Davis, Burleigh B. Gardner, and Mary R. Gardner's *Deep South*, University of Chicago Press, Chicago, 1941; W. Lloyd Warner and Paul S. Lunt's *The Status System of a Modern Community*, vol. 2, "Yankee City Series," Yale University Press, New Haven, 1942; James West's *Plainville, U.S.A.*, Columbia University Press, New York, 1945; Art Gallaher, Jr.'s *Plainville Fifteen Years Later*, Columbia University Press, 1961; August B. Hollingshead's *Elmtown's Youth*, John Wiley and Sons, New York, 1949.

between them were more sharply etched and inflexible than in rapidly expanding areas.[1]

The chief reason for studying small communities lay in the fact that they *were* small enough to study. Examination of large and fast-changing metropolitan areas is exceedingly difficult to undertake, especially with such limitations in personnel and financial resources as exist. It is quite possible that past emphasis on urban versus rural class differences and the more recent emphasis on patterns in places that are no longer part of the great dynamism of the country do not adequately reflect current trends throughout the nation.[2]

Hence some description must be included here briefly of socioeconomic developments since the beginning of World War II that may be conspicuously modifying the picture of the social class structure through the introduction of new patterns of living and working.

Movement to the suburbs, which has been so conspicuous that it cannot fail to attract attention, is one of these developments. Some suburban communities are composed largely of the families of business and industrial executives and professional men who commute to the city to work. Other suburbs have provided exodus for ethnic groups who were ready and eager to move from the congested urban areas where they had formerly lived; many of their inhabitants have found employment in furnishing services to the more affluent communities. Still other suburbs have grown up almost overnight because of new industries that were being established nearby.

A related but somewhat less noticeable development of the past two decades has been the vast interstate migrations resulting from the expansion and decentralization of industry, business, government, and the military establishment, and from the provisions particularly in the South and Southwest for the retirement

[1] Lerner, Max, *America as a Civilization.* Simon and Schuster, New York, 1957 p. 534.

[2] Vance Packard is so convinced of this probability, and so concerned about a possible decrease in opportunity for social mobility, that he has set down his conclusions in his widely read book entitled *The Status Seekers*, David McKay Co., New York, 1959.

of older people. Large numbers of industries have moved their headquarters halfway across the continent perhaps, or more often have opened widely dispersed new plants. Some corporations and government agencies, as well as the military establishment, make transfer of managerial personnel and technical specialists a systematic policy. It is reported that nearly three-quarters of all the moving done by long-distance vans is accounted for by members of large organizations, both private and governmental, who are being transferred.[1] Housing developments, shopping centers, and local service businesses, often located many miles from the nearest city, have quickly opened to meet the needs of these vast numbers of persons, many of whom have come from great distances and significant segments of whom will keep on moving at frequent intervals.

Predominantly, interstate migrants are of two age-groups: the young, generally between twenty-five and thirty-five years old, and those in the retirement category. In the housing developments available, families with varied geographic and social class background find themselves thrown together, obliged to put down new roots. William H. Whyte makes the penetrating remark, in describing those families where many of the husbands hold managerial or technical positions in large organizations, whether private corporations, government agencies, or the armed forces:

> These people confound the usual concept of class. Some can be described as upper class, some middle class, but it is the horizontal grouping in which they come together that is more significant. It does not declass them; however muffled, the differences in family background between organization people will never be erased. But they will be superseded. When organization people speak of the boat they are all in together, it is the horizontal grouping they are describing. They assimilate one another, and the fact that they all left home can be more important in bonding them than the kind of home they left is in separating them.[2]

[1] Whyte, William H., Jr., *The Organization Man.* Simon and Schuster, New York, 1956, p. 270.

[2] *Ibid.*, p. 270.

In communities being built for older people, similarity in the design and price of all the houses tends to emphasize similarities rather than differences in interests and ways of living. Within a relatively small area on the Gulf Coast of Florida, for example, one can see a succession of recently completed housing developments, advertised as retirement homes, beginning with a community where every home is in the $9,999 category and progressing at $1,000 intervals until one reaches a community where houses sell for $19,999. However low the price tag, shoddy the basic materials, and poor the construction, the unmistakable impression given by these developments is that they are all middle-class homes. Like their counterparts in many other places, they recall Lerner's statement that "America has moved from relatively clear divisions and modes of life to a situation where the divisions have become more blurred, the stratification has become more subtle with shadings that are imprecise and elusive, and the modes of life have tended to converge in a large category of middle-class living."[1]

Although persons who live in housing developments or many of the new suburban areas often maintain that these places not only look but are classless, the statement is perhaps more true as a suggestion of a trend than an actuality. Regardless of the fact that middle-class persons with a college education give the dominant tone to the communities designed primarily for those in professional and managerial positions, there are many other residents who have succeeded in moving up to an appreciably higher standard of living. From Whyte's point of view, it almost seems as if these communities were made for expanding the lower limits of the middle class. "They have become the second great melting pot."[2]

As newcomers to the middle class enter these housing developments, they rapidly discard many of their former values and tastes. Not only are women quick to change their home furnishings, clothes, and recipes to conform to community taste, but families may even change their political party and church affilia-

[1] *America as a Civilization*, p. 471.
[2] *The Organization Man*, p. 300.

tion to appear more like others. Shopping centers have been surprised and gratified by the upgrading in merchandise that buyers have demanded and have bought lavishly (on credit). Group activities abound, including the morning kaffeeklatsches; new families are generally warmly welcomed, and often helped, if necessary, to learn how to "fit in." As a result, many are reported genuinely to like the environment; they find it friendly and sustaining until they move on—hopefully to another development on a higher economic level than the one they have left.

But there are also less favorable aspects to suburban living. The frequent absence of public transportation makes difficult the occasional enjoyment of city or open country for those women whose husbands must use the family automobile during the day. Some families have difficulty in adjusting to the lack of privacy of community living and to the continuous strain toward group conformity.[1] Very often, after budgeting for items being bought on credit, families discover that no financial leeway exists even for an inexpensive vacation. Instead, there is often the gnawing realization that should an economic depression or some emergency such as acute illness appear, they would be in a serious plight. "Suburbia does not condone shabby gentility. The amenities that a severe cutback in expenditures would put in jeopardy are not marginal; to the family on the edge of the middle class they are social necessities."[2] Competitive standards of living, moreover, tend to become progressively harder to maintain for families where the husbands are not advanced as rapidly as are the members of the executive and professional groups.

Most difficult of all perhaps is the psychological insecurity of those who have taken a large step upward in the middle class and who cling desperately to their new status lest they be thrown back again. Under such circumstances it is little wonder that two questions tend to repeat themselves over and again in these communities, "How do we [they] rate?" and "Do we [they] belong?" There is something of a vicious circle quality, as one is reminded, about this constant reassessment of each other's posi-

[1] Keats, John, *The Crack in the Picture Window*. Houghton, Mifflin Co., Boston, 1955.

[2] Whyte, William H., Jr., *The Organization Man*, p. 308.

tion. "Yet it is at once the price of mobility and the product of effort. . . . It is a way by which every individual puts out antennae to feel where he is in relation to others."[1]

The suburbs and housing developments to which we have referred are those that foster middle-class values and assimilate their inhabitants into that value system. But there are other new communities that consist primarily of persons from the working class. About the transformations in ways of living promoted by them we know much too little. Recently Professor Bennet M. Berger has written a book dealing with largely semi-skilled, white automobile workers who moved from a drab industrial city in California, following a Ford plant relocation, to a relatively pleasant suburban tract where they were in the process of buying the houses in which they lived.[2]

Berger stated that "the achievement of a certain level of domestic comfort seems to be about the extent of any major change" in the living style of these workers.[3] He maintained that they displayed neither sociability nor status consciousness, and hence the theories of upward mobility and the melting pot were not applicable to them. It should be noted, however, that this tract had had only two and a half years in which to develop a neighborhood character. Moreover, he observed that the wives appeared much more "suburban" than the men in their interest in belonging to local organizations, subscribing to magazines, and meeting in small groups over morning coffee. Probably the wives had had more education, as is often true in the working class. It remains to be seen to what degree they might, over a longer period of time, assimilate the educationally and socially most deprived families into a common community culture.

PATTERNS OF LIVING OF THE LOWER CLASSES

In contrast to the foregoing picture of the way of life of what has been designated as the new middle classes, we must attempt to describe some of the observable aspects of a quite different

[1] Lerner, Max, *America as a Civilization*, p. 526.

[2] *Working Class Suburb: A Study of Auto Workers in Suburbia.* University of California Press, Berkeley, 1960.

[3] *Ibid.*, p. 23.

pattern about which professional people know the least. This will be called the pattern of living of the lower classes. Many of the aspects of behavior to be described are as applicable to the unskilled working class as to the group designated "lower class" on the preceding scale; some are applicable to the skilled working class and some even extend into the middle class.[1]

The features to be described are broadly familiar to most Americans, but they are generally considered inconsequential or unrelated to one another, and may elicit responses of amusement, disgust, or anger. From the anthropologist's point of view these features are "significant and meaningfully interrelated aspects of a distinctive culture pattern,"[2] and understanding of this pattern is not only important but essential for those institutions and agencies offering services to these groups.

Grammar and pronunciation provide one of the most immediate ways of identifying lower-class membership. "Ain't" replaces various forms of the verbs to be, to have, and to do; the double negative is frequently used; and pronunciation follows the most developed form of the local dialect.[3] It is this pronunciation and the often unfamiliar colloquialisms that middle-class persons may find "quaint" or amusing. "My old man" and "my old woman" are used to refer to one's husband or wife. "Pa" and "ma" are

[1] Dr. Walter B. Miller, an anthropologist, who has devoted several years to the study of lower-class culture, has attempted to estimate how many persons exhibit the characteristics of this cultural pattern. He concludes that 15 per cent of the population comprise the "hard core" lower-class group, although from 40 to 50 per cent are directly influenced by it in some respects.

[2] Much of the following description, including the quotations, has been taken from an unpublished paper, "Cultural Features of an Urban Lower Class Community" by Dr. Miller. See also his paper, "Lower Class Culture as a Generating Milieu of Gang Delinquency," *Journal of Social Issues*, vol. 14, no. 3, 1958, pp. 5–15.

[3] Pronunciation or "accent" is so revealing that persons trained in listening to the way a person speaks can generally detect the geographical area and the social background in which he grew up even though he has long left them behind him. In *Personal and Oriental* (Harper and Bros., New York, 1957, pp. 161–162), Austin Coates, an English writer, illustrates this generalization in his story of a Buddhist monk in Burma who had once been a London Cockney. Writes Coates: "To the end of his life he would never be able to conceal, had he indeed any wish to, that he was born in London. He spoke with a dry, whining, complaining Cockney accent. He discussed material affairs with the nasal intonations of an aircraftman complaining that he got sausages for breakfast when he wanted bacon. . . . His accent impelled speculation on his origin. Had he been dumb he would have belonged to the world. Because he could speak he might still belong, by right of mental conquest, to the world, but by birth he belonged to a certain social class in a certain part of London, a link which years and the Sutras, a shaven head and yellow robes, had not effaced."

customary forms of address for parents. Women use obscene words in talking with other women that are not heard in middle-class circles. Men engage in patterned forms of mutual deprecation and insult that are generally intended as jokes but sometimes seriously.

Almost as conspicuous identification as incorrect grammar is the tatooing on men's hands and arms, and the appearance of girls and women in public during the day with their hair in curlers perhaps partially covered with a kerchief.

Much of life, weather permitting, is spent in the street. Women gather in small groups on the sidewalk or in yards, or spend hours leaning out of windows watching street activities. Men congregate on the corners or in the corner bars. Families congregate on the front doorsteps. The strong emotional attachment to a particular locality and the relatively low attachment to the house or apartment are in sharp contrast to the middle-class love of home and privacy, both of which a family expects to be able to reproduce wherever it moves.

The lower-class community is tightly knit with strong patterns of interrelationships, a highly developed "grapevine" for informal communication, a willingness to contribute to a common fund to help an unfortunate member of the community, and a sense of "all being in this together." This sense is manifested by the local self-help associations, rapid identification of a stranger, suspicion of outsiders, and the rigid rule against "squealing" or revealing information to them.

Higher-class groups are often regarded as powerful and considered a legitimate target of exploitation. Thus to steal from a large organization, lie to the welfare worker, or try not to pay what is owed the grocer or landlord is considered less bad than informing on a community member. The capacity to "con" or outsmart representatives of middle-class agencies is often valued, violation of laws relating to gambling is widespread, and fictions to conceal the prevalent but illegal lower-class marital system are common.

Local, semi-formalized "clubs" and informal groups that congregate regularly proliferate in lower-class communities. They

are generally composed of members of only one sex, and take the form of ethnic clubs, barroom cliques, adolescent street-corner gangs, women's clubs that meet at one another's homes, men's amateur athletic teams and their affiliated "social" clubs. The solidarity produced by these associations is directly related to the structure of the lower-class family.

In this type of family the father frequently tends to be unstable, undependable, or entirely absent. A considerable proportion of lower-class marriages may be viewed as of two kinds, both deviant to middle-class standards: "serial monogamy" where the woman has a succession of temporary mates and lives without a mate during the interim periods; and the kind where the marriage persists over some unit of time but where the husband is frequently away for long stretches, recurrently away for shorter periods, or contributes little to the family group. In such situations the parental role is assumed predominantly by women—a fact that has critical implications for the development of the child. The mother is the dominant figure in the children's life, the father is usually regarded with bitterness and scorn. "The mother-son relationship," writes Dr. Miller, "is *the* dominant relationship of lower-class society—the one relationship the lower-class male, no matter how tough or irreverent, holds sacred."

It may be assumed that the one-sex peer group rather than the two-parent family group represents the most significant relational unit for both sexes in lower-class communities. For youngsters over twelve or thirteen membership in one of these units constitutes the major psychic focus and reference group. Men and women leave these units periodically "to form temporary marital alliances, but these lack stability, and after varying periods of 'trying out' the two-sex family arrangement, gravitate back to the more 'comfortable' one-sex grouping—whose members exert strong pressure on the individual *not* to disrupt the group by adopting a two-sex household pattern of life."

