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SOCIAL SCIENCE IN NURSING

*Applications for the
Improvement of Patient Care*

By

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RUSSELL SAGE FOUNDATION

New York

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1960

Nurses

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RUSSELL SAGE FOUNDATION
Printed in the United States
of America

Library of Congress
Catalog Card Number: 60-8952

WM. F. FELL CO., PRINTERS
PHILADELPHIA, PA.

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Preface

IN RECENT YEARS both the medical and nursing professions have increasingly emphasized the necessity, not merely for treating disease entities, but for treating patients as "total persons." At the same time patients have become more insistent that physicians and nurses be given better preparation to perceive and understand them as persons. Notwithstanding this convergence of points of view, however, achievement has lagged behind what is desired. Many causes have contributed to the slow rate of change. Among them has been the continuing preoccupation with the physical and biological sciences, important indeed for the understanding of disease but at the expense of the social sciences that are prerequisite to understanding of a "total person."

Medical and nursing schools are now beginning to explore how the training of their students can be broadened, particularly through more recognition of those disciplines concerned with human behavior and attitudes. This book reflects the interest of nursing education, as well as nursing service, in struggling with the problem of patients as people. It deals specifically with an experiment in one school of nursing undertaken by a sociologist who sought to demonstrate the immediate usefulness of the social sciences to the clinical practice of nursing. The experiment was initiated at the request of a dean remarkably sensitive to the psychological and social needs of patients; it was financed in considerable part by an interested foundation. Even under such favorable circumstances, the study would scarcely have been possible if many schools of nursing had not paved the way for it.

In their attempt to widen and deepen students' perceptions of the needs of patients, various schools after World War II began

to add experienced public health nurses to their faculties. It was not the function of these nurses to develop further courses in their specialty but to suggest what lessons had been learned from work with families, community agencies, and particular groups of persons that might well be introduced throughout the curriculum. As a consequence, increased attention was given to the patient's family as a primary unit of consideration, to the role of the nurse in health counseling, to planning for continuity of care, particularly for mothers and children, the elderly, and persons who could benefit from physical or mental rehabilitation. Topics such as these could hardly receive attention without ultimately opening the door to an interest in what anthropologists, sociologists, and social psychologists had learned not only about "the family" but about different types of families, about the psychosocial aspects of rehabilitation, or about problems involved in communicating effectively with persons who differ widely from the nurse in educational background, beliefs and values, and motivation.

Not long after the assistance of public health nurses had been solicited, several schools of nursing asked psychiatric nurses to try to determine how their knowledge of psychological factors and the dynamics of nurse-patient relationships might be used to enrich nursing courses generally. This attempt provided an opportunity to look more searchingly at patients and particularly at nurses in their relationships with patients and with other members of the staff. Almost for the first time it became abundantly clear that hospitals are anxiety-inducing institutions, and that few students can weather their training without undergoing a succession of traumatic experiences. Instead of expecting them to repress or suppress disgust, frustration, and anxiety as had generally been true in the past, psychiatric nurses began insisting that students be given an opportunity to express their emotions, and be provided with psychological support to help them over foreseeable humps. Simultaneously these nurses assisted students in understanding the causes and meaning of many kinds of patient behavior to which little attention had been paid, and demonstrated how the emotional reactions of staff to patients' attitudes and behavior could be either beneficial or harmful.

Once the therapeutic significance of nurses' emotional reactions became a subject for careful scrutiny, the door was further opened for social scientists to help nursing schools explore many questions, the answers to which might be found in anthropology, sociology, or social psychology. One question, for example, that has plagued all nursing services and that has received much attention from psychiatric nurses is why some patients are unconsciously overlooked and neglected. Why are patients often labeled "uncooperative" or "demanding" and hence viewed as unworthy of little more than technical care? Explanations are frequently discovered, as Professor Macgregor's text demonstrates, in cultural differences that form a barrier between nurse and patient. Only as the nurse learns to recognize and accept such differences is she likely to find herself comfortable in trying to meet the psychological needs of the particular patient.

With the clearer realization, moreover, that relations between a nurse and other members of the hospital staff might also play an important part in determining the quality of nurse-patient relationships, examination of the social system of the ward, the hierarchically structured nursing service, and even the hospital as a whole appeared relevant. Here social scientists are well qualified to assist in raising pertinent questions for study and in providing research tools for finding possible answers. Does the social system produce undue frustration and anxiety in the nurse who ministers to the patient's needs, or does it nourish her own legitimate need to succeed and to receive appreciation? Does it warp her into a pattern of tight conformity to procedural and administrative rules, or help her to view necessary rules only as a base on which she can build progressively greater competence in patient care?

From the vast array of questions of a behavioral nature that nursing now has before it for exploration, Professor Macgregor has chosen those that she believed would lend themselves most readily, in the limited time allotted her, to profitable classroom discussion. She wisely selected topics that would give students (and often faculty) ready help in their clinical practice, rather than ones that might perhaps be of greater theoretical interest to

social scientists or to nursing educators who do not carry responsibility for clinical aspects of training. In the pages that follow she has described in detail why particular subjects were selected, how they were presented, and what have been the reactions of the students and faculty. She has, besides, given generous samples of the actual content offered. Also included is reference to her own preparation for, and exceptional interest in, conducting this experiment.

It remains for me, therefore, only to express the gratification of Russell Sage Foundation in having had a part in this undertaking, and particularly in having persuaded Professor Macgregor to initiate it. The Foundation believes her report will be of substantial help to schools of nursing as well as to graduate nurses and physicians who are concerned with the day-by-day care of the ill. It believes the report additionally should be of interest to all those persons who sometimes think of themselves and their families as past or prospective patients in hospitals. To them it can be said that the exclusive reason for sponsoring this study was in behalf of better patient care.

When Dean Virginia Dunbar and the Foundation were exploring the possibility of instituting a course in applied social science, she recalled how nursing students in her day had been admonished a hundred times over to be kind to patients, to make them comfortable, to treat them all alike. She regretted that nursing education had been rarely able to translate these admonitions into specific guides to good clinical practice. Before her recent retirement from the deanship she spoke glowingly of the fact that in much current teaching, and particularly in the work that Professor Macgregor so well reports in this volume, nursing was at last finding *how* these precepts might be transformed into reality.

ESTHER LUCILE BROWN
Russell Sage Foundation

November 15, 1959

Introduction

THIS BOOK is the product of a three-year experimental project on the application of the social sciences to nursing. It was conducted at the Cornell University-New York Hospital School of Nursing and supported by Russell Sage Foundation. That such an experiment could be undertaken is the reflection of three important trends in America today in thinking about people who are ill. One of these is the increasing recognition that many of the causal factors of illness, recovery, and relapse are social, psychological, and cultural, as well as physiological. Another is that in illness reliance upon the physician alone means failure to make use of valuable skills and knowledge which the professional nurse is developing. And last, that the social sciences can make important contributions to the improvement of patient care, for which there is a growing, indeed, an insistent demand.

In addition to a relatively favorable climate of opinion which makes it possible to explore new fields, the inception and undertaking of an experiment is frequently an outgrowth of a combination of interests of several individuals, of the institutions they represent, and to some extent coincidence. It is true of this particular project. Auspicious for such a project was the realization by leaders in the health professions of the strategic position of the nurse in the total care of patients, coupled with an awareness that accomplishment demands both a reassessment and a nationwide upgrading of the entire nursing profession.

In 1953 Dean Virginia Dunbar of the Cornell University-New York Hospital School of Nursing had become convinced of the need for a full-time social scientist on the faculty. Such an addition, she believed, would not only strengthen the School's educa-

tional program, but would contribute much needed knowledge about human behavior to the nursing care of patients. Although the functions that the social scientist might perform were clear to Dean Dunbar (for example, teaching nursing students and serving as a consultant to the faculty) the specific social science content of a course of study and methods that would be most applicable constituted an important aspect about which little was known. However, it invited systematic investigation. At the same time Dr. Esther Lucile Brown of Russell Sage Foundation, whose writings have given considerable impetus to the professional development of nursing,¹ was particularly interested in a study that might demonstrate the specific social science perspectives and materials that would be most useful for integration in nursing school curricula and the clinical and research areas. As a consequence of plans developed by Dean Dunbar and Dr. Brown, and approved by the Foundation, the project described in this book was instituted in the autumn of 1954.

In accepting the appointment to undertake the study, it seemed to me that it was not a complete shift from the kind of work I had been doing but rather a logical sequel. My first contact with patients had been in 1945 toward the end of World War II at a midwestern cancer hospital. At that time important medical research was being greatly hampered by the loss of medical photographers to the armed forces. In view of the present urgency, I had agreed, with considerable trepidation because of unfamiliarity with the subject matter, to serve temporarily as a medical photographer.² In the operating rooms and in the laboratory I literally focused on the human organism, both internally and externally. Initial preoccupation with the technical and clinical aspects, however, was quickly replaced by an intense interest in the reactions of patients to their disease and its sequelae, as well as the different degrees of skill with which these were handled by medical and nursing personnel.

¹ For example, *Nursing for the Future*. Russell Sage Foundation, New York, 1948.

² I had formerly been a documentary photographer. A commission by the United States Bureau of Indian Affairs resulted in the book, *Twentieth Century Indians*, G. P. Putnam's Sons, New York, 1941. See also *This Is America* written in collaboration with Eleanor Roosevelt, G. P. Putnam's Sons, New York, 1942.

In 1946 I began a study of the psychosocial and cultural aspects of facial deformities and plastic surgery. The research involved intensive and repeated interviewing of several hundreds of patients and their families, attending operations and working closely with doctors, nurses, and allied personnel. For nine successive years in such capacities as research associate, coordinator of an interdisciplinary research project, and consultant, attention was centered on patients and their disabilities, and the psychosocial and cultural factors associated with problems of adjustment, management, and rehabilitation.

During these years the conviction was steadily growing that success in healing the sick and disabled depends in no small degree upon qualities other than clinical knowledge and manual dexterity. These are qualities that lie in the area of human relations and are frequently designated by such terms as warmth, sympathy, compassion, and understanding. But as medicine and nursing become more specialized, patient loads heavier, the shortage of medical and nursing personnel more acute, and hospitals larger and more impersonal, they are also qualities about the lack of which a sophisticated public is becoming increasingly restive and vocal.

At the same time new discoveries in the field of human behavior were producing knowledge which, as some social scientists, physicians, and nurses realized, could provide an extra and important dimension to the efforts to improve patient care. Such knowledge, however, needs to be transmitted to and absorbed by those in the medical and nursing professions if it is to be efficacious. And much of what was available was hidden in research reports or in journals written by and published for social scientists. It was for this purpose, then, to help make available useful social science knowledge, that I accepted the opportunity to shift attention from patients to an important group in our society who are dedicated to their care, namely, nurses.

In a sense, therefore, this report is a distillation of some twelve years of research and teaching as a medical social scientist. It is also a reflection of my observations and thinking about the psychosocial and cultural aspects of illness and adjustment to it.

Much of the approach to my thinking about human behavior is a reflection, too, of my contacts during graduate work with the stimulating minds of Margaret Mead, Ralph Linton, and Robert MacIver.

If I were to review this book—and writers are frequently their own severest critics—I would find it far from satisfying. Because of the requirements of this particular report and the limitations of space, it has been necessary to deal with many important topics in a manner that is suggestive rather than comprehensive. Proper treatment would demand a series of books but this is beyond the scope of this study.

The plan of this book is as follows: It is divided into three parts. Part One is a discussion of the rationale for incorporating the social sciences into nursing and what the behavioral disciplines are. Following a customary practice of those in the health professions, the method of case presentation has been utilized as a point of departure. Through six brief descriptions of typical situations concerning patients and medical personnel, an attempt has been made to demonstrate the practicality and significance of social science findings for furthering the understanding of the behavior of the individual patient, and the implications of such knowledge for diagnosis, management, and treatment.

Part Two is a description of an experiment in applying the social sciences to nursing education and clinical practice, and what effect the experiment has had on nursing and the care of patients. Here I deal not only with procedural questions, but also with specific social science theories, concepts, and substantive material.

Part Three consists of a discussion of some of the problems of collaboration that are encountered at the present time as the social sciences and the nursing profession converge. Problems often arise when members of the practicing professions and scientists work together, but particularly so when social scientists who are relatively new to the field of nursing embark on it. Questions regarding such problems and effective ways of dealing with them are becoming more and more frequent, and it is in order to throw some light on them that the report ends with this discussion.

The book has been primarily designed and written for nursing educators, administrators, practitioners, and nursing students. It should, however, be useful to physicians and members of allied professions who seek ways to understand better those individuals for whose physical and mental health they are responsible. Parts Two and Three would be useful, we hope, to social scientists interested in working in the fields of medicine and health. Finally, Parts One and Two might be profitably read by those who are, or who will be, patients. Understanding is a two-way process, and the layman, no less than the physician and nurse, has much to gain through efforts toward larger understanding in the field of human relations.