Under such circumstances the "family" has a very different meaning and function from that in middle-class circles where it is

the primary psychological focus for the child.[1] The lack of a stable father in the home presents difficulties in sex identification for the boy. Until he joins the corner gang at about ten his mother is his primary object of identification. His lack of a satisfactory male figure from whom to learn essential aspects of the man's role may well produce inner fears about homosexuality; these fears in turn contribute to the strong emphasis on toughness and masculinity that dominate lower-class male culture. In addition, he may have internalized his mother's perception of men as unreliable and reprehensible, and thus developed lifelong feelings of self-hatred. Because of the "sacredness" of his relationship with his mother, it is difficult for him to express directly any hostility toward her; instead, this pent-up hostility may be turned toward his wife when he marries, and often takes the form of resentment against her attempts to limit his "freedom."

This family system has an equally important impact on the lower-class girl. Although she has a female figure with whom to identify, there is little opportunity for identification with a satisfactory figure of the other sex. She is, moreover, exposed to her mother's complaints about the inadequacy and undependability of her father. As a consequence, she is likely to develop highly unrealistic fantasies, reinforced by the habitual reading of magazines of the *True Confession* type, about the kind of husband she wants and expects to find. "Her resolve that *her* husband will *not* be the same kind of man as her father is almost inevitably frustrated. Unless some extremely unusual life circumstance occurs, she will meet and mate with men reared in the same cultural milieu and by the same unstable-father kind of family as her own."

After the period of brief courtship and early marriage is ended, the girl's husband will probably resume the behavior pat-

[1] For a brief discussion of how the social role and the stability of the family differ in the several classes, see August B. Hollingshead's "Class Differences in Family Stability" in *Social Perspectives on Behavior*, edited by Stein and Cloward, pp. 45–52. For excellent illustrations, which contrast behavior in unskilled working-class families with that in the lower-middle class, see Jerome K. Myers and Bertram H. Roberts' *Family and Class Dynamics in Mental Illness*, John Wiley and Sons, New York, 1959.

tern that he has temporarily suspended. He will gravitate to the corner bar, spend much of his money betting on the horses and numbers, go on the usual Saturday night spree, return home drunk and extremely hostile to his wife, and heated arguments will follow. The girl feels disillusioned and cheated, communicates to her children her resentment against her husband and men in general, and the same life cycle is repeated. This cycle is reinforced by many of the values and concerns of lower-class culture and is widely prevalent; hence it cannot be regarded as a relatively isolated manifestation of a pathological family situation or "broken home."

Extramarital pregnancy is common among lower-class girls, particularly among depressed minority groups such as Negroes. Although there is concern about the practical difficulties involved in who will bring up the child, there is little of the intense shame and urgency for concealment found in middle-class families. In commenting on these extramarital pregnancies, Dr. Richard A. Cloward agrees with Miller that they are a response to restriction in opportunities to form stable, monogamous unions. "The problem of many girls in the lower class is not that they are likely to become unwed mothers but, rather, that the possibilities for becoming *wed* mothers . . . are extremely limited. Unless conditions which encourage and support a stable, monogamous family system are mobilized, it seems extremely unlikely that rates of illegitimacy can be appreciably reduced."[1]

[1] "A Proposal for the Prevention and Control of Delinquency by Expanding Opportunities." A Demonstration Project Conceived and Developed by Mobilization for Youth, Inc. (214 East Second St., New York 10009), 1961, p. 51. Mimeographed.

Chapter 6

IMPLICATIONS OF SOCIAL CLASS AND ETHNIC BACKGROUND FOR HEALTH SERVICES

BEFORE THE APPEARANCE of recent studies of the relation of cultural factors to medical and health services, the late Dr. Alan Gregg, then vice president of the Rockefeller Foundation, discovered what he considered to be the large potential importance for the clinical practice of medicine of an understanding of social class. His discovery resulted from reading the *Yankee City Series*, which the Yale University Press had begun to publish in 1941 under the authorship of W. Lloyd Warner and his colleagues. With nothing more than these volumes for systematic background, Dr. Gregg decided to make an informal investigation of what commuters from Westchester County to New York, chiefly business executives and professional men, knew about social class, where they placed themselves and others in the class structure, and whether recognition of class variations helped them explain differences in ways of thinking and acting. Daily conversations with persons beside whom he sat down on the train convinced him that he had found something scarcely less important than psychiatric knowledge in interpreting many aspects of behavior and attitudes.

As he reviewed with the writer on various occasions what he had learned, he declared that if he were only younger he would make as much effort to have this area of social science knowledge introduced into the medical school curriculum as he had in encouraging the introduction of a broad first-year course in psychiatry. He admitted he had discovered that consideration of social class was threatening upon first encounter to some of the

persons with whom he had talked. He maintained, however, that this difficulty could be overcome with probably less discomfort than that suffered initially by health practitioners who had attempted to understand psychoanalytic theory or who had had a personality assessment. Hence, said he, he would begin a talk on social class to young practicing physicians as follows: "Gentlemen, this evening we are going to deal with a subject that you may find very upsetting if you have not thought about it before. But your ability to face up to this subject and become acquainted with its content and its applicability, may determine to no inconsiderable degree your future success as clinicians."

Since that time social scientists, often working in medical and health centers in collaboration with members of the health professions, have made studies designed to attempt to indicate relationships between cultural factors, including social class and ethnic background, and various problems encountered in public health. To a lesser degree similar undertakings have focused on questions of immediate concern to clinicians. Although many efforts are still in early stages, several important gains have already been achieved: the published reports have established relationships some of which had scarcely been envisaged formerly; insufficiently concrete as are most of the reports in providing specific answers to practical problems, some offer helpful guidelines to how answers can perhaps be found, and scattered through them are at least isolated data and suggestions that practitioners might find immediately useful.

Because it is not possible to review any considerable portion of these studies in this brief monograph, an arbitrary selection has had to be made. Those that are discussed here have been chosen as illustrative of the nature of the work being done and of their applicability to aspects of patient care as well as to public health programming.

SOCIAL CLASS AND RECOGNITION OF SYMPTOMS NEEDING ATTENTION

In 1954 the Columbia University Press published a pioneer study by the late Professor Earl L. Koos entitled *The Health of*

Regionville. Regionville was a pseudonym for a small town in upper New York State; approximately 500 families in it, representing all the socioeconomic groups, were interviewed during four years about perceptions concerning their health and what medical attention they thought was indicated. Koos found that three social classes would encompass the town's population: Class I, composed of families whose husbands were professional men, business owners, or managers; Class II, where the heads of families were wage-earners or fairly prosperous farmers; and Class III, where the family heads held the least desirable jobs or had poor farms.

During the third visit to these families, the persons being interviewed were asked to indicate whether each of a list of readily recognizable symptoms should be called to the attention of a doctor. Although it had been assumed that some class differences in attitudes would appear, the significance of the differences was

PERCENTAGE OF RESPONDENTS IN EACH SOCIAL CLASS RECOGNIZING SPECIFIED SYMPTOMS AS NEEDING MEDICAL ATTENTION

Symptom	*Class I*	*Class II*	*Class III*
Loss of appetite	57	50	20
Persistent backache	53	44	19
Continued coughing	77	78	23
Persistent joint and muscle pains	80	47	19
Blood in stool	98	89	60
Blood in urine	100	93	69
Excessive vaginal bleeding	92	83	54
Swelling of ankles	77	76	23
Loss of weight	80	51	21
Bleeding gums	79	51	20
Chronic fatigue	80	53	19
Shortness of breath	77	55	21
Persistent headaches	80	56	22
Fainting spells	80	51	33
Pain in chest	80	51	31
Lump in breast	94	71	44
Lump in abdomen	92	65	34

Reproduced from Koos, Earl Loman, *The Health of Regionville*, Columbia University Press, New York, 1954, p. 33.

unexpected. Recognition of the importance of the symptoms was uniformly high among the 51 Class I respondents; only "loss of appetite" and "backache" were checked as needing medical attention by fewer than 75 per cent. The 335 Class II respondents indicated less sensitivity; "continued coughing" was the single item where they showed the highest percentage of recognition. Among the 128 Class III respondents the indifference to most symptoms was marked; 10 were checked by 25 per cent or fewer and only three, all associated with unexplained bleeding, were checked by more than 50 per cent.

Class disparity existed, moreover, between the symptoms recognized as important and what was done about them when they occurred. For the educationally and financially deprived, costs were not only a primary consideration, but "going under the knife" and the hospital as "the end of the road" were terrifying perceptions, while a sense of urgency was often relatively weak. Said a Class III mother, who had had a prolapse of the vagina for more than two years, "I wish I could get it fixed up, but we've just got some other things that are more important first. Our car's a wreck, and we're going to get another one. We need a radio, too, and some other things. If my husband's job holds out, we'll get them, and then I'll have it done, if it doesn't cost too much. . . . But it's got to wait for now—there's always something more important."[1] By comparison, in a Class II family every cent possible was being saved and every member was making sacrifices in order that the mother, with a similar diagnosis, might have surgery performed.

The attitudes of a family's reference or peer group also proved to be important in determining whether medical attention would be sought. Women in Class I were heard to remark that regular visits to the pediatrician or asking the doctor to make a home call if a child had chicken pox were not considered necessary by some of the mothers; yet they "went along" with these practices because it was the expected thing to do. In contrast, a housewife in Class III stated, "I'd look silly, wouldn't I, going to see a

[1] *Ibid.*, p. 38.

doctor for a backache. My mother *always* had a backache, as long as I can remember, and didn't do anything about it. . . . If I went to the doctor for that, my friends would hoot me out of town."[1]

Subsequent studies in various places have elaborated on other than the economic reasons for class or ethnic disparity in the use of therapeutic and preventive resources. Orientation to time appears to be a not unimportant factor that had received insufficient attention until social scientists pointed to how some class and ethnic groups tend to live in the present while others live in the future.

Commenting on the study, *A Thousand Families*, of Newcastle, England, Margot Jefferys noted that, regardless of health insurance, mothers in the poorest families often postponed a visit to the doctor's surgery, or refrained from calling him in, until the situation was serious. The relatively smaller or delayed use of pediatric and prenatal clinics by the wives of unskilled workers could be partially accounted for, in Mrs. Jefferys' opinion, by general attitudes toward the present and the future. "The preventive services of the local health authority are essentially future-oriented services and will only appeal to those with a sense of the future."[2] Among the several reasons that working-class parents have more children than they can support or even want, is their inability, Dr. Rainwater believes, to project their lives into the future.[3]

Persons who are familiar with Professor Lyle Saunders' *Cultural Difference and Medical Care: The Case of the Spanish-Speaking People of the Southwest*, will recall his delightful and pertinent discussion of how the Spanish-speaking of the Southwest have a long heritage of orientation to present and recently past time, to clocks that walk, and to leaving until mañana what does not have to be done today.[4] By contrast, for Anglo-Saxons, including

[1] *Ibid.*, p. 37.

[2] Jefferys, Margot, "Social Class and Health Promotion: Some Obstacles in Britain," *Health Education Journal*, May, 1957, p. 114.

[3] Rainwater, Lee, *And the Poor Get Children: Sex, Contraception, and Family Planning in the Working Class*. Quadrangle Books, Chicago, 1960.

[4] Russell Sage Foundation, New York, 1954, pp. 117–122.

those who staff health clinics and provide medical services, "time is money," clocks run, and patience wears thin when patients are late or fail to appear for appointments.

For some years Drs. Florence R. Kluckhohn, an anthropologist, and John Spiegel, a psychiatrist, have attempted to analyze the interrelatedness of factors that contribute to the emotional "health" or "illness" of families. One of the factors examined was difference in concepts of time in their sample families, composed of old-stock Americans, and Italian Americans and Irish Americans whose parents were born in this country but whose grandparents came from Europe. Among the last two groups, like the Spanish-speaking, orientation tended to be to the present, then the past, and finally the future. Among the old-stock Americans it was first to the future, then to the present, and last to the past.[1]

Closely linked with attitudes about time are those concerning man's relation to nature. This relationship was a second factor considered in the Kluckhohn and Spiegel study. As has been noted earlier, the prevalent American culture has emphasized dominance over nature or man as the master of his fate. On the other hand, the Italian and Irish Americans studied viewed themselves as subject to nature or as working with nature more readily than as its masters.[2] Mrs. Jefferys commented on a similar attitude among unskilled workers in the Newcastle sample. "They tend to meet difficulties by resigning themselves to them, and by adjusting to them, rather than by fighting to overcome them. Where illness is concerned, they are more likely to adopt a fatalistic attitude and to discount their own ability to take effective preventive measures."[3]

SOCIAL CLASS AND MENTAL ILLNESS

Slightly more than half of all hospital beds, as is well known, are occupied by mentally ill patients. Large numbers of other

[1] Kluckhohn, Florence R., "Family Diagnosis: Variations in the Basic Values of Family Systems," *Social Casework*, vol. 39, February–March, 1958, p. 69.

[2] *Ibid.*, p. 69.

[3] "Social Class and Health Promotion," *Health Education Journal*, May, 1957, p. 115.

persons receive treatment in clinics and private offices of psychiatrists, while still larger numbers go untreated. Because so little is still known about the cause, treatment, prevention, and cure of mental illness, recent years have seen the initiation of studies by behavioral scientists designed to supplement those of neurologists, psychiatrists, and biochemists. The behavioral scientists have made the assumption that the social environment in which people live is related to the development of mental illness. As part of that social environment, social class and ethnic background have received attention.

Two large research undertakings of the 1950's were particularly concerned with social class. One of them was the community study of Greater New Haven, which resulted in many published papers and two volumes: *Social Class and Mental Illness*, by Hollingshead and Redlich, referred to earlier, and its companion, *Family and Class Dynamics in Mental Illness*, by Jerome K. Myers and Bertram H. Roberts (John Wiley and Sons, New York, 1959). An early step in this study was the taking of a census of all New Haven residents who were receiving psychiatric treatment on a specified day of the year, whether in private offices, clinics, or hospitals over a considerable part of the United States. One thousand, nine hundred and sixty-three such persons were found. The population of New Haven, as well as the persons in the patient census, were then assigned to five social classes on the basis of residential area, and the occupation and education of the head of the family. Three per cent of the population were in Class I, nine in Class II, 21 in Class III, 49 in Class IV, and 18 in Class V.