In reading this book one should bear in mind that with the exception of the specific experiment conducted at Cornell University-New York Hospital School of Nursing, not all of the material is based upon my experience at the School or the New York Hospital-Cornell Medical Center. Some of the material has been drawn from observations made during my professional affiliations with five different medical institutions, ranging from a large city hospital to a private specialized hospital, to large and small voluntary general hospitals. Also included are observations made in the course of research work in outpatient clinics and the private offices of practicing physicians. In the past five years additional data have been gathered from formal and informal interviews with nursing practitioners, educators, and administrators from many parts of the United States, and from such diverse countries as Japan, Nigeria, Brazil, and England. In all instances, and for obvious reasons, care has been taken to disguise the identity of patients and others that are mentioned. While the facts relevant to the situations that are reported have been preserved, certain identifying facts have necessarily been altered.

In undertaking this study and in writing about it, I have had an admitted bias which I believe my social science training has helped me not only to recognize but to make allowance for. It has to do with patients, and the concern that is natural for us all, about people who are sick. My contention is that it is not enough to point to, or to be complacent about, the superior quality of

medical and nursing education and practice in the United States today as contrasted with that of fifty, ten, or even five years ago; or to point to that provided in other less advanced countries. Everything that can be done should be done to make it even better. Consequently, some readers may find parts of this report disturbing and construe them as criticism. But criticism is not the intent, though a challenge to traditional complacency is. The book is not written in a monotone of amiability—to use David Riesman's words. Nor does it conform to the popular precept of learning theory that to get a point across one must always begin with a positive approach. It is my belief, however, that to secure improvement and to make constructive evaluations, areas of weakness must be uncovered and discussed. Only by doing so can we have solid foundations on which to build for the future.

Acknowledgments

So many persons have directly or indirectly made this study possible that it would be impossible to acknowledge them all individually.

My appreciation goes especially to Dean Emeritus Virginia Dunbar and to the many members of the School of Nursing Faculty and Nursing Service whose cooperation not only facilitated my work, but whose enthusiasm and friendliness made the entire experience a gratifying one. Though the writer alone is responsible for the contents of this book, I am very grateful to many of my nursing, medical, and social science colleagues for reading parts or all of the manuscript and for their constructive suggestions and criticisms. In particular, I wish to thank Dean Muriel R. Carbery, Veronica Lyons, Dr. Clara Hardin, Margery Overholser, Lucille Wright, Dr. Margaret Mead, and Dr. Stanley King.

I am especially indebted to the students who played a significant part in the project, for it was first with them, and in a sense through them, that I was able to test the usefulness of the experiment to introduce and integrate social science into the clinical services.

I wish to express appreciation also to my colleagues in social science and medicine who so willingly gave their time, by way of lectures, to a young and developing program—Dr. Beatrice B. Berle, Dr. Renée Fox, Dr. Lawrence E. Hinkle, Jr., Dr. Rhoda Metraux, Dr. Lester L. Coleman, Dr. August B. Hollingshead, Dr. Margaret Mead, and Dr. Bertram Schaffner. I am particularly indebted to the last four mentioned for permitting me to include their lectures in this book.

For her invaluable assistance, detailed commentaries, and incisive criticism of the manuscript, I am deeply grateful to Dr. Esther Lucile Brown of Russell Sage Foundation.

Lastly, but of immeasurable importance, was the editorial assistance provided by Jean Whitnack, William F. Broadhurst, and Margaret R. Dunne. To them, to Esther Heckel, who acted as secretary for the project, and to Joan Pagano of Russell Sage Foundation, who typed the manuscript, I am also greatly indebted.

FRANCES COOKE MACGREGOR

November 1, 1959

PART ONE

**IMPLICATIONS OF SOCIAL SCIENCE
KNOWLEDGE FOR PATIENT CARE**

Chapter 1

The Need for Social Science in Nursing Education

PERHAPS ONE OF THE MOST DIRECT WAYS of grasping the significance of what the social sciences can contribute to the improvement of patient care is to look into the lives of individual patients. Hence, we present below six case histories that seem especially revealing of the situations that can and do occur when people are ill, and when medical personnel lack understanding of the social and cultural aspects of human behavior.

CASE HISTORIES¹

Juan Martinez, an eighteen-year-old Puerto Rican, was referred to the writer by the surgeons in the plastic surgery clinic, on the grounds that he was "probably a psycho case" and should be sent to a psychiatrist. Their reasons for thinking so were as follows: He had come to the clinic because of a scar over his right eye. The scar, hardly perceptible a few feet away, was in the shape of an X mark and not more than three-quarters of an inch long. The patient was not especially good-looking, and his hair and clothes revealed little concern with grooming. His apparent "overconcern" about a "minor" cosmetic defect that detracted little from his general appearance, coupled with the difficulties he attributed to the scar—getting a job, avoidance by other people—led the surgeons to doubt the reality basis for his complaint. In their opinion he was psychologically disturbed.

What lay behind this patient's request for plastic surgery? A young man of more than average intelligence, he came from a family of relatively high social status in San Juan, Puerto Rico. His older brothers and sisters were college graduates. He had been

¹ All names of persons used in the case histories in this report are fictitious. No reference to any real person, living or dead, is intended here.

brought to New York by his divorced mother five years before. Because she was unable to support herself and her son adequately, they were living on the fringe of an underprivileged neighborhood. Recently, when he had attended a public dance, he was accidentally hit by a chair during a brawl and his face was cut.

His concern about the scar was due to the following reasons. Among lower-class Puerto Ricans there are those who engage in such illicit activities as pimping, prostitution, and the selling of narcotics. When there is trouble, as there frequently is, a customary form of revenge or retaliation is to slash the adversary's face with a knife or a piece of broken glass. The intent is to mar the face permanently so that the victim "will never forget what he did to deserve it." Furthermore, everyone else will know that he has betrayed or double-crossed someone.

For many Puerto Ricans such scars, large or small, carry important symbolic significance. Those who have them are looked upon with contempt; they find it difficult to get jobs and are shunned by "respectable people." This boy had already felt the impact of social disapproval. Few people would believe that his scar was the result of an accident. He was the more upset since he had looked forward to returning to Puerto Rico, but now he did not dare go back because he felt he was disgraced. He believed also that he had "brought a cloud on the family name." He said tearfully, "No one in our family has ever had a scar on his face." For him it was almost the equivalent of saying, "No one in our family has ever been in prison." What the surgeons called "a minor cosmetic defect" had major social and psychological implications for him. Given the social and cultural milieu in which he lived, his response to his disfigurement was an appropriate one and not, as the doctors had assumed, symptomatic of a psychic disturbance.

* * * *

Maria, an eleven-year-old girl of Italian parents, was scheduled for an operation for a lip deformity. Admitted to an eye, ear, and throat hospital the night before, she was frightened by her surroundings and obviously anxious about the coming operation. Before going to surgery she was found to have a slight temperature, and the operation was postponed. A few weeks later she was again brought to the hospital, and again her temperature was above normal. It was decided to refer her to the pediatric division of another hospital, where she was kept under observation for nearly two weeks. According to the report, the cause of the temperature remained undetermined. Because Maria's teeth were in poor condition, it was suggested they be examined as a possible cause. The

findings were negative. The doctors were puzzled but reluctant to operate unless the temperature abated.

Fear of hospitals is a reaction pattern commonly found among Italians. Using this information as a possible lead, the consulting social scientist interviewed the parents. They suspected that the rise in temperature was "because she was so scared," and they also reported that she had been enuretic "ever since this business about the operation started." They freely admitted that they were "terrified" of hospitals themselves. Their fear was shared by their younger daughter of three, who refused to eat and insisted on sleeping with the mother whenever the elder child was hospitalized.

On the basis of this information it was suggested they keep a check on Maria's temperature at home for a specified period and then report to the hospital. During this time her temperature remained normal. It was decided, therefore, to schedule her for surgery, but in order to prepare and reassure her, she would be admitted four days before the operation. Though her temperature again rose slightly, the operation was successfully carried out with no untoward results.

* * * *

At a midwestern hospital, Mrs. Dietrich, who was forty-five years old and a professional writer, was found to have cancer of the breast. There were no postoperative complications following the removal of her breast and her recovery appeared to be uneventful. Not only because she was an author but because she laughed and joked and never got morose, the staff regarded her as an extremely intelligent and well-adjusted woman—so much so that she was exhibited by the hospital surgeons as their "perfectly rehabilitated patient."

Six months after leaving the hospital Mrs. Dietrich went into a state of partial amnesia. In a letter describing her experience, she wrote of the suddenness with which this occurred. She had, said she, "simply discovered one day" that her breast was gone. "Suddenly, I was 'lost' for five hours; then I came back. I cried, asked why it was gone, what had happened. I had to be told [about the operation] all over again by my family and family doctor. I had completely forgotten. I had awakened that morning feeling very tired. I told my husband that I had a strange 'burden,' and that nothing, not even a trivial thing would I be able to assume that day. I laughed about it, went on about my usual work and routine, then when someone did tell me a tiny bit of bad news about a member of my family, I cracked. I did not lose my identity, or my orientation. I knew who I was, who everybody was, where I was,

but 'discovered' for the first time that the breast was gone. I cried for hours. My young doctor here, who has sympathy at least, kept urging me to remember the little things about the cancer, the operation, my coming home, working on my book, until gradually it all came back to me, bit by bit. When I told my surgeon at the hospital, he was a little resentful, and said quickly, 'That kind of thing is none of my business; not my job.' I hushed, then I said quietly, 'I thought you wanted to know the bad spots your patients have as well as the good ones.' And I said no more to him.

"My profound knowledge of psychiatry, and of myself, I think, helped me climb back quickly. My husband said I was climbing as if I had fallen into a well of time. He said he had never seen me use my conscious mind so obviously as when I began linking one memory to another to pull myself out again. But it was an earth-shaking experience; and for weeks, even months, I was not sure I wouldn't 'go' again. I had taken the operation too well, I suppose. All my rehabilitation work gave me a kind of pride. I wanted to rise above it, and get back to my book, and I did so. But deep down, I had not come to terms with my mutilated body; and, of course, with the fear of 'the return.' "

* * * *

For nearly a year, ten-year-old Bobby had been troubled by enuresis. His mother had taken him to several doctors and various treatments were tried, but none was successful. To add to his parents' concern, Bobby was a problem at school. His work had fallen below average. He didn't concentrate, the teacher said; he was restless and cried easily. Sometimes he was incontinent in school. On one occasion he was punished by being made to stand in front of the room. Both in and out of school he played with children much younger than himself. Recently, his mother discovered that he had been pilfering money from her purse to buy candy for them.

Bobby was a good-looking boy but he had conspicuous lop-ears. Since he never mentioned them, his parents did not think he was concerned about them. They had decided between themselves, however, that when he grew older they would have them corrected if he wished it. But they were not aware of the unhappiness his ears were causing him. He had not told them how the older children made his life miserable by saying, "You look like a taxicab going around the corner with both doors open," and by calling him "Dumbo" and "Donkey Ears." However, a new and observant teacher in the school sent for his mother and pointed out the possible

connection between the appearance of his ears and the many problems he was having, and suggested plastic surgery.

At the clinic Bobby expressed delight when he heard that his ears would be corrected. It was here that he finally told the writer of his experiences with other children and his feelings about them. After the operation, his mother reported that his enuresis had ceased entirely. A month later his teacher gave a glowing account of his improvement in both work and conduct. Furthermore, he was now playing with boys of his own age and he no longer stole money.

* * * *

At a large center for the rehabilitation of the physically handicapped, a team of doctors, nurses, psychiatrists, and a social worker were discussing a recently inaugurated program for reducing the incidence of decubitus ulcers (bedsores) among a group of hospitalized patients. Each patient had been given the responsibility of examining himself thoroughly every day with a mirror in order to detect any symptoms of breakdown in the skin. This procedure, it was hoped, would prevent any lesions from remaining unnoticed until they became serious. On the whole, the method had proved most successful and the staff checked off the names of patients who had recently remained free of decubiti as a result.

One of the patients, however, Miss Miller, had deliberately ignored the new directions and had developed a lesion. It was around her as a "problem case" that the discussion centered. Staff members were noticeably annoyed. They pronounced her "uncooperative" and "stubborn"; and the prevailing opinion was that the lesion could have been prevented had she examined herself as the other patients did. One of the doctors asserted that "there was just no good reason" for her attitude.

Why had Miss Miller been "uncooperative"? Not known or investigated by the staff was the relationship between certain important factors in her background and her behavior in this particular situation. Born and reared in an impoverished rural area in the deep South, she had never seen herself in a full-length mirror. More relevant, however, were the prevailing customs of that rural area and the precepts of her religion, both of which held that it was immoral to view one's naked body. Knowledge of these facts would have explained her reluctance to conform to the newly prescribed orders.

* * * *

Sarah was a fourteen-year-old girl whose lack of psychological readiness for surgery was the subject of a clinic conference. The surgeon suggested that the excessive anxiety of the mother was a factor in

the child's resistance to a minor operation. The psychiatrist who had been called in to see Sarah declared that in his opinion the mother was not so much anxious as outright hostile toward her daughter. What kind of mother was it, he asked, who would slap her child's face on learning that the child's menses had begun? This fact he had learned from Sarah herself while questioning her about the menarche. For him this was substantial and sufficient evidence of the mother's hostility, even cruelty. What he had failed to take into consideration, or to explore, was the possibility that there might be some other explanation for the mother's behavior.

Both Sarah and her mother were Orthodox Jews from East Europe, among whom it is the custom for the mother to slap her daughter's face at the time of the menarche "to bring the roses to the cheeks," or to bring good luck. By assessing behavior in terms of his own cultural standards of what is normal or abnormal, the psychiatrist was led to a false interpretation. The mother's behavior in this situation was not aberrant. Because it was a custom of their culture, it had no deeper psychological implication for the child than the ritualistic and facetious spanking an American child is given on his birthday.¹

These six incidents could be multiplied over and over with infinite variations. They are not cited in a spirit of criticism of the practitioners involved but, as already suggested, to illustrate the kinds of situations that can and do occur when medical personnel lack understanding of the social and cultural aspects of human behavior. They exemplify, too, the all-but-inevitable consequences: for the patient, misdiagnosis, poor management, psychic damage, and suffering; for the doctor and nurse, frustration and dissatisfaction.

In each instance, the patient's well-being was the prime concern of the physicians. They gave both time and thought either individually or in concert in order to help him. Conferences were held, situations discussed, precautionary measures taken, and even psychiatric consultations requested. Within the boundaries of their training and knowledge of the sciences of human be-

¹ The cases of Miss Miller and Mrs. Dietrich were obtained from personal communications. The others came from the writer's personal research files or from the files of the interdisciplinary project, "The Psychosocial Aspect of Facial Deformities and Plastic Surgery." This project was initiated and coordinated by Frances Cooke Macgregor, and directed by Dr. John M. Converse. It was conducted under the auspices of the Departments of Psychiatry and Surgery at New York University College of Medicine, 1949-1951, and supported by the National Institute of Mental Health, U.S. Public Health Service.

havior, they left no stone unturned. Yet in each situation the lack of social, psychological, and cultural approaches to problems of health and illness either prevented greater skill in diagnosis or maximum effectiveness in treatment and care. In focusing primarily on the physical aspects of disease and disability, the physicians neglected to view their patients as distinct personalities whose life experiences as members of particular social and cultural groups had given them certain beliefs, expectations, fears, patterns of behavior, and ways of feeling. In short, a variety of social, psychological, and cultural factors were operating in differing degrees of dominance in the patients' behavior and reactions.

Some of these factors, which will be dealt with later on, were relatively complex and could easily escape the attention of those who lacked the insights provided by the social sciences. Yet even more obvious ones tended to go unrecognized as necessary dimensions to be taken into account. For example, in the cases of Juan, Maria, and Sarah, who were from Puerto Rican, Italian, and Jewish backgrounds respectively, the physicians, though alert to the concepts of psychosomatic medicine and psychology, had not been sensitized to the cultural determinants of behavior. This resulted both in inaccurate diagnoses and in the loss of time and money. On the other hand, in the case of Mrs. Dietrich, a lack of knowledge of the psychological trauma which many women experience following amputation of the breast, irrespective of their intelligence or education, misled the surgeons and nurses into praising her for an adjustment that in reality did not exist. In so doing, they disregarded an important aspect of both preventive medicine and rehabilitation, that of providing the patient with the proper kind of support. As for Miss Miller and Bobby, it was predominantly the influence of the attitudes and customs of their social and cultural milieu which resulted in behavior that was not understood.

THE SOCIAL SCIENCES AND MEDICAL EDUCATION

It is situations of the kind just discussed that provide the theme for this book and the rationale for the experiment reported in later pages. If the needs of patients are to be met in as compre-

hensive a fashion as possible, knowledge from the social sciences must supplement that from the physical and biological sciences and from psychiatric theory. Such knowledge is requisite for physicians, nurses, and other professional groups working directly with patients. Our experiment was confined to one aspect of this broad theme: what portions of the social science literature might be most directly useful to nurses and how might the material selected be best utilized within a collegiate school of nursing.

Before turning to an exploration of this question, something must be said briefly about the present status of the social sciences in medical education. This is necessary in view of the fact that professional preparation for medicine and that for nursing are generally discussed as if they were not only independent but unrelated to each other. Yet in the problems of health and illness, medicine and nursing are inextricably linked. So much that is crucial to the solution of such problems is contingent upon the kinds of training that both physicians and nurses receive. It is apparent from the cases cited above that neither the doctors nor the nurses involved were sufficiently knowledgeable in the social sciences to solve the behavioral problems with which they were confronted. For their deficiencies, however, they cannot be held responsible. Only as the two professions can move ahead more or less parallel in their preparation can such problems lend themselves to possible solution.

Until very recently the body of knowledge from the social science disciplines that could be applied to the understanding and care of patients has been denied the clinician. Even at the present time it is not considered a mandatory part of the curriculum in most medical schools, and rarely are any specific prerequisites in the social sciences required for admission. There is, however, an increasing recognition on the part of some medical educators of the need to rectify this situation. For example, Dean Berry of the Harvard Medical School has said:

Our preoccupation with scientific medicine has tended to let the patient fade into a faceless, nebulous creature, often no more than a number on a test tube or an entry on a chart. Such an attitude is not consistent with the best medicine. Moreover, it is not "scien-

tific." While the student is learning a great deal about the patient's 17-ketosteroids, undeniably important, he tends to overlook the patient's anxieties and hatreds, his attitudes in his family setting, and the pressures that hem him in. These, too, are important. They must receive greater attention. In brief, scientific medicine is a misnomer, I think, when it is exclusively preoccupied with the physical and chemical constitution. . . .

No one can seriously challenge the value of the contributions that natural science has made to clinical medicine. It is also important to appreciate that significant new avenues to understanding man are being opened up rapidly by psychology, anthropology and other of the social sciences. To say this does not imply that any of the old ways of characterizing man are losing their value—quite the opposite! It means, rather, that students should have a better chance to view the patient in broader perspective, taking into account the entire family and community setting. Man shall not live by bread alone—the orthodox medical sciences, though more and more important, are less and less the *whole* story.¹

As this is being written, the Johns Hopkins School of Medicine has officially announced a revised program "to remedy medical education's present shortcomings." It deplores the "iron curtain" that now drops precipitously at the end of college, thus cutting in two what should be a continuous educational experience. The result is that the medical student tends to lose interest in everything except technical requirements. The School notes that modern health problems require a knowledge of sociology, psychology, and anthropology; and suggests that these behavioral sciences be established as basic to the study of medicine.²

A number of medical schools, realizing the importance of the social aspects of illness, have instituted comprehensive or family-care programs that allow students to study a patient in relation to his family, occupation, and environment. Others have introduced a first-year course that consists of material taken from psychiatry, and to a lesser degree from the behavioral sciences. As yet, however, few schools offer formal courses built exclusively on a social science foundation, although plans for such courses are in

¹ Berry, George Packer, "Medical Education in Transition," *Journal of Medical Education*, vol. 28, March, 1953, pp. 32-33.

² *Johns Hopkins Magazine*, vol. 8, June, 1957, pp. 6-7.

process of formulation in some places. Even when medical faculties are interested in broadening the curriculum, the task is difficult, so overcrowded is it already.

Not all medical educators are convinced that the social sciences should be included in the education of a physician. Even to such innovations as comprehensive care programs there has been some outspoken resistance. "This new trend of focusing on the patient as an individual," said the head of one medical college department, "is reducing the scientific training and stringent discipline formerly required of doctors. It is not only impairing the training of doctors who should be learning more about physical functions, but it offers an 'out' for those who are less qualified." Still others contend that students are not so unfamiliar (as they are said to be) with the socioeconomic and environmental factors in the patient's life, since "practically all of them have been members of families for twenty years or more before entering medical school." Moreover, their own need "for various forms of student aid suggests that they also have some familiarity with the economic problems of life."¹

It is true that the progress made in psychosomatic medicine has given most physicians an awareness of the relationship between the emotions and health and illness, and of the need to view the patient as a whole rather than as a disease entity. In practice, however, this unitary approach to health and disease is often more theoretical than actual. While consideration is paid to emotional disturbance, "mental stress," or anxiety, the social, cultural, and psychological stimuli which elicit these responses are less understood or are treated superficially. Moreover, many clinicians, rigorously trained as they are in the natural sciences, are frequently suspicious of any nonphysiochemical orientation, and tend to view with skepticism the scientific validity claimed by students of human behavior. They are reluctant to admit that there are general laws which hold for behavior, attitudes, and feelings. Many a physician reconciles his denial of the theoretical and practical contributions of the social sciences on the ground

¹ Weiskotten, Herman G., "Lasting Values in Medical Education," *Journal of the American Medical Association*, vol. 164, June 1, 1957, p. 536.

that medical healing is an art as well as a science, and that competence in the art of medicine develops intuitively with years of clinical experience.¹

THE SOCIAL SCIENCES AND NURSING EDUCATION

While the medical profession is engaged in charges and counter-charges regarding the value of comprehensive care programs and the social sciences, and in what seems to be a struggle over definitions of "total patient care" and "the whole patient," the nursing profession, generally, and nursing educators, in particular, have been receptive to what the social sciences can offer. For a considerable time, moreover, they have been seeking ways and means of putting these sciences to greater use. Because the nurse is in closer and more continuous contact with patients than is the physician, nursing education has consistently recognized and emphasized the need for understanding the patient. "Total patient care," "comprehensive care," "tender loving care," have become concepts which students hear as soon as they enter the school of nursing. The importance of understanding factors in interpersonal relationships is stressed. In most collegiate schools courses in psychology and sociology are either required upon admission or as part of the nursing curriculum. While some hospital schools are lengthening their formerly brief orientation to psychology and possibly sociology, the recognition of the need for greater insight into human problems as related to illness has led to an earnest attempt in some places to integrate principles from psychiatry, mental health, and the social sciences into theory and practice throughout the curriculum.

The enthusiasm of nursing educators for introducing social science courses into schools of nursing has not always been commensurate with amount of progress. Actually, progress has been slow because difficulties have been encountered in the implementation of policies recognized as important for nursing education. Ten years ago when Margaret Bridgman studied the situation, only 70 per cent of the collegiate schools and 20 per cent of the

¹ Alexander, Franz, *Psychosomatic Medicine*. W. W. Norton and Co., New York, 1950, p. 23.

hospital schools could meet the modest recommendations concerning the social sciences set down in *A Curriculum Guide for Schools of Nursing*, published by the National League for Nursing in 1937. Moreover, courses such as professional adjustments and the history of nursing were often counted as social science. In spite of much progress during the past decade, the hours devoted to behavior sciences in many schools are still too brief to provide what Miss Bridgman described as "adequate understanding of even the elementary principles." In her opinion the failure lay in an already overcrowded curriculum, and in the lack of qualified instructors.¹

But there are other reasons why progress has been slow. The social sciences are relatively young disciplines. As applied sciences in such fields as health and medicine, they are even younger. Many of their scholars, particularly in the fields of anthropology and general psychology, have devoted themselves primarily to theoretical considerations and pure research. They have been, for the most part, more concerned with raising hypothetical questions than with seeking answers to practical problems. Even today, there is a noticeable dichotomy between what is recognized as pure science and applied science, with some exponents of the former contending that the latter is not a science at all. They are of the opinion that what has been said about applied anthropologists is true in general; while it may be laudable for the social scientist to investigate practical problems, he is no longer acting within the social science field but in the nonscientific field.² The pure scientist, it is maintained, should keep a "scholarly aloofness" and detachment from practical problems requiring action.

In the past twenty-five years many social scientists have broken with this particular point of view and have turned their interest to areas where they might apply their scientific training and knowledge. More recently, an increasing number has recognized that the practicing professions, such as medicine and nursing, offer promising fields for research. Yet even here only a relatively few have related the results of their research to the needs of these

¹ *Collegiate Education for Nursing*. Russell Sage Foundation, New York, 1953, pp. 144-145, 152.

² Evans-Pritchard, E. E., "Applied Anthropology," *Africa*, vol. 16, no. 2, 1946, p. 94.

specific professions.¹ Because of lack of adequate interpretation by social scientists as to what their disciplines can offer, the nursing profession has been left uncertain about the precise relevancy of the social sciences for nursing and patient care. At present many nursing educators wish to have pertinent portions of these disciplines integrated into both the theoretical and clinical courses in the curriculum, and to make use of them in research undertakings. When they turn to social scientists for counsel, most of the latter have not been close enough to the problems of patients, hospitals, and health agencies to be able to serve in an advisory capacity. Thus, progress in the incorporation of the social sciences has been retarded, and achievement has frequently been superficial, fragmentary, or unsystematic.