When comparison was made between the class assignment of the population and that of the patients, several clear-cut facts emerged. A definite association was found to exist between class position and being a psychiatric patient. The rate for the mentally ill receiving psychiatric treatment in Class V was three times as high as the rate in Classes I and II, which were combined because of their small size. When type of psychiatric disorder was examined, the neuroses were found to be highest in Classes I and II, with a decline in rate in each succeeding class.

On the other hand, the psychoses had the lowest rate in Classes I and II and increased with each class until the rate for Class V was seven times higher than that of Classes I and II. If schizophrenia alone was considered, which was the diagnosis of 58 per cent of all patients, its rate in Class V was nine times that of the two combined classes.

What was just as conclusive as these rates was evidence showing a significant relationship between social class membership and where and how a patient is treated. The higher the social class, the greater the percentage of patients who receive treatment in private practice or private hospitals. The use of clinics was proportionately greatest in Classes III and IV. The state and Veterans Administration hospitals had a concentration of lower-class patients. Treatment had been categorized at the beginning of the study as including psychotherapy, organic treatments, and custodial care. Psychotherapy was the favored method of treatment in Classes I and II; organic treatments in the intermediate classes; while the lowest class tended to receive little more than custodial care, since the new tranquilizing drugs had not yet come into use and the concept of the therapeutic community was only beginning to be formulated.

The portion of the investigation that resulted in the second volume was composed of an intensive case study of 50 patients between twenty-two and forty-four years of age, equally divided as to sex. They were selected from the Class III and Class V categories, with each category represented by equal numbers of schizophrenic and neurotic patients. Myers and Roberts cautioned their readers that their emphasis on social class should not be interpreted to mean that they considered it the only or the most important factor related to the development of psychiatric illnesses. Research and clinical findings pointed to the importance of constitutional, organic, intrapsychic, and interpersonal factors as well as environmental.[1] They cautioned, furthermore, that social class did not seem to be a direct cause.

Rather, living at a given social level apparently helped to determine the probability of a patient's exposure to certain pres-

[1] *Family and Class Dynamics in Mental Illness*, p. 247.

sures from the external environment and the development of certain internal stresses. It affected the patient's familial and community experiences, such as types of interpersonal relationships, family roles, opportunities for employment, and mobility experiences. Living under such differing life conditions also may have affected differentially the patient's intrapsychic processes and ego development which seem more directly related to the development of functional mental illness.[1]

The second research undertaking, generally known as the Midtown Community Mental Health Study, for which the late Dr. Thomas A. C. Rennie, Dr. Leo Srole, and Dr. Marvin K. Opler of Cornell University Medical College carried major responsibility, went a step farther to include people from their selected area who either were in treatment or who required psychiatric help without having received it.[2]

"Midtown" was a white residential section of New York City, ranging from great wealth to poverty, with approximately 172,000 persons.[3] About one-third were native-born New Yorkers; one-third were American-born migrants to New York; and the remaining one-third were foreign-born immigrants, chiefly German, Irish, Czech, Hungarian, Italian, and British. Three social classes were used for describing the population: upper, middle, and lower. A large staff of professionally trained persons spent some two hours interviewing each of 1,660 individuals representing a random cross section of the portion of the community that was between twenty and fifty-nine years of age.

When the staff psychiatrists had evaluated the psychological data obtained from each interview, they concluded that 75 per cent of the persons in the sample manifested symptoms of anxiety, and that the figures were similar for the three classes. Hence they concluded that anxiety is a highly generalized psychological

[1] *Ibid.*, p. 248.

[2] The results of this study have been published, or are planned for publication, as the *Thomas A. C. Rennie Series.* Volume 1, *Mental Health in the Metropolis: The Midtown Manhattan Study* by Leo Srole and others, was published in 1962 by McGraw-Hill Book Co., New York.

[3] This summary has been taken from Dr. Opler's paper, "Urban Life and Mental Health: Socio-Economic Status and Mental Disorder in the Metropolis," *American Journal of Psychiatry*, vol. 113, March, 1957, pp. 831–836.

phenomenon. All other "symptom constellations"—rigidity, suspiciousness, depression, hypochondriasis, alcoholism, immaturity, neurasthenia, withdrawal, and passive dependency—were most prevalent in the lower class and least prevalent in the upper. In the psychiatrists' rating of mental health, the ratio of severely disturbed to symptom-free respondents was roughly three times larger in the lower class than in the middle class, and approximately three times larger in the middle than the upper class.

However, the proportion of severely disturbed who were in therapy at the time they were interviewed was only 1 per cent of the lower class, 4 per cent of the middle, and 20 per cent of the upper. It was found, furthermore, that the men with downward mobility (as compared with the occupations held by their fathers when the latter were in the forty to fifty year age-range) had the highest rate of severe disturbance, and those with upward mobility the lowest. This suggests that mental disorder tends not only to deter upward occupational mobility but also to precipitate downward mobility.

SOCIAL CLASS AND PUBLIC HEALTH

It should be apparent from the foregoing that social psychiatry and the mental health movement, as well as public health generally, have good reason to interest themselves in variations among social class and ethnic groups. As Dr. Marvin K. Opler has reminded readers, "differences in incidence, prevalence, and type of disorder provide a practical basis in planning for mental health problems and give insight into the necessary ingredients of preventive techniques."[1]

Public health, however, is faced not only with the problem of class-linked mental illness but with the problem of chronic physical diseases. Before some of the communicable diseases were largely wiped out and others reduced in incidence or severity, it had long been assumed that socioeconomic factors played a considerable role in the high mortality resulting from them. On the other hand, it was assumed that the chronic diseases bore no

[1] *Culture and Mental Health.* Macmillan Co., New York, 1959, p. 13.

relation to social class, since they were not apparently aggravated by poor sanitation, crowded and inadequate housing, and similar environmental conditions.

The study that Dr. John M. Ellis has made of Houston, Texas, based on the average number of deaths for a three-year-period, indicates a clear relation between mortality from chronic as well as communicable diseases and socioeconomic group.[1]

The seven diseases leading to the highest mortality among the white population were tuberculosis, pneumonia, malignant neoplasms, diseases of the heart, diabetes mellitus, nephritis, and vascular lesions. Using a five-class scale, Ellis was able to demonstrate an inverse relation between socioeconomic status and mortality. Death rates were much higher for each disease in Class V than in Class I. (It is interesting to note from his statistical tables that, except for malignant neoplasms, Classes II and III showed a relatively favorable mortality experience for the chronic diseases.)

Among the nonwhite population of Houston, which has a lower standard of living than the white population, mortality showed the same inverse relationship. The total death rates for all seven diseases, moreover, were higher among the nonwhites than the whites. White males had slightly higher rates for diseases of the heart and diabetes, but the death rate among the nonwhites for vascular lesions was more than twice as large.

In commenting on his data, Ellis maintains that it is reasonable to assume that the chronic diseases should show higher death rates among people of low economic status. In many instances these diseases respond to treatment if they are diagnosed early and adequate treatment is secured. But the obtaining of medical intervention requires access to information regarding the importance of early diagnosis, motivation to act, and the financial ability to afford expensive and often prolonged treatment.

With the problems of providing mass information and stimulating motivation, the public health movement has concerned

[1] "Socio-Economic Differentials in Mortality from Chronic Diseases" in *Patients, Physicians and Illness*, edited by E. Gartly Jaco. Free Press, New York, 1958, pp. 30–37.

itself assiduously for years. Yet it has often been in a quandary about why its educational endeavors have not met with greater success in changing attitudes and in encouraging large segments of the population to take advantage of existing resources for the detection and treatment of disease. In recent years behavioral scientists have pointed to the fact that the public and mental health movements have been conceived and implemented primarily by upper-middle-class people and, although their efforts have frequently been directed toward the working class, their greatest success has been with the middle class.[1] The assumption appears to be that middle-class values and even forms of expression are so incongruent with the values of the lower socioeconomic groups that communication often fails to produce the desired effect and may in fact produce adverse effects.

A study concerning information about mental health provides some evidence to substantiate this assumption. An analysis was made of the material dealing specifically with the nature of mental health, which appeared in 27 mental health pamphlets.[2] Approximately 60 per cent of the text analyzed contained statements that the authors identified as falling within the middle-class cultural mold, and the accompanying pictures portrayed middle-class households and executives at work. Themes running through the material were classified by the authors as follows: adjustment and conformity, problem-solving, value of work, control of emotions, planning ahead, striving, and community participation.

The authors suggest that the mental health movement contributes to the maintenance of the middle-class sociocultural structure by providing authoritative, "scientific" support to middle-class values and orientation. To the extent that the movement is successful in advancing this mental health prototype as a desirable model to emulate, it may have a disorganizing effect on the lower-class persons who accept it. The "message" sets forth

[1] Simmons, Ozzie, "Implications of Social Class for Public Health" in *Patients, Physicians and Illness*, pp. 107–113.

[2] The following description is taken from Gursslin, Orville R., Raymond G. Hunt, and Jack L. Roach, "Social Class and the Mental Health Movement," *Social Problems*, vol. 7, Winter, 1959–1960, pp. 210–218.

a very unrealistic way of life for those who must make some adjustment to the conditions and culture of the lower classes. Persons who take on the behavior implied in the mental health model are likely to find themselves alienated from lower-class society as well as subjected to other stresses of upwardly mobile types. The authors conclude, "We are confronted with the paradox that the mental health educational effort may actually operate to produce that which it is manifestly intended to combat."[1]

This report reminds the writer of schools visited in an Indian village in one of the Latin American countries some years ago. Middle-class teachers from a predominantly Spanish cultural background were not only attempting to teach small children to memorize facts that had almost no meaning within their cultural pattern, but were teaching in the Spanish language, a completely foreign tongue to the boys and girls. Just at that time a "cultural mission" arrived from the federal ministry of education to promote the concept, very new to the teachers, that the content of the early grades should consist of material relevant to Indian life and the teaching should be in the native language. Gradually facts about the country as a whole and the use of Spanish could be introduced to prepare these youngsters to participate in the national life. Unless the content and the language were changed, said the members of the cultural mission, children would continue to drop out of school before they had learned either Spanish or anything immediately useful to them.

Social scientists conclude that it may be almost equally important to attempt to learn what content and forms of communication are needed if both public health personnel and private practitioners are to increase their effectiveness in working with persons whose social and educational background is quite unlike their own. Mrs. Jefferys has suggested that in Britain the existence of marked differences between social classes in morbidity and delinquency rates represents the major challenge for the health and welfare services. "The elimination of these differences de-

[1] *Ibid.*, pp. 215–216.

pends, in the first instance on discovering the interacting social, economic, and genetic factors responsible for them; in the second place, it involves the imaginative use of this knowledge to modify the influence of these factors so that they eventually become ineffective."[1] Most readers would probably agree that class and ethnic, as well as genetic, differences present a comparable challenge in the United States, and that far more research of a discriminating nature than is now available will be necessary, including experimental research about how to make "imaginative use" of it.

SOCIAL CLASS AND ETHNIC FACTORS AND DIRECT PATIENT CARE

Unfortunately, the kind of literature that would be most immediately helpful to doctors, nurses, and social workers who provide attention to the individual patient in the office and hospital is particularly limited. It is either scattered through the basic texts and journals of the behavioral sciences or it is often a byproduct of research connected with mental illness.[2] Some indication, however, must be given of the nature of pertinent studies.

Studies of Stress

Reference has been made repeatedly in earlier pages to stresses suffered by individuals and groups that result from ethnic background, social class, and intergenerational conflicts in families undergoing acculturation. Marvin K. Opler has pertinently observed, "It is less important to know the Melting Pot is producing acculturation than to know the strains are there today."[3] Hence the subject of external pressures and internal strains has received particular attention from persons working in the psychiatric field. But the subject is scarcely less important for those concerned

[1] "Social Class and Health Promotion," *Health Education Journal*, May, 1957, p. 116.

[2] The fact should not be overlooked that studies such as the *Yankee City Series*, *Social Class and Mental Illness*, and *Family and Class Dynamics in Mental Illness*, as well as discriminating fiction, provide a wealth of descriptive material about life patterns beyond what could be presented in this monograph.

[3] "The Influence of Ethnic and Class Subcultures in Child Care," *Social Problems*, vol. 3, July, 1955, p. 18.

with psychosomatic complaints or with furnishing understanding care and comfort to the physically ill and their families.

As illustrative of these studies we wish to refer to the examination by the late Dr. Paul Barrabee, a sociologist, and Dr. Otto Von Mering, an anthropologist, of ethnic variations in stress that they found within families that had a psychotic member hospitalized at the Boston Psychopathic Hospital, now named the Massachusetts Mental Health Center. It was their basic contention that variations in modes of stress not only exist between ethnic groups, but that these differences are related to differences in family social structure as influenced by ethnic values.

What makes this examination of general interest are the descriptions of family patterns among lower-class Irish, Jewish, and Italian families and middle-class Old Yankees from the Boston area. The descriptions are the product of a synthesis of data collected from some twenty hours of interviewing *each* of 69 patients between eighteen and thirty-five years old, as well as all available relatives, and the doctors and social workers concerned. The excerpt presented below will give persons in clinical practice an opportunity to judge the potential usefulness of such material. It deals with central tendencies in emotional relations within the families of the four ethnic groups and the effect of these tendencies upon the male child.