There are urgent reasons for fostering the application of social science concepts and methods to nursing. As already indicated, total patient care cannot be achieved unless those in charge are scientifically trained and knowledgeable in the sciences of human behavior. Second, because of the educational lag in the behavioral sciences in medical schools, the average physician is still not being provided with the necessary knowledge of the psychological, cultural, and social components of health and illness.² Third, the increasing incidence of chronic illness, diseases of old age, and mental illness demands more than ever a large number of nurses who have a highly trained sensitivity to patients, their fears, desires, and needs. Fourth, since it is the nurse more often than the doctor who works closely with the patient, it becomes imperative that she seek out and master all the relevant knowledge available that will give her insight into her patients and their behavior. Her success then depends to a large extent on skills other than those of a traditionally technical nature. Wherever she is working, whether it be in a hospital, public health agency, doctor's office, or an industry; whether it be in South Dakota or New York City, or among the Papago Indians, her

¹ Young, Donald, "Sociology and the Practicing Professions," *American Sociological Review*, vol. 20, December, 1955, p. 646.

² Even during their premedical education students are sometimes discouraged from studying the social sciences. See Back, Kurt W., Robert E. Coker, Jr., and Thomas G. Donnelly, "Public Health as a Career in Medicine: Secondary Choice Within a Profession," *American Sociological Review*, vol. 23, October, 1958, p. 535.

patients will represent diversities in at least one if not many respects, such as diversities in ethnic and regional background, religion, class membership, and psychological makeup.

As was demonstrated at the beginning of this chapter, these are factors that play an important role in patients' reactions to illness and hospitalization, and in their attitudes and responses toward management, treatment, and rehabilitation. They also play an important part in the quality of interaction between the nurse and the patient; for as others have noted,¹ they may set up barriers to communication and understanding by fostering fear of differences, social distance, prejudice, hostility, stereotyping, and so forth, reaction patterns which may have been learned by either the nurse or the patient or both. For example, a nurse who has been taught to mistrust "Orientals" may react to a patient who is Japanese with suspicion and hostility, or, as a devout member of a religious faith, she may judge the behavior of another patient as morally wrong rather than as behavior to be understood. On the other hand, a patient from the working class may withdraw from a nurse who comes from a social class other than his own. In such instances, the patient's needs will not be met adequately and the nurse will experience little reward.

If mutually satisfying relationships are to be established, the nurse must be skilled in working with patients of varying backgrounds. Knowledge of sociopsychological and cultural factors and the attitudes and behavior fostered by them is essential if the nurse is to understand her patients and herself, and if she is to make more effective use of her professional skills. Without it, she is likely to treat these differences as oddities, as intolerable, or as something of no importance.

Another reason for incorporating the social sciences into nursing is related to the increasingly important role of the nurse as observer, listener, supporter. As we have already said, it is the nurse, more often than the physician, who has the opportunity to be with, to observe, and to teach the patient. And it is the nurse, if she has developed the power of critical observation and evaluation, backed by a fund of scientific knowledge, who is in a

¹ Taba, Hilda, "Discussion" in *Education and Anthropology*, edited by George D. Spindler. Stanford University Press, Stanford, Calif., 1955, p. 78.

position to pick up significant clues that may have bearing upon the patient's response or resistance to treatment, such as his reluctance to follow prescribed exercises or diet, or his failure to keep clinic appointments. It is also the nurse to whom the patient so often turns for explanations about matters the doctor did not make sufficiently clear or which the patient did not fully understand. Patients frequently feel under considerable stress when they are with the doctor because his findings and decisions are of such vital importance to them. At such times they may hear only part of what he tells them; they "forget" to discuss matters which might bear on their situation; or they are reluctant to discuss various subjects because they are too embarrassed or too anxious. In these instances, it is the nurse to whom they will often look for assistance.

It behooves the professional nurse, then, to recognize the privilege that is hers, of being near and working with people who are in trouble, people who are in pain, frightened, helpless, and wholly dependent upon doctors and nurses; people who are often afraid to communicate verbally what is really terrifying them but hope, somehow, to convey it through their eyes, their skin, their gestures. The nurse must see her function not only as that of making certain the patient has a comfortable bed, correct medications, and the physical necessities, but of being an emotional detection agent as well. This is a function that is mandatory if she is to give proper psychological support and to serve as intelligent liaison and interpreter between the patient and the doctor.

The nurse who is skilled in this respect is traditionally regarded as a "sensitive" nurse. By this, it is usually meant that she is not only warm and responsive but is "intuitively" able to anticipate and meet the emotional needs of the patient. The discrepancy between the nurse who has this special gift for working with patients, and the one who is regarded as having no sensitivity whatsoever, is commonly accounted for on the assumption that such a quality is "instinctive"; people are born with or without it. Hence, patients and their doctors consider it a matter of "luck" when they obtain the services of a sensitive nurse.

Moreover, the notion is still extant that training in the social sciences will somehow dull the nurse's sensitivity, prevent her

from detecting her patient's emotional needs or from being kind and responsive. "What nurses need is heart, not facts," said a prominent physician upon learning that a course in social science was to be presented to nursing students. And another physician, who was pioneering in a research field related to the emotional aspects of an eye disease, admonished the writer to make the course elementary. "What we want," he declared, "is less education and more nursing. I wouldn't have one of those educated nurses in my office. We have a nurse with us who has been only through high school. She is wonderful. She doesn't think, but I don't want her to. Every day she asks me what iritis [inflammation of the iris] is. She can't remember, but she's a wonderful nurse."

There is no scientific evidence to disprove the commonly accepted belief in intuitiveness or particular sensitivity. But in the acceptance of the "either you have it or you don't" position, two important points have been overlooked. Sensitivity that is dependent alone upon certain idiosyncratic qualities in the individual may, we now realize, get in the nurse's way as much as no sensitivity at all. By this is meant that too much sensitivity may be difficult to manage, or it may lead in time to emotional numbness. The problem in either case is not to extinguish it but to bring it into balance. Secondly, we no longer need to leave entirely to chance those qualities recognized and approved in the "good nurse." Sensitivity to patients and their needs, in the sense implied here, is a specially trained awareness of human behavior based on a fund of knowledge that is scientifically sound. It is a synthesis of feeling and discipline. The ability to "play by ear" and to improvise in relation to patients' problems and needs, valuable as this is, is not enough. It is important to know *why* a patient has particular problems and needs. It is the "why" regarding human behavior that is the concern of the social sciences and their special contribution to nursing and patient care. They provide a substantial body of systematic and scientific knowledge as well as useful concepts, methods, and tools, which, if made accessible to nurses and nursing education, can help to develop the kind of disciplined sensitivity that gives deeper meaning to the words "compassion" and "understanding."

Chapter 2

The Social Sciences and Their Relation to Problems of Health and Illness

IN THE CHAPTERS THAT FOLLOW we will describe an experiment in the application of the social sciences to nursing education. Before doing so, however, it might be useful for those in the nursing profession who are uncertain about the nature of the social sciences, if we discuss briefly their scope and foci of interest.

At the outset one thing should be made crystal clear. Any attempt to define the social sciences is hazardous. One need only search the literature or consult social scientists to realize that there is no complete agreement concerning the various aspects of the academic disciplines that comprise the social sciences as they are presently organized. To achieve consensus about so large and roughly articulated a field, so many qualifications would be necessary that there would be little sense in taking on the task—one of the reasons some persons avoid it. Nevertheless, there are certain things characteristic of each discipline and fruitful collaboration between the health professions and the social sciences that demand some awareness by the former of what they are.¹ Our objective in the present discussion, then, is simply to try to bring a modicum of order into an area about which there is understandably so much confusion; and to provide the nonsocial science reader with an orientation in some of the specialties that have become traditionalized as sciences of human behavior.

¹ Also, social scientists should be oriented in the disciplines that their collaborators represent. For further discussion of this need, see Chapter 13, Problems of Collaboration.

The social sciences with which we are concerned in this book are sociology, social psychology, and cultural anthropology. As sciences that have in common the study of why people behave as they do—what makes them tick—they are frequently referred to as the behavioral sciences. All the social sciences, of course, are concerned with the social actions and behavior of human beings; and the fact of their interrelatedness is today fully acknowledged. This is seen in the present trend toward multidisciplinary attacks on problems of human behavior. Formerly, however, with the exception of history (which deals primarily with the social past as recorded by people), political science, law, and economics focused on the study of separate institutional systems. But in treating these systems as isolated and self-contained they were inclined to place emphasis upon such disparate abstractions as “the political man,” “the economic man,” and “the social man,” and to neglect what is a scientific commonplace today, “that all aspects of the behavior of an individual tend to hang together and to interact in some fashion, rational or irrational, and that on an institutional level, likewise, everything affects and is affected by everything else.”¹ Their failure to emphasize this led some to refer to them as the “unsocial social sciences.”² In contrast to these sciences, the growth and development of sociology, social psychology, and anthropology has been largely related to the view that all aspects of human behavior are interrelated and interdependent.

To define these three behavioral sciences simply and concisely is difficult, if not impossible. Even if we could, such definitions would offer little real understanding of their nature. More profitable, we believe, would be to explore the concepts with which they deal—a method we will use in this book. It is even difficult to make a sharp distinction between the disciplines. Although each of them is studying some aspect of human behavior, there are no absolute boundaries between them. Furthermore, in any attempt to separate or classify the topics and areas

¹ Lynd, Robert S., *Knowledge for What? The Place of Social Science in American Culture*. Princeton University Press, Princeton, N.J., 1939, pp. 13-15.

² *Ibid.*, p. 155.

of interest that are the concern of each, there must be added the provisional statement "at the present time." In the past thirty years cross-fertilization of these disciplines has been taking place at such a rate that in many instances what was once historically the special domain of one has become, or may soon become, a focus of interest for another.¹

But even though the distinctions between the various disciplines are blurred, and on some levels indistinguishable, there are differences which those who wish to make effective use of the social sciences should be aware of. These are in the areas of specialization and emphasis, theoretical approaches, research methods and techniques, and the kinds of primary data they produce. In an attempt to clarify for the reader the place each of these disciplines holds in relation to the other, and to make some of the more gross distinctions between them in orientation and methods of inquiry, the following brief and admittedly oversimplified summaries are given.

Sociology

Sociology, the broadest of the three sciences, is the study of group life and human behavior with particular interest in the activities and processes by which social life goes on. Its subject matter covers a number of fields, any one of which may provide a professional lifetime of specialization; for example, social class, social organization, social pathology, human ecology, social change, social theory, urbanism, rural life, crime and delinquency, the family, the community, and race relations.

In its approach to the study of human behavior, the task of sociology, like that of other sciences, is to deal with classes of phenomena, not with individual cases. For example, in studying such problems as suicide, divorce, or crime, the sociologist does so in order to isolate and define the social processes of behavior. And he seeks to formulate natural laws and generalizations in regard to human nature and society that are of universal

¹ Even the term "behavioral sciences" has more recently been used to denote "all those intellectual activities that contribute more or less directly to the scientific understanding of problems of individual behavior and human relations." See The Ford Foundation, Behavioral Sciences Division, *Report*, 1953, p. 13.

validity.¹ In other words, sociology as a scientific discipline is concerned with problems related to various fields of human behavior as social phenomena rather than as social problems.² This is a distinction that is important to make in view of the confusion that persists among many persons in medicine and nursing concerning the difference between sociology and the practicing profession of social work. Because of this confusion further comment here should be appropriate.

Social work is a vocational activity, or rather, a social technology. It has a strong psychiatric orientation, uses principles borrowed from biology, dietetics, medicine, psychology, and sociology but derives "its spirit from philosophy, religion, ethics, and moral values. . . ." As Herman D. Stein recently said: "The heart of the distinction between social science and social work lies in the difference between the function of an academic discipline and the function of a professional discipline. The underlying function of the academic discipline is to acquire and to disseminate knowledge—even if it is knowledge only for its own sake. This is the overriding purpose of all science. The professions have as their major function the application of knowledge for the rendering of services. The central objective of social work is to help people—through social planning, and through preventive and direct services."³ In short, the practicing professions are interested in *doing*, the sciences in *understanding*. This is not to imply that sociology is any less interested in or concerned with the betterment of human society—an interest that played a major part in the foundations of sociology. But what it does insist upon is that attempts at human betterment must be based upon indisputable facts rather than governed by sentimental or theological notions.⁴

¹ Reuter, Edward Byron, *Handbook of Sociology*. The Dryden Press, New York, 1941, p. 157.

² As contrasted to the older and rather widely held conception of sociology as a discipline whose members were concerned with grappling with concrete and practical problems of community life.

³ Stein, Herman D., "Social Science in Social Work Practice and Education," *Social Casework*, vol. 36, April, 1955, pp. 148-149.

⁴ Barnes, Harry Elmer, "The Development of Sociology" in *The Making of Society: An Outline of Sociology*, edited by V. F. Calverton. Random House, New York, 1937, p. 675.