> . . . There is an alliance or mutual preference between the mother and son in our Irish families. The mother exhibits a sex-linked preferential solicitude. However, she shows a lack of overt affection, which is coupled with strict discipline and a failure to reward in general for parentally approved behavior. The son experiences stress over this constellation of factors and tends to react to them with excessive dependency feelings on his mother which are punctuated by frequent verbal aggressions.
>
> The Irish father remains somewhat detached from his son but maintains a supervisory right that is all-inclusive. Like the mother, the father frequently belittles his son about his "looks" and behavior to make him feel subordinate, which is very stressful to and resented by the son. However, the Irish son does not develop strong emotional reactions toward his father and is apt to accept his subordination to him with little conflict because the number of situations in which he

could experience subordination to him is much less in comparison to those he experiences with his mother.

The mother-son relationship in our Jewish families tends to be highly emotional. The mother is apt to be overprotective and overtly affectionate. She employs the withdrawal of love technique as her primary means of control. This emotional situation engenders in the son a distressful concern over the inconstancy of maternal love. He responds to it with highly ambivalent feelings to his mother, combining an exaggerated dependency and deep-rooted repressed hostility. The Jewish father is not very punishing, but he also yields much of the control over his home life to his wife. The Jewish son is not likely to have strong negative feelings toward his father, but neither is he likely to accept him as a role model.

The Italian son is the recipient of sex-linked preferential treatment from both his parents. There is little concern with affection and practically no overt display of it, but the Italian mother is apt to be oversolicitous, partly due to the superior status of males, and partly due to her concern over her son's physical welfare. The father's rigidity and propensity for physical punishment induces the mother to act as a buffer between father and son. The son reacts to this situation by feeling obligated to carry out maternal commands without hesitation, which tends to increase his emotional dependence on her. While the son enjoys the protection provided by his mother against his father, neither parent shows interest in his personal problems. Moreover, the father's extreme strictness tends to create a fear-ridden respect for him in the son, so that the latter feels he cannot dare reject the father as a role-model though he rejects him as a symbol of warmth. It is these aspects of the son's emotional position in the Italian home which prove very stressful to him in the long run because role expectations are not supported by emotional security.

The element of positive affect is important in the Yankee family, but there is a pronounced tendency not to display it overtly. The mother is quite overprotective and restrictive in the care of her son, who often must compete with his sisters for the affection of his father. The competition for parental affection between siblings of both sexes is both intense and highly stressful for the Yankee boy, especially since he has to reach constantly for indirect signs of love in things that his mother does for him rather than to look for and find evidence of love in a more direct fashion. The Yankee father is not very dominant, nor inclined to make much use of physical punishment. He is likely to be rejected as a role model, but also is not apt to be the object of the intense affect that the son feels toward his mother. The

great difficulty in identifying with his father in a specific area of conduct and in having to rely almost exclusively on his mother's emotional guidance appears to be very stressful to the Yankee boy. The Yankee mother uses the withdrawal of love technique of control more importantly than any other, but she differs from the Jewish mother by emphasizing the moral implications of transgression rather than its impact upon her personal attitudes. The vague pervasiveness of the moral implications of all his conduct appears to be highly stressful to the Yankee boy, who responds with a deep emotionality to his mother that contains a high degree of guilt and a strong sense of inadequacy.[1]

Some persons may doubt the reliability of data obtained under the conditions noted above. Hence we wish to present another illustration where social scientists attempted to discover what "well" mothers from several European backgrounds thought about the child-rearing practices of day care centers in one part of New York City. Like the illustration already presented, no case can be made for the scientific validity of the data. Rather, this description is presented to indicate the range of variation in relatively subtle values from group to group, and to suggest how serious the consequences of established practices may be for the children of parents caught in culture conflict.

In one [Day Care] Center it was found that the German-American mothers . . . harped on the disciplinary problem of children. Coming from urban and rural lower-middle-class families abroad, work and discipline were more important than the encouragement of spontaneity. With highly controlled and rigid backgrounds of their own, they overcame such spontaneity as was encouraged in the nursery school program. Such efforts were backed or instigated by paternal demands in the first generation for greater obedience. In several children, the home-school schism led to further behavioral problems in school since acting out and the easy expression of feelings was forbidden at home. . . .

Irish mothers, in the same districts, worried less about discipline. Compliance to authority, far from being a discipline, had an official

[1] Barrabee, Paul, and Otto Von Mering, "Ethnic Variations in Mental Stress in Families with Psychotic Children," *Social Problems*, vol. 1, October, 1953, pp. 50–51. For a discussion of culturally determined family roles, particularly husband-wife roles, see John P. Spiegel's "The Resolution of Role Conflict within the Family" in *The Patient and the Mental Hospital*, edited by Greenblatt, Levinson, and Williams, Free Press, New York, 1959, pp. 545–564.

and sanctified glow about it or was self-rewarding in such areas as school and church. In the family scene, Irish mothers *had* authority, and unlike the German did not need to assert it. Yet boys and girls showering in the nude, hardly a problem in German mothers' consideration of the school, was frightening [to] the Irish. It unleashed or projected personal and cultural attitudes about nudity, sin and sex, for which unfortunately the children were not prepared by parental instruction. "We don't talk about such things," might be uttered crisply. Usually the very fears and pruriency grew richly in silence and neglect. . . .

While German and Czech mothers welcomed cleanliness and coolness for their children, the sunbathing which went with showers was called a part of good "physical culture," consistent with support of Czech *Sokol* or German *Turnverein* activities. Yet even here there was not always unanimity in values. Slovakian mothers from more rural backgrounds welcomed the exercise, but frowned on nudity for little girls more than for boys. In contrast to this last patriarchal attitude, Czechs argued with more sophistication and urbanity that what was good for boys was good for girls as well.[1]

One of the most widely quoted studies of the cultural components of stress among patients hospitalized for physical difficulties concerns itself with differences among patients of Jewish, Italian, and Old American origin in their responses to spontaneous pain.[2] A Veterans Administration hospital was selected for the study by Dr. Mark Zborowski, an anthropologist, because of its considerable number of patients from each of the ethnic groups. Like these federal hospitals generally, the patients were predominantly below the middle class; unfortunately for the research they were exclusively men. Eighty-seven patients who experienced acute pain, chiefly from herniated discs and spinal lesions, were interviewed for approximately two hours each; the interviewing was generally followed later by informal conversa-

[1] Opler, Marvin K., "The Influence of Ethnic and Class Subcultures on Child Care," *Social Problems*, vol. 3, July, 1955, p. 17.

Those interested in how child-rearing practices within the family vary according to social class and between Negroes and whites are referred to Allison Davis and Robert J. Havighurst's "Social Class and Color Differences in Child Rearing" in *Social Perspectives on Behavior*, edited by Herman D. Stein and Richard A. Cloward, Free Press, New York, 1958, pp. 419–432.

[2] Zborowski, Mark, "Cultural Components in Response to Pain," in *Patients, Physicians and Illness*, edited by E. Gartly Jaco. Free Press, New York, 1958, pp. 256–268.

tions and observation of the patient's behavior, and discussion with physicians of medical aspects of the problem.

Jews and Italians were selected chiefly because the medical experts suggested that they displayed similar reactions to pain, and it has been popularly assumed that similar reactions reflect similar attitudes. Both groups were very emotional in their expression of pain: they complained, groaned, moaned, and cried without embarrassment; they called for help, expected sympathy and assistance particularly from members of their family, and did not want to be left alone.

But the attitudes of the two groups toward pain were very different. The Italian patients appeared to be mainly concerned with the immediacy of the pain experience and were disturbed by the actual pain sensation. If given drugs that relieved them of their pain, they seemed to forget their suffering and to appear happy and gay. The concern of the Jewish patients was focused chiefly upon the symptomatic meaning of pain and upon its significance in relation to their health, welfare, and the welfare of their families. Thus in their complaints and behavior they expressed primarily their worries and anxieties. Often the Jewish patient was reluctant to take the analgesic offered him because of his fear that it would be habit-forming, or because it would only relieve the pain temporarily and not cure him of the disease that produced the pain. After such patients had been relieved, they frequently continued to appear depressed and worried, since they felt certain that the pain would recur as long as there was no complete cure.

The Old Americans presented still another picture. They complained little; instead, they attempted to report to the doctors on the quality, localization, and duration of the pain, and tried to cooperate as fully as possible with all the members of the staff whom they viewed as helping them to get well. When members of the family and friends were present, efforts were made to minimize the pain and to avoid complaining and arousing pity. If the pain was unbearable, these patients frequently wished to be alone so that they could moan or cry without being seen or heard. To keep from being a nuisance and to be as cooperative

as possible was viewed as the ideal form of behavior, which some of them characterized as "American." (This was also the ideal behavior as seen by the professional staff, and persons who did not try to achieve it were often considered deviants, hypochondriacs, or neurotics.)

Like the Jewish patient, the attitude of the Old American toward pain was one of future-oriented anxiety. He too was concerned with its symptomatic significance, but while the Jew tended to be pessimistic or at least skeptical in outlook the Old American was fairly optimistic. For him the body was thought of as a machine to be well taken care of, to be checked periodically, and to be repaired by an expert if there was difficulty. Confidence in physicians as experts and in the progress of medical science permitted a considerable degree of optimism even under intractable pain, if only something were being done. Hospitalization itself was perceived as the evidence of action and hence the Old Americans were inclined to prefer it to home treatment, while Jews and Italians were more often disturbed by its impersonal atmosphere.

Culturally Conditioned Perceptions and Relationships

An upper-class Jewish woman in her early forties was admitted to a long-established Woman's Hospital for a hysterectomy. Because of her attractiveness and ability, her social position, and the thoughtful consideration of a devoted family, she had received much attention and recognition throughout her life; she had, however, recently experienced the severe shock of her husband's sudden death.

The surgical intervention was highly successful, but shortly afterward the patient began to regress emotionally and then physically. The surgeon, who could not understand this unexpected occurrence, requested that a psychiatrist-friend of the patient come to the hospital as a consultant. After visiting the patient, the psychiatrist reported to the surgeon that the cause of the difficulty was entirely clear. The only problem, said he, was that Mrs. P had selected the wrong hospital. She had chosen an Old American institution where emotional restraint and cooperation were held by staff to be cardinal virtues.

When Mrs. P did not receive the degree of individualized attention to which she was accustomed and which she fully expected, she became complaining and demanding. The more emotion she dis-

played, the more staff unconsciously tended, so the psychiatrist hypothesized, to withdraw from her. The more they withdrew, the more upset she had become until her physical recovery was retarded. The patient should have gone, concluded the psychiatrist, to the Jewish hospital in the city. Although it had no systematic knowledge about ethnic and class differences in overt reaction to stress, it was accustomed to care for patients who expressed their feelings readily and freely. In that institution it might be the quiet, restrained patients who would be overlooked and hence might receive inadequate attention.

In commenting on this explanation later, the psychiatrist said he was curious about what the surgeon had made out of the remarks; perhaps the latter had thought them scarcely short of flippant. But, said the psychiatrist, he was almost sure he was right in his interpretation although only a few months earlier such an explanation would never have occurred to him. In the meantime he had had much conversation with social scientists working in the hospital with which he was connected. These discussions had led him for the first time to examine the importance of certain cultural factors as determinants of the perceptions, attitudes, and behavior of patients, and equally those of the staff in interaction with patients.

The foregoing case suggests that systematic study is urgently needed of the extent to which ethnic and social class background influences the way patients see and react to the hospital, the treatment they receive, and the persons who provide treatment and care;[1] and similarly, the way staff perceive and react to patients and to each other. Not until far more is known about this possibly very important subject will professional schools have the material necessary to include in their teaching programs, or will doctors, nurses, social workers, and others be able to benefit, as Dr. Gregg had hoped, from new perspectives in the understanding of patients.

Psychiatrists have made some beginning in looking at this problem, particularly as the result of their examination of communication between therapist and patient. They would probably agree with Dr. Ozzie Simmons' generalization that the degree to

[1] For an instructive description of how various social levels of patients participating in a Family Health Maintenance Demonstration viewed the respective usefulness of physicians, public health nurses, and social workers, see *Patients' Views of Medical Practice* by Eliot Freidson, Russell Sage Foundation, New York, 1961, pp. 106–109.

which the qualities ideally defined as essential to the therapeutic process (mutual trust, respect, and cooperation) will be present in a given relationship, tends to vary inversely with the amount of social distance between clinician and patient. "The greater the social distance, the less likely that participants will perceive each other in terms of the ideal type roles of professional and patient, and the more likely that they will perceive each other in terms of their social status in the larger society."[1]

The therapeutic relationship should function best, generally speaking, where clinician and patient are most nearly alike in social background and mode of communication. In the two large studies of social class and mental illness described earlier, it was evident that the upper classes not only received more treatment but predominantly of the psychotherapeutic variety for which mutual trust, respect, and cooperation are essential. Although the economic factor is certainly an important determinant in obtaining such treatment, it is not the only one.

It is widely assumed that psychiatrists will have difficulty in establishing rapport with patients of the lower classes: in part, because of their lack of understanding of the life background of these persons; in part, because of the patients' lack of understanding of what is involved in a therapeutic relationship and also lack of skill in communication with those on higher educational and status levels. Dr. Edward A. Kennard cites a relevant study of 1,216 persons referred to a Veterans Administration mental hygiene clinic.[2] Thirty-two per cent of them were not accepted for treatment, probably because it was thought they would not benefit from it; of the remaining number, 27 per cent refused to undertake treatment even though it was offered them. For those that began, the median length of treatment fell between six and seven interviews; in two-thirds of the instances treatment was terminated by the patient himself, who had undoubtedly hoped to find some quick solution of his difficulty.

[1] "Implications of Social Class for Public Health" in *Patients, Physicians and Illness*, edited by E. Gartly Jaco, pp. 109–110.

[2] "Major Patterns of the Mental Hospital: U.S.A." in *Patients, Physicians and Illness*, p. 404.

Even though in the treatment of physical disease the therapeutic process rests less upon rapport than in psychotherapy, the foregoing assumptions concerning the applicability of social class and ethnic factors cannot be ignored. The observation has been reported frequently that many medical students and house staff receive their training preponderantly through the care of indigent patients whose lives are so foreign to them and whose social and economic as well as medical problems are so overwhelming that there is little real understanding between doctor and patient. Where medical students are sent into homes for a brief experience of seeing patients in their family environment, they may be accompanied by a public health nurse or a social worker who attempts some interpretation of sociomedical problems. Generally such small prior preparation or subsequent discussion is provided of class-linked differences in behavior and attitudes that students assigned to lower-class areas may be left with feelings of frustration and discouragement, if not hostility. It may be assumed that under these circumstances only the more perspective are likely to make observations that would subsequently be of particular value to them as practitioners.

> One medical student discovered that the members of the impoverished Negro and Puerto Rican families she visited never sat down at the table together for a meal. Instead, they ate whatever was available at such times as they came home. This discovery was both surprising and disturbing to her. Brought up as she had been in a social class where assembling at the table at regular hours is one of the conspicuous symbols of family life, she kept asking herself how there could be a family, other than biologically, if its members never met as a unit over meals. Had teaching materials been at hand and provision made for their use, this one question might well have furnished the basis for considering how the very concept of "the family" as a psychosocial entity varies from class to class, and how some knowledge of patterns of family behavior might enlarge the social competence and perhaps save the time of therapists interested in patient-centered medical practice.

Some medical schools have concluded that home visits to lower-class families provide poor preparation for a subsequent practice that is likely to be with middle-class patients. They

have, however, believed that it was valuable for students to gain insight into the effect of family relationships on health and sickness, or at least to see sick persons within the context of the family. That the plans they have consequently made may not produce the desired results without more attention to behavioral factors is illustrated by the following example.

> The medical school under consideration decided that each student should be given the experience of providing health counseling on a continuing basis to one family that was roughly comparable in social and economic background and in age to his own. It was later discovered, however, that the students were learning relatively little about meeting the total health needs of a family. They brought with them no organized body of psychological and sociological knowledge about families that would have furnished the necessary frame of reference for observation, and the differences between the families in their charge and their own were not sharp enough for pertinent questions to come to mind.
>
> As a consequence, a psychiatrist was asked to conduct a weekly discussion. He introduced such important subjects as child-rearing practices and sibling rivalry, but suggested that more comprehensive teaching was indicated. It is doubtful whether the university was canvassed for a behavioral scientist, who made "the family" his specialty, to participate in the discussions. A social caseworker on the staff of the department had had considerable experience in working with families, but she was not asked to assist because the medical faculty viewed her training and role as associated with service to the lower classes.
>
> She was distressed by what she considered the waste of students' time in learning to do health counseling through association with only one family whose problems were relatively narrow in scope and were not seen within a comparative frame of reference. Had she been permitted to accompany the students on their initial visit and provide casework supervision, she believed she could have helped them in their relationships with their particular families, and could have alerted them to something of the range of variations in family behavior that would be encountered within a broader definition even of the middle class.

Let us turn now from the problem of how medical students learn to perceive significant differences in value systems to the problem of differential perception of patients and staff within the

hospital setting. Of late, social scientists and psychiatrists have exhibited much interest in the "sick role," or the process whereby a person becomes a patient subjected to many kinds of limitation of his former independence of action and judgment. Similarly, attention has been given, as was seen in Part 1 of this series of monographs, to his perceptions of and reactions to the physical and social milieu of the hospital. The resulting analyses would seem to furnish much practical helpfulness to physicians and nurses who seek to deepen their insight into what it means to a person to find himself a hospitalized patient.[1] Unfortunately, this literature has as yet lacked the specificity required if it is to be useful in predicting class and ethnic variations in patient attitudes and behavior.

Staff express generalizations, however, about the satisfaction or dissatisfaction that various kinds of patients manifest toward the hospital and the care they receive. Not infrequently nurses are heard, for example, to state that private patients are very critical and expect a great deal of service; many ward patients on the other hand may be characterized as satisfied and grateful for what is done for them. In contrast to this latter statement, mention is also made of a type of ward patient, perhaps from the lower middle class, who seems afraid that he will not get his "money's worth" or that other patients will get more attention, and hence is exigent in his demands. Medical house staff and nurses both refer frequently to patients from the bottom of the social scale as difficult, rude, and aggressive.

Until their validity is tested, such assumptions are not very helpful and may even be harmful. If they should prove true and are elaborated upon, they might well yield important clues for how interpersonal relations between staff and patients could be reordered and better handled. Implicit in these assumptions are scores of related questions that also await answers. To what extent, for instance, do upper-class patients appear critical and desirous of much attention chiefly because they have a better

[1] As illustrative of literature on the sick role and perceptions of hospitalization, see Stanley H. King's *Perceptions of Illness and Medical Practice*, Russell Sage Foundation, New York, 1962, pp. 208–210, 349–390; Henry D. Lederer's "How the Sick View Their World" in *Patients, Physicians and Illness*, edited by E. Gartly Jaco, pp. 247–269.

word skill, wider general experience, and more self-confidence about making their wants known than other groups? How often are uncomplaining and apparently satisfied ward patients only trying to conform to what they think is expected of them because they are afraid that they would otherwise be neglected? Would they express similar satisfaction after they had left the controlling environment of the hospital?

What are the techniques used by the several classes and ethnic groups for handling their relationships with staff? Is it possible that some of the lower-class patients may try to *compel* respect through being aggressive, demanding, or even abusive; that others may seek to keep from getting hurt through psychological withdrawal, thus appearing sullen, morose, or apathetic, or, like the rural Negroes described earlier, through calling loudly on God for help?[1]

Is it possible that answers to such questions might reveal that many of the current assumptions reflect objective observation less than the effect of social class, professional training, and expected role performances upon the perceptions of those who make the assumptions? However that may be, it would seem that essential progress in total patient care requires that research be developed as rapidly as possible in order to furnish predictive knowledge about how the attitudes and behavior of patients, and also of staff, are influenced by the kind of socialization they have undergone. As such knowledge became available it could be introduced into professional schools and programs of inservice and continuing education much as has been the teaching of psychiatry, which has already broadened and deepened perspectives.

[1] Jefferys, Margot, "Social Class and Health Promotion: Some Obstacles in Britain," *Health Education Journal*, May, 1957, p. 116.

Chapter 7

OTHER PSYCHOSOCIAL AND CULTURAL FACTORS

AFTER A LONG DIGRESSION we now return to the discussion begun in the first two chapters about the desirability, if not necessity, of obtaining more than the customary social data concerning each patient for whom comprehensive care is to be provided. Of several additional categories of data that were suggested for inclusion only two have been examined in any detail—ethnic and socioeconomic or social class background. An attempt has been made additionally to look at the concept of culture because all the nonbiological determinants of human behavior are embedded in its matrix.

The reason a disproportionate amount of attention has been given ethnicity and social class is not that we consider them more important than the other social factors. It is because they are still largely neglected by persons in clinical practice. The discomfort that their consideration arouses in some may account for an appreciable part of the neglect. More importantly, perhaps, the very fact that they are so "obvious" and so interwoven with the life experience of every individual is a reason for their being taken for granted. However, like the other social components (which are also obvious but have received more attention because of economic and legal imperatives or theoretical formulations advanced by psychiatry, social work, and public health), they prove upon analysis to provide important tools for clarifying aspects of "the human condition."

More than a decade ago Jules Henry, an anthropologist, addressed himself in an insightful paper to "awareness of the significance of the commonplace." The text for his paper derived

from Franz Boas' statement that much of human thought and behavior lies within the area of the "taken for granted," and hence unexamined; it also derived from a statement by Edward Sapir that "the things we take for granted in our ordinary everyday life are as strange and unexplainable as anything one might find."[1] With this assumption as a basis, Dr. Henry selected part of one recorded interview between a doctor and a fifteen-year-old boy who was being treated in a child guidance clinic. Then he attempted to fill in the cultural background out of which the ideas and attitudes expressed had probably emerged, but which "would ordinarily be 'taken for granted,' and hence incompletely understood."[2]

Two paragraphs of generalizations appearing in the paper are quoted here. They refer to failure to use social case material after it has become available, while we are concerned at this point with the somewhat different question of what kinds of data are needed and why; they refer, furthermore, specifically to psychiatric treatment rather than predominantly medical or surgical treatment. But what the author has to say about attempting to sensitize ourselves to the importance of the obvious has general application to the question of trying to think about the psychosocial needs of patients.

> As one reads case records and case discussions in scientific papers, one cannot but be impressed with the small quantity of data that actually seems to be used in the management of any patient. The workers assigned to a patient appear to select certain parts of the record which they use in treatment and to throw the rest of the case away. It seems to me that we therapists have not yet learned to use the wealth of material our patients give us. And this is because a good deal of it is so much part of ourselves, of our cultural background, that it belongs in the realm of the automatic, the habitual, the implied, the taken-for-granted. But I believe that it is precisely here, in the area of the taken-for-granted, that we will find the new understandings we need to help our patients—and ourselves.

* * * *

[1] Henry, Jules, "The Inner Experience of Culture," *Psychiatry*, vol. 14, February, 1951, p. 87.

[2] *Ibid.*, p. 88.

> Step by step, in myriad ways, we have become the products of training almost beyond comprehension in its intricacy. And it is precisely because it is so intricate that it must be lived "automatically"—without thinking. . . . We cannot carry on our lives if we have to think about every word we say and every action we perform. To live our culture from day to day we must forget about it. But this forgetfulness, while a necessity for efficient functioning in everyday life, is something the worker in the field of mental health cannot afford any longer. He must *think about what he thinks about in order that he may think about what the patient thinks about.* This is not merely a rephrasing of the "know thyself" doctrine, which was carried into psychoanalysis under the dictum that the analyst must know his own weaknesses, that it is only through learning about himself that he can understand others. For what is involved in the present discussion is not so much knowledge of the inner self, but rather of the outer reality that has been incorporated into that inner self. What is emphasized here is not qualities that develop out of the life experience of the individual in his own particularness, but rather those aspects of experience which he shares with a large number of people in his society.[1]

THE PRACTICAL USE OF THE "OBVIOUS" IN PATIENT CARE

In so brief a monograph it is impossible to suggest information that would appear helpful and the meaning of that information for all the psychosocial factors listed in Chapter 2. Because we have thus far said little about most of these factors, however, three have been selected for brief discussion here as illustrative of the practical use to which all of them can be put.

Psychosocial Aspects of Age

Let us begin with the first factor listed. At the moment the word "age" is mentioned various images flash through the hearer's mind. For persons in the health professions where child growth and development and the health-sickness continuum over the life span are receiving increased attention, the images may well reflect this orientation. Perhaps the doctor or nurse catches a mental glimpse of the baby within the family setting and the process of child rearing that goes on; of the little boy or girl

[1] *Ibid.*, pp. 88, 103.

moving into the larger environment of playmates, school, clubs, and gangs; the vast changes in his personality that accompany adolescence; his exciting years of courtship, marriage, and having a home and children of his own; the importance of work, family, friends, and recreation in the middle years; the possible intellectual enrichment and larger sympathy and understanding of the later years, but the frequently accompanying loss of relatives, friends, employment, and health. The greater the number of these images that can be brought to mind and the richer their content, the greater the likelihood that when the clinician meets a patient of any age-group, he will begin to feel some acquaintanceship—on the basis of this one psychosocial factor—with the *person* under consideration.

Out of the vast array of psychosocial interests, situations, and conditions that can be associated with age, let us select one for closer examination. It is obvious, and hence usually taken for granted, that other persons besides the family exert great influence over the individual from childhood until death. These persons are likely to be playmates, associates with whom one works, members of the same club or church, or those with whom one is thrown through circumstances. These are persons whom one knows in a face-to-face relationship and on more or less of a basis of equality.

Social scientists have given extensive study to the essential role played by what they call the peer group in influencing an individual's interests, attitudes, and pattern of behavior. They emphasize the particular importance of the peer group during the later years of latency and early adolescence not only for the satisfaction it gives its members but as a means of preparing the child for increased independence from his parents and of broadening his social environment.

Now that the fact of the importance of informal group relationships has been brought into full consciousness where it can be used, thanks to the concept of the peer group, we are ready to look at an example of its application in a hospital situation.

> Just before frequent and large outbreaks of polio came to an end, a particular voluntary hospital found itself admitting some fifteen

adolescents in rapid succession. These boys and girls were not only kept together in a ward unit but, with the assistance provided by a polio agency, an adjoining sun porch was converted into a dining- and living-room lavishly equipped with recreational facilities. When their condition permitted, these young people were sent as a group to the physical therapy unit and the therapeutic swimming pool. Their progress was rapid, and, as reported in the first of these monographs, it was generally recognized that much of it could be accounted for by the support, competition, criticism, and ridicule that they gave each other. Their common tragedy and their community living had drawn them into a tightly knit peer group.

One boy was not permitted to be a member of the group. His wealthy parents insisted that he must have the best treatment the hospital could provide; they interpreted the best treatment as including a private room and private nurses around the clock. In spite of the unending attention he received, his progress was so much less rapid that the attending physician and the supervisory nurses expressed concern. It seemed clear to them that what he needed, besides the attention of staff who by age and authority were symbolic parental figures, was the influence of the peer group.

The physician was asked why he did not write an order to have the boy transferred. He replied that he did not feel free to go against the express wishes of the mother and father. Someone then inquired whether he carried medical responsibility for seeing that the best possible treatment was provided, and, if so, whether that responsibility did not extend to making use of every therapeutic potential.

In this illustration we have seen how a hospital set up and utilized a group situation that was considered highly beneficial. Because one boy was excluded from participation, the pertinent question was raised of professional responsibility in such an instance. In connection with our discussion a much broader question is of practical importance. When should hospital personnel attempt to create the opportunity, if necessary, for a peer group to form, and how can they foster its development? Should its use be limited chiefly to pediatric and adolescent patients, and persons undergoing physical and mental rehabilitation? Or should the appropriate physician or nurse consider, in reference to each patient, what the potential usefulness of a peer group might be and at what stage in the patient's sickness or recovery, as well as what kind of role a group might most helpfully under-

take? Perhaps clinicians would also wish to consider to what extent the social class and ethnic background of the patient might be a significant determinant of his need for the help of a peer group.