In investigating the problems with which they are concerned, sociologists employ a variety of methods. Many are the same as those used by specialists in all fields of the behavioral sciences as well as by other disciplines; for example, observation, experimentation, the use of records and documents, content analysis, the personal interview, and statistical analysis. A major preoccupation of sociological research today, however, as an examination of professional books and journals will reveal, is with statistical analysis and quantification of data. Particularly popular are large-scale surveys aimed at studying various aspects of behavior. These may be concerned with problems of communication, social change, the growth and decline of population in a given area, or attitudes of people toward medical care. In conducting their inquiries, sociologists lean heavily on such techniques as sampling, the questionnaire, the single interview, and, more recently, the "panel" design which calls for repeated interviewing of samples. Usually sought are large masses of data which can be statistically manipulated and analyzed. Some investigations are designed to show systematic differences and how frequently a phenomenon occurs. Others, which require the use of refined statistical procedures, are designed to throw light on causal and probabilistic relationships between the variables studied and perhaps to answer the question *why*, or to anticipate future behavior or events.

Social Psychology

Social psychology is the most recent of the behavioral sciences and has its origins in the last quarter of the nineteenth century. Because it lies in an intermediate zone between psychology and sociology, it is an area not easily demarcated. Such is the marginal status of social psychology that universities are still not agreed on whether social psychology should be offered in departments of sociology or psychology, or both. Actually, it would be easier to point to specific social psychologists, to their research, the concepts they use, and to the points of view they represent, rather than to attempt to define the discipline itself. Generally

speaking, however, social psychology is interested in group processes, or social interaction between people as they affect the individual, the social determinants of individual motivation, perception and action.

During recent years psychologists, who formerly concentrated on the individual and did research into the biological basis of behavior, have become more and more conscious of the social and cultural determinants in the behavior of man and of the necessity of taking into consideration his social relations and background. At the other extreme, sociologists have come to realize that in seeking the total explanation of social phenomena they cannot afford to ignore the field of individual interactions or attitudes, nor the many psychological components that play a part in the origin and explanation of the phenomena they are studying. Social psychology, then, is an indispensable aid to both psychology and sociology.¹

Like sociology, the scope of social psychology is wide, and as new techniques are developed and contact with allied disciplines increases, it becomes wider. Some of the major problem areas that are of particular interest to social psychologists are the socialization of the child, culture and personality, individual and group differences, attitudes and opinions, social interaction and group dynamics, sociometry, and leadership.² In addition to the social research methodology and techniques they have developed, social psychologists have drawn upon those employed by sociologists, general psychologists, and anthropologists. One, upon which considerable reliance is placed, is the case history. With this method detailed material is collected on the life history of an individual, the premise being that to understand his personality and behavior one must have knowledge of his past life experiences. Projective techniques, aimed to diagnose hidden and unconscious regions of the personality, while more commonly used by clinical psychologists, are also utilized by social psychologists in their studies of personality. Among these are the Rorschach

¹ *The University Teaching of Social Sciences*. United Nations Educational, Scientific, and Cultural Organization, Paris, September, 1954.

² Klineberg, Otto, *Social Psychology*. Rev. ed. Henry Holt and Co., New York, 1954, pp. 14-16.

(or "inkblot") Test, Free Association tests, and the Thematic Apperception Test.

Like their colleagues in sociology, social psychologists are particularly interested in the field of attitude measurements, public opinion surveys, and in studies of motivation such as in voting or becoming a nurse. In their use of questionnaires, sample interview surveys, the devising and administering of scales, and so on, the two disciplines are almost indistinguishable. In general, however, the sociologist's major interest is group behavior; the social psychologist's concern is the behavior of the individual in the group situation.¹

Anthropology

In its broadest definition, anthropology is the study of man, and includes archaeology, physical anthropology, ethnology, linguistics, and cultural anthropology. Cultural anthropology is concerned with the culture of man, that is, the learned patterns of behavior which a group of people share in common. Unlike the term "society," which refers to the structural relations between people and the interaction among them, culture is an abstraction which refers to a society's distinctive way of life.

Culture is not biologically inherited but is a "body of learned behavior which a group of people, who share the same tradition, transmit entire to their children, and, in part, to adult immigrants who become members of the society. It covers not only the arts and sciences, religions and philosophies to which the word culture has been historically applied, but also the system of technology, the political practices, the small intimate habits of daily life, such as the way of preparing or eating food, or of hushing a child to sleep, as well as the method of electing a prime minister or changing the constitution."² It is, in short, a learned and shared way of thinking and feeling and believing.

Anthropology is predominantly a field science. It is not a subject limited to study in the library, for by tradition it requires

¹ *Ibid.*, p. 7.

² Mead, Margaret, editor, *Cultural Patterns and Technical Change*. United Nations Educational, Scientific and Cultural Organization, Paris, 1953, pp. 9-10.

of its students field work before they are accepted as professionals. The anthropologist uses real-life settings for his laboratory. Working cross-culturally, he attempts, by comparative examination, to describe the characteristic patterns and systems of different cultures. But in using this method he is careful to avoid invidious comparisons, for his interest lies in understanding people, not in establishing the superiority of the way of life of one people over another.

Unlike the sociologist, the anthropologist depends less on sampling and statistics than on direct and participant observation. He depends less on quantitative data than on that obtained from repeated and intensive interviews with a few informants. Fieldwork, as Alfred L. Kroeber has said, is for the anthropologist an opportunity, a privilege, and a professional cachet. He wants the face-to-face experience with his subjects and eschews the anonymity of the sociological questionnaire which seems to him "bloodless." He is strong on photographs, films, and tapes that reproduce sights and sounds.¹ In working, part of the anthropologist's task is not so much that of asking questions, as discovering what *kinds* of questions to ask. He is less intent upon obtaining measurable quantities of data than in learning what are the recurring regularities or patterns of behavior, an important feature about anthropological research which warrants some amplification.

Because of the magic and power with which statistics are endowed these days, there is a tendency for some to discount the validity of anthropological findings. Criticism is leveled at them on the basis of "insufficient" sampling, and research which is qualitative rather than quantitative. Part of this misunderstanding (and it is only part) centers around the fact that anthropological sampling is a *different* kind of sampling and that what the anthropologist searches for is also different.² Let us take a simple

¹ Kroeber, Alfred L., "The History of the Personality of Anthropology," *American Anthropologist*, vol. 61, June, 1959, p. 400.

² For a fuller discussion of anthropological methodology see Mead, Margaret, "National Character" in *Anthropology Today*, edited by A. L. Kroeber, University of Chicago Press, Chicago, 1953, pp. 642-662; and Weakland, John Hast, "Method in Cultural Anthropology," *Philosophy of Science*, vol. 18, January, 1951, pp. 55-69.

illustration. The sociologist who is interested in, for example, job dissatisfaction among nurses, is preoccupied with gathering, by means of hundreds or thousands of questionnaires, a mass of material which can be coded and run through an I.B.M. machine. The results of this process, it is anticipated, will give him the incidence and distribution of dissatisfaction in his "population" and also relationships with other characteristics of it. The anthropologist, on the other hand, studying the subcultures of nursing and using first-hand observation and intensive interviews with a relatively few informants, finds that among some nurses job dissatisfaction does exist. This he views as a piece of knowledge which, to be useful for him, must be seen in its relation and interrelation to the *whole* of nursing. Furthermore, it is a phenomenon which requires further examination in order to learn the *hows* and *whys* of the nurses' dissatisfaction. To continue to find out if job dissatisfaction exists is for his purposes no longer necessary. For once it has been established how and in what ways nurses are dissatisfied, a point is soon reached "where the testimony of great numbers of additional informants provides no further validation."¹ This is not to imply that incidence and prevalence are of no interest to the anthropologist, but that the techniques for establishing them are those of sociology and social psychology.

In actual practice today the distinctions between these three sciences are far from being as sharp as these brief descriptions might suggest. As we have already indicated, there is considerable overlapping, merging, and "borrowing" among them. More and more social scientists, irrespective of their particular field of specialization, are utilizing the knowledge and the methods of all three in what is known as the interdisciplinary approach. This they find is increasingly necessary, for though "the individual has been assigned to Psychology, society to Sociology, and culture to Cultural Anthropology . . . it is now becoming apparent that the integration between the individual, society and culture is so close and their interaction so continuous that the investigator

¹ Benedict, Ruth, *The Chrysanthemum and the Sword*. Houghton Mifflin Co., Boston, 1946, p. 16.

who tries to work with any one of them without reference to the other two soon comes to a dead end.”¹

Since these disciplines are all concerned with problems of human behavior, they necessarily deal with subject matter that is often “sensitive” or controversial, or that tends to arouse emotions. A social scientist engaged in studying and analyzing, for instance, race or religious prejudice, or the reaction to a program of planned parenthood in a community, must approach his task impartially, regardless of his personal feelings and opinions. He must look for the reason for the prejudice or reaction, not for something or someone to blame. He seeks knowledge that will help to explain the prejudice, even though such knowledge may arouse opposition from those who view his findings as disadvantageous to their position.

THE SCIENTIFIC APPROACH TO HUMAN BEHAVIOR

Largely because of the kinds of problems with which they deal, the social sciences have sometimes been regarded as less scientific than the natural sciences. There are some who believe that human behavior is too complicated and unpredictable to be studied scientifically; that it does not lend itself to systematic inquiry or the formulation of general laws. There are also those who, because of the confidence they have in the validity of their own personal life experiences and observations, discount the need for the tedious and rigorous training in the scientific method in approaches to problems of human relations. Common observation, such persons believe, and common sense—which popular magazines tell us is what psychology really is after all—teach us all we need to know about people; the social sciences are merely statements of the obvious. Consequently, the unsophisticated without blinking an eye will indulge in the most sweeping statements about human behavior and its aberrations. “It is just common sense,” they will say and to prove a point, will cite some untested notion that has filtered down to us from one generation

¹ Linton, Ralph, *The Cultural Background of Personality*. D. Appleton-Century Co., New York, 1945, pp. 4-5.

to another, such as, "a rolling stone gathers no moss," or "he who hesitates is lost," or "you can't change human nature."

With the popularization of psychology and psychiatry, and more recently cultural anthropology, we have come to have a plethora of lay "experts." For example, concerning such matters as divorce, personality disorders, desegregation, or delinquency, we find radio commentators, politicians, and housewives who believe themselves competent analysts. Though these same persons would hardly presume to speak with authority on such specialized subjects as nuclear physics, biochemistry, or jurisprudence—disciplines in which they have not been trained—they will attempt to interpret and analyze the complexities of human behavior.

The fact is that the study of social phenomena requires the same scientific approach and methodology as the study of natural phenomena. However, since the social scientist is working with human variables, his task is frequently more difficult. Unlike the natural scientist who can often work in a laboratory, control experiments, and measure variations, the social scientist is seldom able to put human groups under laboratory control. Yet in spite of the difficulties involved in controlled experiments and in working with intangibles, there is no fundamental difference in attitude and basic approach between the social sciences and the natural sciences. Both are concerned with knowledge that leads to *understanding*. What differences do exist are those of degree; that is, differences in emphasis and in the subjects upon which they focus attention. Both the natural and social sciences are objective and empirical. Having as their aim the search for regularities, both employ the same methods: systematic observation, formulation of hypotheses, experimentation, and testing of data which can be validated and verified. Likewise, the ultimate aim of both is to furnish reliable information on the basis of which prediction may be made.

The acquisition of the scientific attitude is indispensable to a scientific approach. This approach not only demands infinite patience, tedious work, the kind of skepticism that requires evidence, the ability to distinguish the significant from the insig-

nificant, but most important, it requires objectivity. "The man who cannot train himself to curb his personal concern in a problem so that it does not bias his appraisal of his data has no business in scientific work."¹ It demands an intellectual integrity that will not shrink from disclosing findings that show one was wrong.

To develop the scientific attitude is not a simple feat. It means learning to approach a problem with detachment, without emotional involvement or bias. It means leaving one's own feelings and preconceptions out of the situation, to see it as it is rather than as we would like it to be. It is certainly true that when the material for study is human behavior it is far more difficult to be objective than it would be to study, for example, the social organization of the bees or the interaction of atoms and molecules. Emotional entanglements are less likely to develop when studying these subjects than in studying, for example, staff tensions that affect patient care. The tendency for observers to identify themselves with the human objects of their study and, as we are so prone to do in our culture, to measure human actions and behavior as either good or bad, right or wrong, is an ever-present danger to objectivity in the social sciences; a danger from which the natural scientist is more likely to be free as long as he is dealing with problems in his own field of interest.

One's own hopes, fears, and ideas of what *should be* are set aside in favor of discovering what *is*. Whether the naturalist likes or dislikes wolves is not relevant to understanding their relationship to the sheep. The man who studies the bees may be himself a believer in democracy, fascism, or communism, but this must not be allowed to intrude itself into his reports about their social life and how it works for them. The physician does not permit belief in the wickedness of the tubercle bacillus to lead him into underestimating or overestimating its power, nor to neglecting all the other matters that are equally important in understanding and controlling tuberculosis.

Few people will quarrel with all this as long as it is confined to the natural sciences, but many difficulties arise as soon as these few and simple points are transferred to the study of human behavior and an effort is made to view society as the naturalist looks

¹ Lynd, Robert S., *op. cit.*, pp. 183-184.

at the animal kingdom, the physician the functions of the body and the astronomer the stars.¹

CONTRIBUTIONS OF THE BEHAVIORAL SCIENCES TO THE SOLUTIONS OF HEALTH AND ILLNESS

In recent years the behavioral sciences have made impressive contributions to the body of knowledge in the medical and health fields, and the number of contributions is rapidly expanding. To review them here, is neither feasible nor necessary. Exemplary jobs of summarizing or compiling inventories of pertinent social science research and literature have been made elsewhere.² We would like, however, to give some indication of the range and scope of subject matter with which they deal.

The research interests of sociologists have leaned in the direction of ecological studies, studies of social factors associated with morbidity and mortality, of the social organization of medical settings and hospitals for the mentally ill, of ward interaction, social problems of health and illness in the family, community, and industry. Sociologists have also focused attention upon the relationship between social class membership and certain types of illness, both physical and mental. Others have engaged in studying role definition and conflict within the health team, analyzing the role of the physician, the changing role of the nurse, and the doctor-patient and nurse-patient relationships.

Social psychologists have made important contributions to the treatment of problems of human behavior under stress. For example, the problems of the physically handicapped and their rehabilitation have stimulated a considerable amount of research on the psychosocial aspects of different and specific types of physical disabilities. This has ranged from studies of amputees,

¹ Leighton, Alexander H., *Human Relations in a Changing World*. E. P. Dutton and Co., New York, 1949, p. 159.

² Caudill, William, "Applied Anthropology in Medicine" in *Anthropology Today*, edited by Alfred L. Kroeber, University of Chicago Press, Chicago, 1953, pp. 771-806; Leavell, Hugh R., "Medical Progress: Contributions of the Social Sciences to the Solution of Health Problems," *New England Journal of Medicine*, vol. 247, December 4, 1952, pp. 885-897; Health Information Foundation, *An Inventory of Social and Economic Research in Health*, 5th ed., The Foundation, New York, 1957; Freeman, Howard E., and Leo G. Reeder, "Medical Sociology: A Review of the Literature," *American Sociological Review*, vol. 22, February, 1957, pp. 73-81.

the deaf and blind, the aged, the obese, those who have had poliomyelitis, mastectomies, gastrectomies, to persons with rheumatism, duodenal ulcers, tuberculosis, and facial deformities.¹ The attention of social psychologists, however, has by no means been confined to problems associated with disabilities that have been incurred, but equally important, they have been concerned with investigating the causes involved in delaying medical checkups or resisting preventive health measures.

Anthropologists, to a greater extent than other social scientists, have investigated and described, usually within the context of larger studies, medical and health practices of preliterate peoples and other ethnic groups. Mostly cast in the form of descriptive accounts or case studies, the importance of these data, and the implications they have for modern medical care, have only recently begun to be given the recognition they deserve. Even so, recognition, for the most part, has been confined to such fields as public health, preventive medicine, psychiatry, and pediatrics.

Probably because of the relatively little contact which nurses and physicians have had in their nursing and medical education with the research and writings of the kinds just cited, it is difficult for many of them to understand in what precise ways the findings of the social sciences can be directly applied to the care of patients. Concerning the relevance of anthropological findings, for example, nurses, and doctors, have frequently asked such legitimate questions as: What bearing can these have on nursing and patient care in our modern American hospitals and clinics? Of what use is it to know about the superstitions and "unscientific" beliefs and practices of other peoples? What good is it to know that among some primitive peoples mothers insist upon burying the umbilical cord in the ground; that Guatemalan Indians believe that crowding into the sickroom keeps the forces of evil away; that in parts of Mexico a *curandero's* (healer) magic practices are preferred to the ministrations of an M.D.? Or what

¹ For an extensive survey of research reports and literature on the social and psychological adjustment to physical handicap and illness, see Barker, Roger G., and others, *Adjustment to Physical Handicap and Illness: A Survey of the Social Psychology of Physique and Disability*, Social Science Research Council, Bulletin 55 rev., New York, 1953.

bearing can the study of parent-child relationships of the Balinese have on our nursing in pediatrics or obstetrics? How can it help us in surgery or rehabilitation to know that for different people certain parts of the body may be more highly charged with emotion than others? What can studies concerning Chinese attitudes toward food contribute to dietetics in an American hospital? What difference does it make that in Peru existing concepts of hot and cold as applied to food and disease are not the same as ours? How can knowing what we already know, that many Italians and East European Jews are "emotional" and verbal when in pain, help us to provide better care for them?

While granting that learning about these different peoples and their "unusual" or "exotic" ways may be exceedingly interesting or, perhaps, useful for public health nursing in foreign lands, the direct implications for nursing education in this country are sometimes more difficult to see. "It is highly improbable," medical and nursing practitioners say, "that we'll ever have, for example, a Vietnamese¹ or a Zulu for a patient." Other statements frequently heard are the following: "Most people, after they have been in this country for ten or fifteen years, and certainly the children of such people, are 'Americanized.' " "Even if the patients are French or Egyptian they are in an American hospital and should adapt themselves to our ways." "Sickness is a great leveler; it doesn't really make any difference who a patient is."

To provide specific answers to these and similar questions that are frequently raised will not be attempted here. It is hoped, however, that answers to some of them will become apparent in the reading of Part Two of this book.

¹ See Appendix.

PART TWO

**AN EXPERIMENTAL PROJECT
IN NURSING EDUCATION**

Chapter 3

Purpose and Plan of the Experiment

PART TWO OF THIS BOOK is devoted to a report of an experimental project in the application of the social sciences to nursing education and patient care, which was conducted by the writer at the Cornell University-New York Hospital School of Nursing during the years 1954 to 1957. Before describing the experiment, however, it should be made clear that what the writer did and how she did it was shaped in part by the particular character and organization of the school itself.

The Cornell University-New York Hospital School of Nursing is an integral unit of the New York Hospital-Cornell Medical Center, a large voluntary research and teaching institution. Located in the heart of New York City with its vast heterogeneous population, patients represent a variety of races, creeds, and colors. The School of Nursing, composed of some 250 students and 70 faculty members, is distinguished from most other undergraduate collegiate nursing schools in several respects. In the first place, it is 200 miles from the Cornell University campus in Ithaca, New York. Hence, the nursing students do not share in the university environment as do other students where the school of nursing is located on or near the university campus. In the second place, the School has what is referred to as a "five-year" program. Before admission, students must have successfully completed at least two years of academic work in an accredited college. Admission requirements include one year of chemistry and of biology, and one semester of psychology. Following admission to the School, students take a program in nursing of two years

and eight months, at the end of which they are awarded a degree of Bachelor of Science in Nursing.

A third distinguishing feature is the system of faculty appointments. About 15 faculty members have full-time appointments in the School of Nursing. The remainder, who are in the clinical fields, all carry joint appointments; that is, half-time in the School, half-time in nursing service. Their title is that of supervisor-instructor. Throughout Part Two of this book, therefore, it will be necessary for the reader to keep in mind that when the terms "supervisor" and "clinical instructor" are used in connection with the Cornell University-New York Hospital School of Nursing, we are referring to a nurse with a dual appointment.

The typical collegiate nursing school by contrast offers a four-year undergraduate program. During these four years and in conjunction with the required courses in nursing, students are enrolled in liberal arts courses in the college or university of which their school is a unit. Designated courses in the social sciences are generally taken with students from other parts of the university; sometimes a social science instructor is engaged from one of the university departments to conduct a course in sociology or psychology exclusively for nursing students. Many of these courses are very good but, because they are necessarily geared to the requirements of many different kinds of university students, whose majors may be art, English, or history, the content is seldom adequate to meet the particular needs of nursing students in their clinical practice. Even when separate courses are offered, the subject matter is much the same as that generally covered in the liberal arts department. Consequently, many concepts which would be useful for nursing students are not touched on, and perhaps more important, the concepts that are dealt with are not discussed in relation to problems encountered by nurses. It is not surprising, therefore, that instructors find, as some already have learned, that it is difficult to convey the utility of social science for nursing, or that students ask, "How can sociology or anthropology help me as a nurse? How can these subjects be applied to patients?"

Students in one school of nursing, for instance, complained that the thirty hours of classroom instruction in sociology given

to them by a member of the sociology department of the university lacked relevance for their clinical experience. It became necessary, therefore, to assign a clinical nursing instructor to the sociologist to describe to him the kinds of situations student nurses meet and with which they need help. Another sociologist, writing of some problems encountered in teaching nursing students, stated they considered sociology a "waste of time."

Repeatedly the instructor must hammer away at the bearing sociology has on nursing. Even so, no matter how eloquent or persuasive the instructor may chance to be, no matter how ingenious the examples employed to fire the imaginations of the nursing students and describe to them the real nature of their future assignments and activities, it is still an extremely difficult task. Occasionally a student is found who glimpses the significance of sociology for nursing; but this is not too common, and often it would be a good bet to gamble that this student will not remain long in nursing. Sometimes too, and this is more common, students are found who are genuinely interested in sociology itself, but who are often hard-pressed to justify their interest in terms of a significant contribution to nursing. Indeed, it is all very well for instructors, lecturers, and writers to illustrate the significance of sociology for nursing with examples from the literature and from their experience. These expressions are listened to but are really not too seriously believed.

Over against these verbalizations is the picture engraved on the minds of the girls, of the tremendous efficacy of medical technique. Sociology is really a waste of time; medical techniques will make them into great nurses. Somehow they have already picked up the emphasis of modern nursing; stress on the manual of arms, the precision techniques of pill giving, injection giving, enema giving; the skills of bed making and slide staining; the arts of diet formulation and of temperature taking. These, the girls are convinced, are the staple items which, if learned well, will count most in transforming them into present-day Nightingales. It avails nothing to point out to them the statistical ability and interest of their founder-heroine, to indicate her widespread sophistication and broad human outlook; it avails little to recall some of the other personnel in the company of great nurses who were not bound down by slavery to technique, but who were able to see their patients as human beings involved in a variety of social situations.¹

¹ Ravitz, Mel Jerome, *Sociology and Nurses' Education*. Unpublished monograph, 1952.

The experience of these sociologists is not unique. But teaching social science in schools of nursing need not be frustrating, for, as we hope to demonstrate, teaching courses specifically designed for nursing can be a rewarding experience for both instructor and students. This, however, is contingent upon centering it around the particular needs of the nursing profession.

It was for the purpose of developing ways and means of bringing social science knowledge to bear directly on the needs of nursing at the New York Hospital-Cornell Medical Center that the experiment which we are about to describe was conceived. As a joint project between Cornell University-New York Hospital School of Nursing and Russell Sage Foundation, the proposal called for the appointment of a full-time social scientist to the faculty. Such a person would have the dual role of instructor of students and consultant to the faculty in their roles both in nursing education and nursing service. The major part of her assignment was to select and assemble social science materials which would have direct implication for, and application to, nursing and the improvement of the care of patients. Relevant concepts and methods from these materials were then to be introduced and integrated into the curriculum including the clinical and research areas.

At the start of this undertaking, we asked ourselves the following questions: What content from the social sciences is most applicable to nursing, to the care of patients? How and where can the concepts and principles of the social sciences best be taught? What teaching methods and what kinds of learning experiences can best help students and faculty members integrate social science concepts and methods into a more effective pattern of comprehensive practice?¹ Where should one begin with students or

¹ It should be noted that *content* was first in order of importance in this experiment. Others have given priority to *teaching methods*. For example, in a study of the "Application of Principles from Social Sciences to Nursing," conducted by the University of Washington School of Nursing in cooperation with the Commonwealth Fund, emphasis during the first two years of the study centered around the problem: "How (by what teaching methods) can students best be helped to develop the ability to apply social science principles to nursing care?" This emphasis, according to a progress report prepared by Anne W. Rohweder (p. 7), covering the period January, 1955, to January, 1956, was justified "on the basis that the development of effective teaching methods is necessary regardless of specific course content."

faculty members? Presently we noted that these same questions were asked us over and over by nursing educators and administrators, as well as social scientists interested in entering the field of nursing education. Such questions appear to be a reflection of the current dissatisfaction with treating the subject of applied social science and nursing solely in theoretical terms or in the form of generalizations. Largely because of this manifest desire for specificity and a more pragmatic approach we are presenting this report in the form of a step-by-step account of what we did, and why we did it. We hope that it may serve as a guide for schools of nursing and social scientists whose collaborative goals and objectives are similar to those in this undertaking.

A SOCIAL SCIENCE COURSE FOR NURSING STUDENTS

It was the considered opinion of the administration of the School of Nursing and the social scientist that designing and teaching a course for nursing students was of first importance. Obviously, the inclusion of a social science course in the curriculum is one direct method for achieving integration. But the mere fact of its inclusion, whether it be built on one of the disciplines such as sociology or a combination of all three, is no guarantee that it will prove useful to nursing students. If it is to have real value, it must be specifically designed for nurses; that is, it should be oriented toward problems of health and illness, and be patient-centered.