Geographic Background

If a patient "looks like an American" and speaks English without an accent, the likelihood is great that hospital personnel will give slight attention to where he came from and whether he speaks the same language, insofar as interests are concerned, as do they. Until after World War I sociologists devoted considerable attention to rural versus urban modes of living and thinking, and the visible evidences of difference were clearly conspicuous. As a consequence, it was much easier than now to keep the significance of variations in mind. Since the coming of the pictorial magazines, radio, television, automobiles and airplanes, and the economic upgrading of most sectors of the population, the outer manifestations of dissimilarity have greatly decreased. The assumption is widespread that America has become one large middle class with little differentiation not only in chain-store purchases but in general outlook and values.

In the great reaches of this nation, however, many people have never seen a "live" theater, "real" art exhibit, or a "skyscraper" of more than a dozen floors. As many more know nothing about tilling the land, breeding cattle, or selecting seed to plant. Regional differences in what people have as their frame of reference and their basis for acquaintanceship and conversation are still very great. Because health personnel are likely, by virtue of their long professional training if not their place of birth, to develop an academic or geographically restricted frame of reference, they may find themselves at a great disadvantage even now in having a common language with many patients.

> The question was raised one day in the Central Office of the Veterans Administration of whether it should attempt to provide some sociological and cultural orientation for those administrative health personnel whom it persuades to move from one hospital to another, often at a great distance and in a totally different part of the

country. Before discussion of the subject was even begun, a psychiatric nurse said she would like to tell about the experience she had had some years earlier when she had gone from the East to a V.A. hospital in an agrarian area west of the Mississippi to be the Chief Nurse.

On the morning after arrival she began visits to the wards to familiarize herself with general conditions and to get acquainted with some of the patients. To her surprise a patient asked her, "Don't you wish it would rain?" She had just arrived and rain was the last thing she wanted. So she said very directly, "Oh, I hope it won't rain for three weeks." With dismay she felt a withdrawn schizophrenic patient move psychologically farther from her. On the second day another patient asked, "Don't you wish it would rain?" She still did not want rain but knowing that she had made some inexplicable mistake the day before, she said heartily, "Wouldn't it be nice if it rained for three weeks!" To her surprise she felt the patient move a little in her direction. Over and again when she visited the wards conversation was about the weather, always in terms of rain. She wondered for weeks why there should be such preoccupation with the subject.

Then she discovered that she was in the heart of the former Dust Bowl. Many of these patients had been children when the farms reverted to dust, when migration became a necessity, and when stark poverty and even lack of adequate food stared whole rural communities in the face. So threatening had been the experience that the fear of recurrence was probably a living reality. Said the nurse in conclusion, "If someone had only told me in advance about this one fact of agrarian life in that area, I could have saved myself much wondering about the patients' obsession, and I could hopefully have handled my contacts with them to better advantage."

Readers may think this example so atypical that the nurse's conclusion has little general applicability. But the reports about health personnel who have gone to places quite strange to them, suggest how much initial orientation to environmental differences might have helped. For instance, doctors, nurses, and social workers unacquainted with the desert and with the three distinct cultures of New Mexico (Spanish-speaking, Indian, and "Anglo") are likely to find themselves bewildered upon arrival. Some soon love the landscape and the cultural heterogeneity and declare that they want to stay "for the rest of their lives." Others

dislike both the aridity and what they view as economic and social backwardness; often they make disparaging remarks or otherwise show their dislike, at the expense of community health services that are struggling to create more comfortable relations with their frequently shy and anxious clients.

Currently staff are being recruited for the fine teaching hospital that has just been completed at the University of Kentucky Medical Center in Lexington, the heart of the lush horse farms and the blue grass country. Staff discover that a large proportion of the patients come from the isolated and poverty-stricken mining areas of the eastern Kentucky mountains where unemployment, illiteracy, and the birth rate are among the highest in the nation. For an occasional person this fact might prove almost as challenging as the Frontier Nursing Service that Mrs. Mary Breckinridge started in those mountains nearly forty years ago. A much larger number, however, might be satisfied with providing only technical care, were it not for the considerable efforts being made by the Medical Center to learn something of the culture of these mountaineers and how to individualize attention to them. If these efforts continue, many members of the staff may come to realize that the experience has not only been interesting and has added a dimension to their understanding of comprehensive care, but has given them insight into the importance of exploring cultural factors wherever they may be.

Religious Background

Reference has already been made to the hospital practice of inquiring about the religious affiliation of all patients, and of frequently furnishing their names to ministers or hospital chaplains representing the three major faiths. Otherwise this important psychosocial factor receives scant use in most nonsectarian hospitals. Even within this context of limited utilization, however, several possibilities need to be taken into consideration.

For many patients visits from a clergyman or rabbi are a source of comfort, for others they are not. Some do not like the personality or the "approach" of a particular chaplain; some have no sense of emotional attachment to the denomination

represented by him. Not to determine a patient's wishes in advance of pastoral visiting shows disrespect for him as a person.

Since the Catholic clergy strive to be present to administer the last rites of the Church before death, even the arrival of a priest may have an alarming effect. A seventeen-year-old Mexican who had been "knifed" was admitted to a hospital. Because he spoke only Spanish, a local priest was called to talk to him. The boy immediately became apprehensive; he took it for granted that the priest's presence meant that he was going to die. Much attention from a Spanish-speaking nursing student and several days of ambulation were necessary before he overcame some of his fear.

The number of patients for whom religion is a private matter unassociated with any church or who are frankly agnostic is large enough to demand that this fact should not be disregarded. In the little essays that Thomas Bell, the novelist, wrote when he knew he was slowly dying from cancer, he discusses his life-long questioning of life after death, and indicates that he hopes the ministrations of the church will not be forced upon him when he enters the hospital for the last time.[1]

How violent the protest against religion can be is suggested by Tillie Olsen's story about the little old Jewish woman who had come to the United States long ago from Russia, where she had been an active revolutionary in the uprising of 1905. As the woman regained consciousness following surgery, she saw that a rabbi was standing by her bed. She could not hear what he said but he seemed to be praying. Later she and one of her daughters had the following conversation:

> "Go away please, I tell him; I am not a believer. Still he stands, while my heart knocks with fright."
>
> "You scared *him*, Mother. He thought you were delirious."
>
> "Who sent him? Why did he come?"
>
> "It is a custom. The men of God come to visit those of their religion they might help. Jew, Protestant, Catholic, the hospital makes up the list for them, and you are on the Jewish list."
>
> "Not for rabbis. At once, go and make them change. Tell them to write [on the chart]: Born, human; Religion, none."[2]

[1] *In the Midst of Life.* Atheneum Press, New York, 1961.

[2] Olsen, Tillie, "Tell Me a Riddle," in *Stanford Short Stories.* Stanford University Press, Stanford, Calif., 1960, p. 95.

Regarding patients for whom the services of the clergyman or rabbi would produce only a negative effect, one question deserves careful consideration. What can the doctor and nurse do—what should they try to do—to give comfort and warm human understanding to patients who are deeply anxious and perhaps dying but are unable to receive help from the church's ministry to the sick?

Understanding of Religious Practices

This question leads directly to some of the broader considerations implied in the psychosocial factor, religion. At present many psychiatrists particularly are interested in the relation between religion and their medical specialty. At the Menninger Foundation, for example, formal exploration has been going on for several years. Dr. Seward Hiltner, a theologian who has served as a consultant to its program, describes an elective seminar on religion and psychiatry attended by a considerable number of the staff who recognize that "they must learn how to understand the religious dimensions of their patients' lives."[1] In case conferences in which Dr. Hiltner has participated, it has been discovered that religious factors, or even their absence, when understood by the staff and students, prove more important in a particular case history than had previously been recognized. Frequently staff or students have become concerned about an issue involving religion and have arranged a special meeting to discuss it. At one of them Dr. Hiltner was asked, "Why are so many people religious in this Bible-belt country? What does it mean, and what should members of a psychiatric team know about it?"[2]

It should be noted that a considerable proportion of the psychiatric residents and clinical psychologists come to Topeka from eastern or other metropolitan centers; many of them are Jewish. Often they undergo a long and somewhat painful adjustment to their new environment where the patients, in the state and federal hospital in which the students receive clinical train-

[1] "A Theologian's Monthly Date with Psychiatry," *Menninger Quarterly*, Summer, 1962, p. 26.

[2] *Ibid.*, p. 26.

ing, tend to be not only from an agrarian background but are often members of Protestant denominations and sects unknown to the residents. Just as some of them have discovered the need for orientation, so it might be concluded that most members of the health professions need an introduction to religions that are not closely similar to their own. Without such an introduction it is easy to lose significant clues in what patients say, or even to make serious misinterpretations of emotional disturbances.

> The case history of a man who had been examined in a psychosomatic clinic was being discussed in a subsequent teaching session. In reading the face-sheet data the doctor who presented the history noted that the patient's religion was Seventh Day Adventist; the religion of his wife was Presbyterian. No further reference was made to this unusual marriage until an anthropologist raised the question at the end of the session of whether the man had been asked how he happened to marry someone with such dissimilar religious beliefs and what the results had been. The head of the psychosomatic clinic, speaking for the group, suggested that doctors' knowledge about different denominations or even the major religious faiths was so negligible that it had not occurred to them to question these data. Later, when visiting a hospital operated by the Seventh Day Adventists, the anthropologist asked some of the staff whether reference to the marriage of an Adventist to a Presbyterian would have attracted their attention. It most certainly would, came the answer; such conduct would be considered so unusual that it would receive careful scrutiny as the basis for finding a possible clue to the man's later arrival in a psychosomatic clinic.

As illustration of the facility with which misinterpretations of emotional disturbances can be made, we refer to an instance that occurred at Duke University Medical Center, which interested John Gillin sufficiently for him to report it in an anthropological text.[1]

> The woman patient under observation talked incessantly and intimately with Jesus. A Northern intern thought this behavior evidence of disorganization of the personality and decided that she suffered from schizophrenia. It was discovered, however, that in the rural Southern community where the patient lived everyone talked

[1] *The Ways of Men.* Appleton-Century-Crofts, Inc., New York, 1948, p. 577.

out loud to Jesus when in a crisis situation. The decision was finally reached that the patient had a mild neurosis induced by her husband's having abandoned her and her inability to find a job.

Some knowledge about the practices of fundamentalist sects is particularly needed, since they often have a strong hold on non-Catholics in the lower classes, if these people attend religious services at all. *Go Tell It on the Mountain* is James Baldwin's unforgettable picture of the nature of such practices.[1] It suggests the extreme importance of these sects with their small churches in providing their members temporary escape from the abuses and hardships customarily experienced, as well as offering them the promise of a better life. Although the members described by Baldwin are Negroes and the setting is Harlem in New York, the practices are nonracial and not geographically circumscribed.

Also needed is knowledge of several relatively new religious movements such as Christian Science, Spiritualism, and the Church of Latter Day Saints (popularly known as Mormonism). Except for the appreciable number of members of the health professions associated with the last named group, relatively little unbiased attention seems to have been given these lively movements. This is somewhat surprising, since they are predominantly middle class in orientation, are in an era of rapid growth and active proselytizing, and the first two practice spiritual healing with no inconsiderable success.[2]

Rejection of Religious Practices by Staff

Thus far we have suggested that, because of their lack of information concerning certain forms of religious expression, doctors and nurses can easily lose clues that would be important in understanding or helping a particular patient. But they may also fail to note or use significant information transmitted by patients as a result of their own unconscious rejection of religious practices about which they might be expected to be informed. Many

[1] Alfred A. Knopf, Inc., New York, 1954. Now available as a Signet Book.

[2] See Geoffrey Murray's objective and interesting report, *Matters of Life and Death*, Sidgwick and Jackson, London, 1953, for an account of spiritualism, psychic research, and faith healing as progressively practiced in England not only by the spiritualists but by the orthodox Protestant churches.

upper-middle-class Protestants show intolerance for certain denominations with which their relatives were identified, after finding others in which they feel more comfortable or after having dropped all interest in church affairs.

The same has occurred within Judaism. As Jews have moved forward rapidly into professional or other positions of prestige, they may have moved away from orthodox Judaism and allied themselves with the conservative or reform branch of the faith. A few have become Catholics, Episcopalians, or Unitarians; more have severed ties with organized religion. They may no longer know the symbolic meaning of orthodox practices; some even appear to have difficulty in relating themselves psychologically to Jews who are not only orthodox but in their view lack ambition to "get ahead." In such instances it is difficult to tell, in the therapeutic situation, whether their failure to pick up and utilize cultural data results from their unawareness of the importance of such data or from unconscious rejection of its relevance.

Miriam, aged five, was referred to a Jewish child-guidance clinic by a nursery school teacher, because she disliked to play with other children and, if she played at all, insisted on playing the part of the mother. She clung to her mother and wanted continuous reassurance of her mother's love and of being preferred to her younger sister; she was afraid of dogs and cats, policemen, and a bogeyman.

Her parents were orthodox Jews, with the orthodoxy expressed more strongly by the mother. The father yielded to his wife's demands, in spite of his engineering training and professional ambition, by holding a job as night clerk in order to avoid work on Saturdays.

Diagnostic efforts led to little useful psychodynamic information. A few months after treatment started Miriam produced material in the play situation that might have been a valuable guide to a culturally oriented person. When she and the therapist played mother and child, Miriam continued to take the role of the mother. She showed great concern about whether the therapist would play the "bad child" who insisted on drinking milk during the meal. Every time the therapist was the bad child Miriam gave in and offered her milk to drink. At a later session the therapist tried to interest Miriam in playing with blocks. She immediately rejected the blocks, and the therapist noted in the case record that they seemed to threaten her.

The social scientist who commented on the case maintained that the child was trying in this play situation to talk about her problem in the language of the orthodox concerns of her mother. To a worker sensitized to cultural material in the nexus of Jewish orthodoxy, the symbolic meaning of "badness" in terms of drinking milk during meals (a violation of the food ritual of Jewish law regarding the separation of milk and meat products) would have been obvious. To this therapist it meant so little that she not only failed to pick up a valuable lead, but actually interfered with the child's attempt to communicate with her by attempting to introduce a new toy—blocks. Indeed they threatened Miriam because the therapist unconsciously "blocked" the child's effort to work out her problem.