With regard to social science courses designed for application to special groups and for special purposes, it should be mentioned parenthetically that such courses have been questioned by some who contend that they can be no more than "watered down" and adulterated versions of the original courses offered in the liberal arts program—an objection which liberal arts faculty members have legitimately made to those courses sometimes found in professional schools of education or technical schools.¹ Properly designed courses, however, of the kind that should be required, are not "weaker" but simply different in content.

¹ "Education in Review," *New York Times*, May 13, 1957.

When and Where Should a Social Science Course Be Introduced?

Because of an already crowded curriculum and the experimental nature of the project, the initial plan permitted a course of only fifteen hours.¹ If feasible, an additional fifteen hours would be added at a later date. Since the time allotted for the course was so limited, the question was, where in the total curriculum could it be placed to the best advantage? It was the contention of the social scientist that if it were given to first-year students before they had had any contact or experience with patients, the material would have little particularized significance. Advanced nursing students substantiated this view. Two years previously they had taken a course in psychological principles of nursing which was oriented toward patient care. In spite of its potential value, they said they had seen little relation to what they had not yet experienced first hand. By the time they were working with patients much of what they had been taught was pigeonholed or forgotten. On the other hand, it was assumed that if the course were given after the nursing students were in the clinical area for any length of time, habit patterns and attitudes might be acquired that would be more difficult to change.

It seemed obvious, therefore, that the course should be introduced at the point when students were having their first contact with patients, and when the materials of the course could serve as active instruments for further learning. This would also allow them to observe, test out, and verify in the clinical services what they had learned in the classroom—perhaps within the same day or week. Moreover, problems arising from their clinical experiences could be used for class discussions. This, it was hoped, would result in a spiraling process whereby knowledge is not added as a series of disconnected facts but is a continuous and connected flow that allows students' insights to be built upon by newer insights provided by the instructor. For our purposes, then, it was decided to begin the course five months after the students

¹ Students were to meet as an entire group for nine of the fifteen hours and in two sections during the other six hours.

entered the School, a point at which they were still in their pre-clinical training but beginning their clinical experience of one day a week.

Considerations in Designing a Course

In designing the course, a number of variables had to be taken into account. As we have said, two years of college including a course in psychology are required for admission to Cornell University-New York Hospital School of Nursing. Most students have also had a course labeled "sociology" or "social studies"; but according to their school catalogues, this may range in subject matter from community and social organization, the family, or social problems, to social work, economic consumption, geography, and history. Obviously, some of these courses bear little relation to the content of the behavioral sciences. Colleges also vary widely in the type of instruction they offer and in their academic standards. Since the students in our classes, averaging 70 in number, represented approximately 40 different colleges, we had to consider not only the unevenness in their formal training and the need to unify their backgrounds, but also we had to present the material in such a way that the few advanced students with a bachelor's or even a master's degree would not lose interest.

What, then, could we expect and require of the nursing students intellectually? Our colleagues in nursing, medicine, and the social sciences reminded us that in selecting nursing as a profession, not a few students eschew intellectual pursuits for a career which they assume demands primarily physical skills and action. It was also implied, because of the heavy class and practice schedule of first-year students, that reading assignments might not be fully met. (Furthermore, the previous course had not required any reading, thereby setting a precedent which it was thought might be difficult to overcome.) Our premise was, however, that the tendency in general education today to underestimate and patronize the young student's ability, is to deny him that respect for his intelligence and motivation that he deserves.

Elaborating on this point, David Riesman, a distinguished social scientist, has written:

This patronization is not surprising, for I think that there has been a secular advance in the maturity of the young, at least in the better-educated strata, in recent years. Older people cannot adequately judge these youngsters simply on the basis of their own recollections of late high school or early college years, even if the recollections were not distorted by envies and amnesias. And while some may think there were advantages in the slower and often gentler growing up in the collegiate era, it would seem that it is no help to today's young people to treat them as if they were less capable and mature than their times have forced them to become. Here, again, we touch on the self-confirming prediction of social affairs: if we regard students as mature, we assist them to become so—and vice versa.¹

In many areas of nursing education the tendency to underestimate the intellectual capacity and maturity of students is even more noticeable. Our position was that we were to be teaching young women who would soon be carrying grave responsibilities and engaging in situations of life and death. Nursing was their career by choice. If they were mature enough to perform the most intimate services for patients, assist in an operating room where a mishap could result in a chemical explosion, care for newborn infants, pour and give high-potency medications, they could also be expected to respond to and handle advanced and challenging material in their courses. This was our assumption from the start, and while the lectures and materials were not so advanced as those we would have given to graduate students in the liberal arts, most of them were on a par with those offered in the master degree programs of some colleges of education, and in some instances even more advanced.

The response was gratifying. Reading assignments were avidly tackled. The librarian reported that students were not only taking out books far ahead of time but were reading beyond their required assignments. At the end of the course students requested

¹ "Some Problems of a Course in Culture and Personality," *Journal of General Education*, vol. 5, January, 1951, p. 135.

a second fifteen hours for the fall term as well as a reading list which they could use in the interim.¹

Aims and Objectives

The course, as we presented it, was an interdisciplinary approach to the study of human behavior, specifically designed for nursing and patient care. Subject matter was held closely within the framework of the medical and health fields to which relevant sociological, psychological, and anthropological knowledge was applied.

Because of the broad scope of subject matter in the social sciences, there is always the danger of attempting too extensive a coverage. This only results in superficial treatment and a smattering of general information for the student. The instructor must therefore continually keep in mind the direct relevance of the content to the needs of nursing and the care and treatment of patients. By this we mean selecting materials and concepts that will have greater specific value for medicine and nursing than those that might be more pertinent, for example, to law, engineering, or religion. Obviously, with the available amount of material that might be utilized, coupled with a limited time for presentation, it was impossible to cover any subject fully, and in our case, no attempt was made to do so.

What we did strive for as a broad objective was to stimulate students to want and to seek further knowledge, and to equip them to learn for themselves by independent study and from experience. The question of what to teach was more a question of what would serve most adequately as a basis for further learning. We endeavored to keep our sights on the dynamic character of a changing world—one that demands of the professional nurse intelligence, imagination, and a sound training. For the nurse, like the capable physician, must be prepared to meet and adjust to the ever-changing techniques and methods of modern medicine, the changing concepts of health and illness, development of new foods and drugs, shifts in population and ways of life. But

¹ The second half of the course was begun at the end of six months. By then students had had a more intense and prolonged contact with patients as part of their clinical practice.

this she cannot do by learning only application of social science knowledge that can be used to answer present-day problems; answers that may be outmoded before they can be put to use.

Tentatively entitled "Psychosocial and Cultural Aspects of Nursing," the specific objectives of our course, in terms of content and presentation, were threefold: to improve the care of the patient by increasing the nurse's understanding of human behavior; to stimulate intellectual and emotional growth and self-knowledge by the development of insights into her own motivation, needs, limitations, and strengths; and to stimulate professional growth. We tried to keep constantly in mind that the course should serve as a basis for professional thinking, not as an end in itself; that it should develop in students a social science point of view but with full cognizance on our part that they were being educated to be nurses.

Our reference points were those situations and problems commonly met by nurses that are potential sources of misunderstanding and where social science knowledge is of particular relevance:

1. Situations in which the different customs, attitudes, and behavior patterns of patients from other cultural, religious, and social backgrounds are likely to be interpreted as strange, irritating, irrational, unacceptable, or the result of ignorance or stubbornness. Typical are those concerning patients whose moral codes differ from the nurse's, who have frequent, and large, groups of visitors, noisily express pain, speak little or no English, resist necessary procedures, refuse required diets, do not keep or are late for clinic appointments; patients whose attitudes toward family, hospital, and community responsibilities are at variance with established norms; whose concepts of modesty seem irrational, who practice "unusual" customs or rituals.

2. Situations in which specific psychological understanding and management are required; for example, patients who are depressed, withdrawn, overdependent, uncooperative, demanding, complaining, aggressive, self-willed, hostile, stoical; patients who "know it all," who have "hospitalitis" or a terminal or chronic illness; who are "psychosomatic" or refuse to help themselves.

3. Situations in which difficulties originate within the nurse herself because of her particular prejudices, biases, and personality characteristics.

4. Problems involving interpersonal relations between patients; patients who offer gifts or tips; who object to a particular nurse or nursing student; and staff dissension about the care of a patient.

Because of limitations of space, it is impossible to reproduce the entire course in this book. Even an attempt to do so, for those who might wish a packaged social science course, would be misleading. In the first place, the content of our course changed from year to year, for reasons that will be given later. In the second place, what we taught and in what form and order, was the direct reflection of the particular professional training and experience of the author, with the consequent limitations and strengths. Another instructor might choose entirely different materials and methods of presentation, depending upon his own special training, competence, and feelings of confidence. A psychologist, for example, might be inclined to begin and perhaps heavily weight his course with the psychology of the individual, or the development of personality, leaving until the end the wider concept of culture.

Content of the Course

We began the course with an introduction and orientation that included much of the material contained in Chapter 2 of this book. We not only wanted to clarify at the outset what the social sciences are, and why they are relevant to nursing; but we hoped also to promote in nursing students some degree of self-consciousness about the scientific attitude and objective method of inquiry. In connection with this subject, the question inevitably arises of whether the acquisition of the scientific attitude is necessary or even desirable for nursing. "Is it not," students ask, "likely to get in the way of the 'tender, loving care' treatment that is stressed in our other classes?" "Is it not apt to make a nurse detached or perhaps even cold in her relationships with patients?" "Is not the scientific attitude incompatible with compassion?"

Our answers to questions such as these are: that to understand, at least, the meaning of science is essential to intelligent participation in our present-day society; that the development of a scientific attitude and an appreciation of scientific methods will not only better equip the nurse to cope with and solve problems that confront her every day, but they may actually liberate her from the kinds of restrictions that interfere with interpersonal relations. Certainly a scientific attitude and compassion are not identical but neither are they mutually exclusive. In this connection, what Flexner has said about physicians is also applicable to nurses: "It is equally important and equally possible for physicians of all types to be humane, and at the same time to employ the severest intellectual effort they are severally capable of putting forth."¹

The essence of scientific method is careful scrutiny, reflection, and decision.² The nurse, no less than the doctor, must use her wits at the bedside and the same intelligence that is used in the solution of a problem. Every patient she confronts is a *different* person. Each one differs from the other physically, psychologically, and socially; and intelligent observation and interpretation are never inconsequential or irrelevant. Scientific knowledge and understanding of the patient as a person will greatly enhance the capabilities of the nurse in aiding the doctor in his search for the cause of illness, of the patient's reaction to it, or lack of response to treatment. It is as important as the quality of humanity for which her profession is noted.

This general orientation to the social sciences is followed by the presentation of lectures, coupled with appropriate readings that serve as a point of departure for developing data and concepts that students can relate immediately to their own observations and experiences in working with the sick. It has been our experience that if newly introduced social science concepts are to be meaningful, nursing students need to have them introduced at the point of action or in connection with their relevance to specific

¹ Flexner, Abraham, *Medical Education: A Comparative Study*. Macmillan Co., New York, 1925, p. 12.

² *Ibid.*, p. 11.

situations encountered. Such terms, for example, as social structure, role, or culture conflict have little meaning except in the framework in which they are used. Moreover, many social science concepts like ethnocentrism, social class, scapegoating, and hostility relate to areas where feelings and biases may be strong, and where care must be taken not to ram them down the students' throats lest they be interpreted as an attack and create even stronger feelings and defences.¹

A question that is currently being asked over and over by nursing educators and social scientists alike is "What specific social science concepts are most useful to nursing and patient care?" In the process of finding out, a considerable amount of valuable time can be spent—and lost. In our particular situation we had benefited from several years of experience in research and teaching in other medical institutions and from close contact with nurses, doctors, and patients. The value of numerous social science concepts had been tested empirically and approximately scaled according to high and diminishing returns of usefulness. The problem for us, then, was not that of trying to discover what concepts were useful. Instead, because of time limitations and the desire to avoid superficial learning, our problem was which ones to select and the order in which to present them.

In the chapters that follow we describe the major areas and concepts explored and give reasons for the particular sequence used. That the reader may have the advantage of more intimate participation in the experimental course, of seeing at first hand what kinds of material nursing students were given (and what they subsequently did with the material), we are including a few of the recorded guest lectures.

¹ Taba, Hilda, "Discussion" in *Education and Anthropology*, edited by George D. Spindler. Stanford University Press, Stanford, Calif., 1955, pp. 33-34.