In contrast to the continued lack of success of this therapist, a second one was able some years later to work within the pattern of Jewish orthodox culture with conspicuous success. When the new therapist planned a birthday party for the child, Miriam expressed concern about whether the ice cream would be kosher.

She looked at me somewhat fearfully [wrote the therapist in her case notes] and asked if I had ever eaten non-kosher food. Then without waiting for an answer, she said she knew that Anna [the former therapist] had not always eaten food that was kosher. I asked her how she felt about that. Her comment was that such people would not be "good Jews." When I asked her what she meant by a "good Jew," she replied that it was necessary to adhere to all the Ten Commandments, although she did not believe in adhering to one of them, "Thou *must* honor thy father and mother." She indicated she did not feel it fair for parents to expect children to honor them when they did not honor the children. When I asked what she meant by not honoring, she said, "Yelling and hitting them." With that she shut up like a clam.

But in one of the next interviews Miriam suddenly asked whether the therapist would ever hit a child. Then she indicated that she would like the therapist to tell her mother not to hit her any more. Although her mother wanted to be friends, said Miriam, she was mean; her mother hit her, so she hit back. She then leaned over the therapist and confided that her greatest fear was adults. This was the reason she yelled so much, she explained, because only if she yelled at them would adults not yell at her and tell her what to do all the time. It was then that the therapist was able to interpret to Miriam the meaning of one of her original symptoms, namely, her tendency to assume the adult role and more specifically the mother role in her play with other children.

Shortly afterward Miriam changed her attitude of strong resistance to a summer camp, and decided to go as a way of making new

friends. She adjusted to the camp fairly well. The clinic was subsequently able to help her more and more to assume the behavior corresponding to her chronological age, to play with children, and to overcome her fears.[1]

The case of Miriam has been presented in some detail because it illustrates how a therapist who permits the patient to talk about his cultural concerns may be likely to get more significant information than the one who tries to get direct answers about matters in which the patient is emotionally involved. Once Miriam was allowed to speak about kosher food, a subject obviously of much moment in her home, she was able to begin to express repressed hostility toward her mother and adults generally.

Examples such as this lead to the general conclusion that the patient should have a chance to talk about what *he* wants to talk about, while the doctor, nurse, or social worker should listen and try to understand what the patient is saying and its importance for him. This conclusion holds, we believe, even though the staff who care for the physically ill are usually not prepared, and hence should not attempt, to interpret the unconscious material expressed by the patient.

[1] A condensation of a case history presented in *Social Science and Psychotherapy for Children* by Otto Pollak and collaborators. Russell Sage Foundation, New York, 1952, pp. 112–117.

Chapter 8

THE PATIENT PROFILE AND COMPREHENSIVE CARE

IN CHAPTER 2 it was suggested that the admitting office of the hospital enlarge the number of items concerning which social information is sought, and that all data collected be forwarded to the nursing unit at the earliest possible moment so that both medical house staff and nursing personnel could examine them before visiting the patient. If the persons responsible for treatment and care have some profile of the patient in mind, the initial contact—the importance of which can scarcely be exaggerated—ought to be easier and more comfortable for staff and patient alike.

Observation of how strangers, who meet at a party let us say, attempt to "place" each other before they engage in any significant conversation, provides some insight into a process that is almost indispensable but is time-consuming and characterized by much cautious "feeling out" of who the guests are. At first, the conversation is usually confined to pleasant trivialities and to indirect probing. No one wants to chance making inappropriate remarks by discussing politics, religion, society scandals, or business matters until he knows the background of the guests; certainly he does not talk about intimate subjects unless he feels he is with like-minded persons. It is only after some common ground has been discovered that conversation tends to become easy and spontaneous.

HELPFULNESS OF A PSYCHOSOCIAL FRAME OF REFERENCE

The hospital is too busy a place to use the "feeling out" process if it can be avoided. As a consequence, staff customarily walk into

a patient's room and, with little more than the mention of a name and a "Good Afternoon," proceed to give directions or ask questions. Neither staff nor patient has had an opportunity to take that initial step so essential to possible subsequent ease and spontaneity of conversation. To deprive the patient of a familiar pattern of getting acquainted with strangers leaves him without his accustomed point of reference, and hence with the possible feeling that at a difficult moment in his life he has been denied any manifestation of staff interest in him.

It is for this reason that the face-sheet data are especially important. The information can serve to give the doctor and nurse some sense of acquaintanceship with the patient before they meet him. Thanks to the self-confidence and knowledge thus provided, they are in a more strategic position to use even a brief visit to put the patient at ease with them. In a manner appropriate to his age, general background, and medical condition, they can inquire lightly about his children or grandchildren, or how his family and job will fare in his absence; they can comment that they want to hear more later about his work as steel riveter, crane operator, certified public accountant, or composer of music; they can mention how pleasant it is to have within the walls of a hospital a fisherman, golfer, or jazz fan.

The purpose of this conversation is to make the patient aware that staff know who he is, are interested in him, his family and job, and regardless of his sickness consider him a person of worth. Often a visit of only a few minutes if time is purposefully used will accomplish significant results in convincing the patient that he is in good hands. He may even make a remark or two that will provide valuable supplementary information about himself. If not, the ground may have been prepared for him to make meaningful statements at a later time.

So brief an initial visit must be considered the irreducible minimum of what is required if staff are to make any pretense to give comprehensive patient care. Success from such a limited visit, moreover, presupposes that the doctor and nurse have had sufficient data at their disposal to form a fairly clear image of the patient; it presupposes also that they have learned to call upon

their experience and intuition in assessing how particular kinds of patients are likely to respond to them and how they can best use themselves to establish rapport.

Where information sufficient to give something of a portrait of the patient is not forwarded by the admitting office and staff consequently must confront a stranger with little knowledge about him, it is imperative that more time be available. Under such circumstances staff need the opportunity to sit down and feel their way in obtaining essential facts and in taking first steps toward establishing a relationship. In order to use this informal visit as productively as possible for collecting data, the staff member will find it helpful to have the list of psychosocial and cultural factors clearly in mind. If he neglects some of the items, such as the patient's level of education, nature of the supporting family group or family substitutes, and recreational interests, he may discover subsequently—as did the nurses whose reports were discussed in Chapter 2—that he lacks information essential for thinking about the patient as a person and for planning total care.

Regardless of the possible availability of good face-sheet data from the admitting office, a question of preference about type of visit merits careful consideration. Would a skilfully used brief visit that was viewed as only the first in a series, or a longer and more leisurely initial conversation be likely to pay larger dividends in providing information for staff use, giving the patient comfort and reassurance, and encouraging him to talk about his anxieties and hostilities? Perhaps the only answer that can now be offered is that many circumstances would be determining factors. Here is an area where careful experimental work is greatly needed to discover possible guidelines for future action.

USEFULNESS OF TECHNICALLY DEFINED CONCEPTS

Lest the reader conclude that far too much emphasis is being placed on a list of terms, called psychosocial and cultural factors or determinants, and too much insistence is being placed on their use, we must make two comments before proceeding with the general discussion. First, each of these items, whether occupation,

recreational interests, sexual behavior, or education, stands for a large and often elaborate body of knowledge that has been accumulated, analyzed, and synthesized in the form of generalizations. Much of the detail in this monograph has been presented to furnish the reader with some small picture of the nature of the body of knowledge and the resulting generalizations behind the shorthand terms culture, ethnic background, and social class.

Second, it is necessary to refer again to the fact that so much of human experience lies within the area of the "obvious" that only as certain aspects of that experience can be selected out of its vast totality, defined, and labeled does the therapist have tools for use. Data that have not yet been carefully classified and given a scientific terminology tend to remain unconsidered and unused by the practitioner, regardless of their value.

Dr. Otto Pollak, the sociologist quoted in the preceding chapter, who collaborated for several years with a distinguished child guidance clinic, shows how social science concepts which had not yet been explored by the guidance staff were able to enlarge their thinking and change facets of their clinical practice. Two of the concepts that received careful analysis by the staff under his direction were the "family of orientation" versus the "family of procreation." Dr. Pollak's comments are reproduced here. They will illuminate the present discussion of the necessity for technically defined generalizations as aids in helping us to see and think about what is within our potential range of vision. They will also suggest the specific importance for all practitioners, not merely psychiatric staffs working with disturbed children, of considering the possible roles of members of the extended family and of family substitutes.

> The usefulness of the concept of the *family of orientation* to child guidance work is easy to demonstrate. One of the outstanding characteristics of child guidance as practiced in the agency is the emphasis on the mother of the child. She is practically the only factor besides the child's personality structure to which attention is paid in treatment, if not in diagnosis. Only occasionally are fathers also seen as part of the diagnostic, and even less frequently as part of the therapeutic, contact. Still greater than the relative disregard of the father in diagnostic and therapeutic contacts is the disregard of par-

ent substitutes, such as uncles and grandfathers where fathers are missing, or grandmothers and aunts where the mother is working or simply emotionally absent and therefore not in sufficient contact with the child. To the person trained in sociology, it would suggest itself that child guidance practice should take greater and more direct note of fathers and in cases in which father and mother substitutes have come into action also of these persons. This would permit better understanding of the personality of the child as well as correctly focused therapeutic effort in many instances.

In individual discussions with child therapists, this is almost always admitted. It is, therefore, puzzling that in spite of the apparent intellectual awareness which exists in this respect, child guidance practice in the agency has remained concentrated upon the child and his biological mother. In consequence, where a mother is emotionally absent and a grandmother, for instance, exerts a harmful influence upon the behavior of the child, great effort is expended to bring the biological mother to fulfill her mother function while the grandmother's continued harmful influence is not directly attacked. . . .

The explanation seems to lie in a lack of necessary conceptual equipment for taking these factors into account. Phenomena for which technological terminology is not available to the practitioner tend to remain unconsidered. This is a point at which the results of the sociological study of the family could be helpful to the agency's practice. The concept of *family of orientation* as distinguished from the concept of *family of procreation* could strengthen the perceptional equipment of the therapists regarding interpersonal relationships affecting the child other than the biological mother-child relationship. Over and beyond that, these concepts could provide them with an inventory approach to the child's surroundings which would work as a check and safeguard against their perceiving only those interpersonal relationships affecting the child in which they have become selectively interested in the course of their exposure to current training practices or their own personal psychoanalysis.[1]

ENLARGING THE CONTENT OF THE PATIENT PROFILE

No matter how fruitful the first visit between staff member and patient may be, it is only the first and presupposes continuing visits, as indicated, for the duration of the patient's stay in the hospital. Little more than the bare skeleton of information can generally be obtained initially; little more achieved toward

[1] Pollak, Otto, "Relationships Between Social Science and Child Guidance Practice," *American Sociological Review*, vol. 16, February, 1951, p. 63.

establishing a helping relationship than the laying of a positive base to replace the negative or neutral reaction that the patient now frequently experiences upon admission. Further information will continue to be required as the patient care plan is put into operation and alterations in it become necessary or desirable.

Even more importantly, staff will need to engage in a continuing process of attempting to evaluate what hospitalization and sickness with its probable physical, social, and economic outcome *mean to the patient.* Only as staff can visualize something of that meaning will they be able perhaps to put aside such stereotyped antithetical perceptions as cooperative versus uncooperative, friendly versus hostile, and confident versus apprehensive, and reach out with sympathetic understanding not to *a patient* but to Mr. B, *the person* who is ill.

> Dr. Fillmore H. Sanford, the psychologist, has commented pertinently: The nurse who thinks in terms of her patient's anxiety, his need for identity, his attitudes toward hospitals, and his needs for affection and recognition and security will think in ways more conducive to good and human decisions about that patient. To live in a world that is conceptually richer than the black-or-white one peopled only by "cooperative" and "uncooperative" patients would seem to me a good thing—especially for the patient.[1]

Let us now look at the social data about the hypothetical Mr. B that were obtained through the admitting office, the physician's first comments, and the conversation the head nurse has had with Mr. B's wife because his condition precluded asking him questions. Then we can try to imagine the kind of further information that will be required and for what purposes.

> Mr. B lives in an area of prosperous small farms in western Wisconsin. He is a forty-year-old Swedish American of the third generation, with a high school education, a wife and three teenage children, several widely scattered brothers and sisters, and a frail, elderly mother who divides her time between him and her other children. He is nominally a Lutheran but rarely goes to church.
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> From modest beginnings twelve years ago he has worked very hard to develop a prosperous dairy farm. He is proud of what he has

[1] "The Behavioral Sciences and Research in Nursing," *Nursing Research,* vol. 6, October, 1957, p. 53.

accomplished and his wife says that if it were not for this setback he would have the farm paid for in another two years just as the oldest child was ready to go to college. He is obviously ambitious for himself and his family. When asked whether he goes fishing or hunting, Mrs. B says he has never had time. It is assumed that he has worked so hard that he has not developed recreational interests. It is suspected, furthermore, that he has been under considerable emotional strain because of his desire to get ahead, and that the strain and lack of leisure and change may have contributed to the acute heart attack that has sent him by ambulance into the nearest hospital forty-five miles from his home.

The physician in charge of Mr. B's care takes it for granted that he will need several weeks in the hospital, followed by greatly restricted activity for some time after his return home. Although it is too soon to be sure, his heart condition may even require permanent reorganization of his work pattern.

This is a medical case like thousands of others throughout the country, except that Mr. B is somewhat younger than the average. Total patient care is scheduled for him insofar as it can be provided. No part of the responsibility can be shifted to a social worker, since the hospital, like most others, does not make social service available to semiprivate patients; however, the social workers are frequently very generous, if asked, in helping staff to explore possibilities for action. A psychiatrist is available upon request for consultation with staff, and a young Lutheran minister comes regularly to the hospital to call on patients, should Mr. B wish to have a visit from him. Mrs. B will not be permitted to stay with her husband after nine o'clock at night, and the doctor has not yet decided when and under what conditions the children may see their father.

Fortunately, enough facts are at hand to give the staff clues about how to begin handling the psychosocial aspects of the care. These very facts suggest scores of questions to which answers will need to be found at appropriate times during the next few weeks. It is hoped that through careful observation and listening, further conversations with Mrs. B, and encouraging Mr. B to speak freely when he is able, adequate information can become available for use. It is also hoped that the patient can talk out much of his anxiety and possible hostility, and perhaps gain some

insight into factors that may have contributed to this cardiac attack. Although the questions that come to mind will change during the course of the hospitalization, the following are examples of those that suggest themselves in the beginning.

What does Mr. B's initial reaction to the hospital, the other patient in the room, and the staff seem to be? What is his overt response to pain and the realization that he has had an acute heart attack? What kind of psychological support appears most promising at this time? Has it occurred to him that he may have to limit his activities and reorganize his life plans? If so, how can he be helped to accept this possibility? If the medical prognosis proves to be poor and he seems to reject facing the future, when and how can the subject be opened?

What inner resources does Mr. B appear to have to help him? What psychological resources can his wife and children provide? Is his mother an important asset or a psychological and economic burden? What role can the brothers and sisters play now and after his return home? Are there other patients in the hospital well on their way toward rehabilitation with whom Mr. B would like to talk?

Can he be encouraged progressively to say how he feels about the hospital and the care he is receiving? To discuss, when appropriate, his worries about money matters, how his family is managing without him, the possibility that he will not be able to send the children to college as he had hoped, that he may even have to sell the farm that he probably views as the very core of his life work? Should Mr. B be one of those tight-lipped Swedish Americans who finds communication difficult, does it mean that he should not be expected to talk, or that repeated opportunities should be opened to him?

What kind of counseling about rehabilitation and health maintenance can staff provide that will be of maximum practicality to Mr. B and his family who live in open country but only five miles from a general practitioner? Would a canvass with Mr. B of various forms of mild recreation suggest diversional activities that he might be willing to cultivate?

Finally, how do the members of Mr. B's family who visit the hospital react to his illness, to the progress he is making, to the possible implications for the future? What psychological help and counseling do they need from the staff? Does Mrs. B find her husband's distant brothers and sisters any source of comfort, of financial help? Are the neighbors a strong asset to her at this time? Will they be able to assist with changes that may have to be made after his return home? What other community resources are available?

PROFESSIONAL PREPARATION FOR COMPREHENSIVE CARE

The foregoing questions have dealt only with the psychosocial aspects of care for Mr. B. Nothing has been included about the even more important technical aspects of diagnosis, treatment, and physical care that must receive large initial and continuing attention. Hence it immediately becomes obvious that if care such as that suggested in this case outline is to be undertaken, drastic changes will probably have to be made in the traditional roles played by the staff and in the way the various categories and levels of staff work together as a coordinated team. More knowledge will also be required about psychological and social determinants of behavior in order that staff may have a frame of reference for obtaining a social history comparable to the medical history, which can be used for predicting patient reactions and planning care programs.

At present a relatively small proportion of hospitalized patients are exceedingly fortunate in having private physicians who are acquainted with them and their families, are on the attending staff of the particular hospital, and have developed notable skill in handling the psychological aspects of patient care. The great majority of patients, however, are dependent upon the attention provided by medical house officers and nurses to whom they are strangers, or by private physicians who either have no knowledge of them as persons or are lacking in skill in interpersonal relations and in making social arrangements. Hospital personnel may be adequate in number and impressive in the wide variety of specialties that they represent. But the organization structure of the institution, the lack of communication, and the sharply delimited roles, described in Part 2 of this series of monographs, make the likelihood of receiving comprehensive care fortuitous for most patients.

The conclusion would appear inescapable, therefore, that training for every profession engaged in clinical practice and also in hospital administration will find itself obliged to give increasing attention to patients as persons; to redefinition of areas of responsibility for each of the several categories of clinical person-

nel; and to better coordination of the roles of both professional and nonprofessional personnel at the point of clinical action. Particularly important will be careful study of that crucial question of who should handle the psychosocial aspects of patient care. Since it is obvious that no one profession can attempt to make decisions about these important matters for all the health professions, joint exploration is indicated.

To many educators such an undertaking must seem staggering in size and complexity, and almost impossible to achieve within the already overcrowded curriculum. We are of the opinion, however, that the undertaking is not as difficult as it seems. Not only have the social sciences undergone appreciable development in recent years, but there are now a considerable number of universities where behavioral scientists are expressly interested in the applicability of knowledge from their fields to the preparation of doctors, social workers, nurses, dentists, public health personnel, and hospital administrators. Another important asset that has received inadequate consideration, particularly by medical schools, is the degree to which undergraduate college education and joint teaching of prospective members of all the health professions might be utilized to achieve some of the desired ends.

It is suggested that experiments be started in perhaps three or four universities that have schools in most if not all of the health professions and strong departments of behavioral science. Joint planning by representatives of the schools and of the social science departments might well result in the formulation of perhaps three undergraduate courses that would then be required of all prospective medical, social work, and hospital administration students, as well as undergraduate students in nursing, physical and occupational therapy, and dietetics. Although these courses would be taught as liberal arts and not applied subjects, concepts and their illustration would be selected that had relevance to the future work of the helping professions.

A course taught by an anthropologist and a sociologist, for instance, might concern itself with the concept of culture and with psychosocial and cultural determinants of human behavior; illustrations, wherever possible, would suggest the usefulness of

these concepts in patient care. A second course in sociology and social psychology might be built around an analysis of social institutions and of role theory; the hospital, medical care plan, or community health agency could be used for purposes of analysis quite as well as the school system or penal institutions, while discussion of the nature and interrelatedness of medical and health roles would illuminate the meaning of the theoretical concepts. A third course drawn from materials developed by experimental and social psychology and psychiatry could introduce students to such subjects as the socialization of the child, learning theory, and functions like perception, attitudes, motivation, frustration, aggression, and ability to love, as influenced both by personality and by social situations.

Such courses would give students a common core of basic knowledge, which would permit them to begin their clinical experience with some systematic frame of reference for understanding people and the institutions that have evolved to care for the sick, prevent disease, and maintain health. The knowledge, moreover, could be acquired in classes where representatives of all the health professions met and became acquainted with each other. That fact alone might keep many misperceptions from developing that now play havoc by emphasizing considerations of status and "uniqueness" rather than realistic appraisal of patient care requirements and what each profession can contribute.

On the foundation laid in the undergraduate social science courses applied training would need to be built during the clinical years. For experimental purposes it is suggested that student representatives of therapeutic teams be assembled and given opportunity, through caring for patients in the hospital, outpatient service, or home, to practice together as a unit under the most expert supervision possible. Here is the place where the roles of doctor, nurse, and social worker—and hopefully of dietitian, physical therapist, and occupational therapist—could actually be tried out in their interrelationships; where easy group discussion of roles, devoid of reliance upon status, could be encouraged; and where practice could be continued until some degree of comfort and flexibility was achieved by the team

members in working together as partners. It is here particularly that supervisory staff would have opportunity to emphasize the desirability of giving responsibility for the psychosocial aspects of patient care to the person or persons, regardless of category, whom the members of the team considered best prepared by training, personality, and proximity to the patient.

With some such education as a background, the members of the hospital staff might come to the task of total patient care without feeling obliged to resort to the old clichés: "there is no time," "the doctors don't want us to talk to patients," "the nurses haven't had enough education," or "private patients wouldn't want to have assistance from social workers." If individual team members had been helped, moreover, to feel comfortable about admitting that they could not relate effectively to a particular patient, or they knew who could do a better job in teaching Mr. B to handle his disability, patient care could be expanded and improved almost immediately. Many patients would no longer lack psychological support or adequate counseling because a doctor was reluctant to acknowledge even to himself that one of the floor nurses had more skill than he in working with some kinds of patients; because a head nurse could not bring herself to ask for consultation from a psychiatrist or social worker; or because an aide was disregarded, although his ethnic or social class background sometimes enabled him to be more effective than either doctor or nurse.

A system of patient care based on a hierarchically structured hospital and on roles circumscribed by status considerations has precluded staff from being able to see that when one faces persons in crisis situations, he should have not the slightest hesitation in seeking every possible assistance both for those persons and for himself. Any reorganization of professional education, therefore, will be almost required to consider not only how prospective staff can be socialized into a different system of relationships. It will also have to consider how they can be given insight into their own individual assets and liabilities, and how assets can perhaps be maximized and limitations minimized within the context of treatment-care-counseling partnerships.

PATIENTS ARE INTERESTING PEOPLE

The importance of knowledge about the psychosocial and cultural characteristics of patients and of the use of that knowledge in the therapeutic situation has been the main theme of this monograph. But knowledge alone, as we all well know, is not enough. Only when it serves to create interest in patients as individuals, and when interest stirs imagination to try to think how patients think and feel, can this knowledge be applied.

Hence much of the space has been devoted to fragments of the picture of "Us Americans," to thumbnail sketches of the way of living and the aspirations and frustrations of the various groups among us. These portraits have been included in the hope that they would transmit some sense of the richness of cultural diversity as contrasted with homogeneity; some feeling for the great drama that is still being played as several groups, the Negro particularly, strive to win full participation in the national life; and some realization of the still unfinished business of helping to allay the insecurities and tensions suffered in varying degrees by members of these groups.

These sketches have been included specifically in the hope that patients, who represent a cross section of the entire population, might be viewed as interesting people rather than as carriers of injuries and diseases that are sometimes of absorbing clinical interest but more often are monotonously routine. If patients are seen as individuals or as members of a group with whom one would like to be acquainted, then the persons who care for them have increased motivation to want to treat them as persons: to find out about them, to listen to what they say, and help them in any possible way. Unfortunately, so many strangers get into hospital beds, which they leave soon afterward, that staff often have difficulty, across the therapist-patient barrier, in conceiving of these strangers as potentially interesting.

This difficulty is less apparent in the many spontaneous contacts that one observes outside the hospital. From them it is frequently possible to note the steps in a process that may lead to mutual satisfaction, enlargement of horizons, or even creative

achievement. At the moment that one perceives Chinese Americans, interior decorators, or tugboat operators, for example, as interesting, a change in attitude occurs within the person making the discovery. He suddenly wants to know more about these people; his imagination is stimulated to think of questions or to picture concerns of theirs that would never have occurred to him otherwise. He realizes he would like a chance to eat a meal in a Chinese home, or listen to hours of "fascinating" talk about interior decorating, or be invited to visit a tugboat. Often he spends time and imaginative effort in trying to achieve the desired opportunity. Occasionally friends express surprise at the spontaneity with which he acts when his interest is aroused; they are amazed that he seems suddenly to have become a more alert, tolerant, or even creatively minded person.

It is imagination stimulated by interest, which has itself come from knowledge or awareness, that helps one reach out to others, that permits rapport to be established even though it may not be verbal, and that enhances the likelihood of creative accomplishment. Sometimes the steps that lead to such accomplishment are achieved through fortuitous circumstances and perhaps painfully. Igor Markevitch, the composer and orchestral conductor, found himself trapped in Italy at the beginning of World War II and unable to leave until its end. His first impression was that he was isolated from everything dear to him, alone, cut off from all the intellectual currents that had nurtured his development. But from his tiny house in the hills above Florence, with little food, and with only an old peasant woman to take care of him and later of the "partisans" whom the house sheltered, another image began to emerge of the meaning of that enforced experience.

Subsequently he wrote that he was "grateful to those years of hardship, in which human nature stood revealed as it really was, for having led me to discover one of the most lovable peoples on earth."[1] Knowledge, interest, and imagination had all grown and expanded until he was able to describe Italian characteristics with rare perceptivity and affection. The very development,

[1] Markevitch, Igor, "Homage to Italy" in *Image of Italy*, edited by William Arrowsmith. A special issue of *The Texas Quarterly*, vol. 4, Summer, 1961, p. 11.

moreover, that resulted from those years awakened him, so he reports, to the realization of possibilities and nuances within himself of which he had not previously thought himself capable, and of the will power to achieve things of which he had never dreamed.

Let us turn to another illustration. Many persons know well the name of Dr. Alice Hamilton, a pioneer in industrial medicine and the first woman to be appointed to the faculty of the Harvard Medical School. Or they know about the even more famous Edith Hamilton upon whom Athens conferred honorary citizenship when she was ninety in recognition of her interpretations of ancient Greece and Rome. Perhaps because of Norah Hamilton's almost painful shyness, fewer persons were acquainted with her. She was an artist; among her favorite subjects for drawing or painting were workers and their families. Thanks to Dr. Alice's concern for the health of men in the hazardous industries, Norah even went to Tri-State region of Missouri, Kansas, and Oklahoma to sketch with profound sympathy the victims of silicosis, their wretched homes, and that "tragic mutilated landscape" of lead and zinc mines.

During her years in New York City her choice spot for sketching was a cafeteria on a congested corner patronized by working men. There she would sit and look and listen to the men at the tables near her until she felt that she was personally acquainted with one or two of them. Then, inconspicuously, she would attempt to draw their portraits. Later she would show her drawings to the writer and describe with quiet vividness each of those altogether interesting acquaintances of hers to whom she had rarely spoken a word. Her skill in observation and imagination transcended the barriers of her shyness and their self-consciousness; her portraits almost always caught the image of the inner as well as the outer man.

Such intellectual and emotional development is not restricted to an Igor Markevitch or a Norah Hamilton. Its possibility exists wherever people find themselves in contact with other people, but certain kinds of situations tend to foster it. Those who provide patient care might well be considered fortunate: they do not even

have to search for an environment where human nature stands revealed, for it is ever present. Nor do they have to try to find a place, as do so many others, where they are urgently needed, and where every increment of growth in knowledge, perceptiveness, and sympathy can be at once translated into greater everyday effectiveness. To them is given the opportunity for the development of these qualities both of knowing and feeling that permits the *caring* for patients of which Dr. Peabody wrote. And from such caring comes the kind of care of the patient that is not only a comfort to him but an act of creativity capable of giving deep satisfaction to those who perform it.