Chapter 4

The Concept of Culture

THE CONCEPT OF CULTURE was one of the first on which we focused our attention. It was selected for the following reasons. Our students were beginning to have, and would continue to have throughout their training, contact with a heterogeneous patient population. The presence of patients from so many different cultural and ethnic backgrounds is always a potential source of daily problems within the hospital in terms of communication, understanding, and optimal care. We are referring here not only to the more obvious problems of language differences or different religious and dietary practices, of which medical personnel are usually well aware, but the kinds of problems which arise because of cultural differences in attitudes, feelings, and reactions that are not so readily recognized or understood. Also, it is at this particular phase in the students' experience that they are most likely to be idealistic and enthusiastic about nursing and eager to learn all, and as quickly as they can, about those things that will enable them to help patients. Another reason for choosing the cultural or anthropological approach was the relative homogeneity of the class itself. With the exception of a very few foreign-born, the majority of our students came from sheltered, middle-class American environments, bringing for the most part sets of attitudes and beliefs characteristic of their particular social backgrounds.

— These students are not unique in the extent to which they are "culture-bound" or ethnocentric. Viewing one's own way of life as the best, the superior, or the "right way," and rejecting the concepts and patterns of those who differ from us as strange, unenlightened, or "not as good," is characteristic of many people.

Nor are nursing students alone in the misconceptions and biases they have concerning human behavior. To sensitize and widen their range of perception and understanding in these areas then, we first concentrated on studies of other peoples rather than on subjects more closely related to the students themselves. This, it was felt, would be less threatening for them, and this did indeed appear to be the case. Furthermore, by studying "primitive" or foreign cultures they would be more able to see that their own assumptions of what is right or wrong, rational or irrational, often represent ideas and beliefs that are not necessarily held by all other people.

Through lectures and the published works of Ruth Benedict, Margaret Mead, Ralph Linton, Clyde Kluckhohn, and others, students enlarged their understanding of culture and personality.¹ They began to see how common misconceptions about human behavior (which must be cleared away if one is to get at the truth) have caused much lack of understanding of other people.

One of the most widely held misconceptions is the assumption that human nature is the same the world over. Class discussions brought out that students understood "you can't change human nature" to mean that it is something inborn or inherited rather than learned. In the cultural framework, however, they begin to look beneath the surface and to see the fallacy of this notion. They learn that people are not motivated by the same needs and goals the world over. Even primary biological drives, like hunger and sex, are modified and channeled by culture: the kinds of food or the type of sexual behavior considered most acceptable in one culture may be scorned by another. In other words, people's preferences are determined not by biological drives alone but by the cultural traditions of the society in which they are reared. Even emotions which are basic, nursing students discover, may be expressed in a variety of ways, depending upon what one learned earlier was an appropriate response. For example, fear may be experienced in the pit of the stomach, the back of the neck, the buttocks, or even the big toe, depending upon how one is reared

¹ See Bibliography for specific references.

and what parts of the body one is taught to identify with the emotion of fear.¹ In the light of these studies, the saying, "It's human nature," now begins to lose its assumed validity as an explanation for many kinds of behavior. It no longer holds water as an explanation of predisposition to war, being selfish, living in squalor, or resisting surgery. Nor can it be offered with a tone of finality as the reason Americans compete for success or for money, or marry for love.

Another widespread misconception that results in misunderstanding, and which cross-cultural studies can help to remove, is the degree to which reason is believed to be a controlling force in man's behavior. As the virtues and reliability of "good hard common sense" are exaggerated in our culture, so, too, are those of reason, so much so that it has led the philosopher Jean-Paul Sartre to comment on the "naive and passionate faith which Americans have in the virtues of Reason."² This exaggerated notion of the power of reason leaves out of account the extent to which responses and reactions are influenced by attitudes, customs, and values that are culturally determined. In a medical setting, lack of awareness that behavior may be cultural, can lead (as illustrated by the case of Miss Miller) to false diagnostic evaluations of a patient's behavior. How often, for example, has nonrational behavior (like the case of Sarah's mother) been evaluated as a personality deviation, or as a manifestation of a mental or psychological disorder? And how often has a psychiatric evaluation been requested (as it was for Juan Martinez) for assessing behavior which actually was appropriate in terms of the patient's own culture?

By relating the knowledge derived from the study of differences among patterns of behavior in peoples of different cultural backgrounds, nursing students become aware of the trap into which they too often had fallen because of this misconception.³ They

¹ Mead, Margaret, "What Is Human Nature?" *Look Magazine*, April 19, 1955, pp. 56-62.

² Sartre, Jean-Paul, *Literary and Philosophical Essays*. Translated from the French by Annette Michelsen. Criterion Books, New York, 1955, p. 101.

³ Lyle Saunders has given this misconception the term "rationalistic bias," and discusses it in his *Cultural Differences and Medical Care*. Russell Sage Foundation, New York, 1954, pp. 235-237.

now observe how frequently it happens within the hospital that what appears to be nonrational behavior of patients is equated with irrationality, stubbornness, ignorance, or stupidity.¹ And they reexamine, with interest and in quite a new light, statements they or others have made about patients such as, "There is just no reason for the patient to forget his clinic appointments." "It doesn't make sense for him to refuse to be shaved with a straight razor." "She is so unreasonable and ignorant that she insists on rubbing the baby's fontanelle with oil to draw out his cold." Thus, students gradually come to see that the ability to secure constructive behavior—one of the ingredients of an optimal nurse-patient relationship—depends upon recognizing the large degree of nonrationality that is present in everyone.

We mentioned earlier that one of the nurse's functions is that of an emotional detection agent. This she cannot be, however, if her own biases, emotions, and system of values prevent her from viewing the patient in terms of his values and way of life, and at his own worth. If, for example, she sees the woman who is a drug addict only as a "social parasite," the Mexican peasant who spits on the floor as "disgusting," the "swarm" of relatives who visit the Italian patient as a "nuisance," or the recently physically rehabilitated patient who does not want to return to work as "lazy," such conceptions are bound to get between her and her ability to give constructive care.

The usefulness of the concept of culture, then, lies in the aid it gives the nurse in understanding her own behavior as well as that of her patient. Awareness of cultural differences enables her to approach him in a way not unlike that of the anthropologist who goes into the field to study another people. In doing so, the nurse endeavors to divest herself of her own biases and standards. She is there to try to understand her patient, his fears and complaints, his statement of values, without passing judgment, without impatience, without the lifted eyebrow or the frown of intolerance.

Students are sometimes troubled by this concept and raise pertinent questions which demand elaboration and clarification: "Does this mean we should relinquish our own beliefs and stand-

¹ We are referring, of course, specifically to nonpsychiatric patients.

ards for theirs?" "Does it mean we should put our emotions in the deep freeze?" These are questions not infrequently asked of all social science which claims to be nonjudgmental. The answer, of course, is "No." It does not mean we must either approve or adopt new behavior but try to understand it.

Social scientists, no less than nurses, have their own opinions, moral codes, religious and political convictions, and, like nurses, are entitled to them. As an American citizen and a member of the community, the social scientist may also be a Unitarian, Republican, and member of the Rotary Club. As such, he is entitled also to the convictions and beliefs which have led him to these affiliations. But as a trained social scientist, he tries hard to keep his particular beliefs and opinions from influencing or determining his observations, interpretations, or deductions in his efforts to ascertain the truth. ". . . he who works in the science of human relations must strive to maintain vigilance over his own emotions and sentiments in order to keep them in their place and to prevent conclusions from leaping along inviting lines of intuitive conviction and thus outdistancing disciplined observation and systematic thinking. . . ." ¹ To do this, of course, is more easily said than done. For social scientists as well as the layman, freedom from biases that are acquired early and are deeply imbedded, is neither easily nor always completely achieved. The mature and professional person, however, tries to recognize his biases and blind spots and to overcome them or allow for them.

As to whether one should become a nonemotional robot is a matter of considerable concern to students who are warned, over and over in their introductory nursing courses, not to become "emotionally involved with patients." In essence, our reply to their questions about this is: our own emotions can be one of our most valuable instruments for understanding others, *provided* we make disciplined use of them.

Cultural understanding is equally useful in reducing the nurse's self-consciousness or resistance to seeking out, specifying, or talking about patients according to their ethnic, social, or

¹ Leighton, Alexander H., *Human Relations in a Changing World*. E. P. Dutton and Co., New York, 1949, p. 137.

religious backgrounds. As Americans, nurses have been reared and schooled in the philosophy and precepts of a democratic society. In the medical setting this is further reinforced by the philosophy that the true healer knows no race, creed, or color—an ideal that is the essence of the medical and nursing arts and requires no defense. But the attempt to translate this literally into nursing education has traditionally led instructors to admonish their students not to “pry” into a patient’s background, and to impress them with the fact that “we treat all patients alike, regardless of who they are.” (The term “regardless,” of course, has interesting and obvious implications.)

As a consequence, nurses not oriented in the cultural approach are usually uncomfortable about using the words Negro, Filipino, Hungarian, Chinese, Catholic, Jewish, or lower class, and actually avoid references to racial, ethnic, social, and religious backgrounds, even when such information is germane to the problem.¹ Except for religion, patients’ charts (as well as the average case presentations by doctors) are obscure in these matters. Religious affiliation is considered necessary for inclusion in the record only for reasons of procedure in case the patient dies. But here again the mere recording of “Jewish” under religion does not reveal whether the patient is Orthodox or Reformed, nor does “Protestant” help us to know if the patient is Southern Baptist or High Episcopalian, a distinction that may have considerable bearing on a hospital situation.

Shying away from gathering or specifying these types of data is usually rationalized on the grounds that all sick people are alike and it makes no difference whether one is rich or poor, Catholic

¹ For example, at one hospital a group of staff nurses and a human relations consultant spent two hours discussing an orderly who had become a “problem.” The nurses said that he was extremely popular with patients and doctors but with them, he had become “uppity,” and behaved as though he thought he was “God’s gift to the world.” The consultant probed for further information about the orderly’s personality, background, marital status, and family situation. On the basis of the data given and using techniques largely borrowed from clinical psychology and psychiatry, he endeavored to analyze and interpret possible reasons for the orderly’s behavior and for the poor relationship between him and the nurses. In doing so, however, the consultant lacked one item of information which in this particular instance was highly significant. The orderly was a Negro. The nurses, following the precepts of their training to regard racial or ethnic data as irrelevant and inconsequential, had not revealed his identity. Consequently, a major reason for the difficulty, their own aroused prejudices, remained hidden.

or Hindu, German or Negro, first-generation or second-generation American. But implicit in this also is the dictum that to admit to or specify differences in people smacks of prejudice and is undemocratic. This form of reasoning results from a confusion between being different and being inferior—confusion that leads to the assumption that a patient who happens to be a Brazilian, Belgian, or an Armenian, might not be proud of the fact and would therefore be embarrassed if unable to say he was an American or a Bostonian “like I am!” In such reasoning both ethnocentrism and prejudice are operating rather than real democratic thinking.

Since people are different, considering people as being different is not “prejudice.” The prejudiced are not those who insist that people are different in various respects and by various reasons, but those who deny it. Insisting that people who are different are not different means making propaganda for misunderstanding each other. Since we are different, we can only understand each other if we admit and are aware in what respects and why we are different. Prejudice comes in only if we misinterpret the existing differences in terms of inferiority and the like.¹

Teaching students that people do differ rather than that everyone is alike is essential for nursing the sick. It is especially important, too, it seems to us, in an age when a cult of tolerance has tended to conjure away all sense of ethnic, racial, or religious difference. This position is in direct contrast to that of anthropology which assumes that not only is each culture dignified in itself, but that to try to understand people in their own cultural terms helps to dispel the prejudices that grow out of alien differences.

Gradually, then, students begin to realize that overemphasis on the “regardlessness” of race, color, or creed, has been to leave out important social, cultural, and psychological components that might shed light on diagnosis, management, and treatment. They find that when they can easily say about a patient, “He is a Sicilian,” “an upper-class Louisianian,” “Jehovah’s Witness,”

¹ Ichheiser, Gustav, “Misunderstandings in Human Relations,” *American Journal of Sociology*, vol. 55, September, 1949, part 2, p. 40.

or "a truck-driver," for the sole purpose of throwing light on a situation, rather than reporting the far more obvious fact that "the patient is a forty-five-year-old male," they may be providing significant clues to his personality, attitudes, responses, and expectations. In this context such pieces of information they find, are just as objective, and not infrequently as relevant, as data on temperature, blood pressure, and pulse rate.

Initially, discussions of problems involving, for example, Puerto Rican patients, Negroes who come from underprivileged environments, or the medical practices of Japanese or East Indians, are likely to put the students on guard because of the presence in the class of nonwhite or foreign-born students. Within two or three lectures, however, they begin to see that by an objective and matter-of-fact approach even sensitive issues may be discussed. To achieve effective intercultural learning, however, a supportive climate is extremely important and the instructor cannot provide it alone. The peer group must also participate. We encourage, therefore, and elicit from our students who are foreign-born or representatives of minority groups, information about the attitudes of their own people toward sickness, diet, old-age, or death—the kind of comparative method used by anthropologists. Treating as we do such information as highly important has the added effect of stimulating active participation by the other students who begin to add comparative material about similarities and differences that exist within their own culture—customs and behavior patterns they had not before thought of as cultural.

One of the most valuable hours spent by the students during their study of culture was the lecture given by Dr. Margaret Mead, associate curator of ethnology at the American Museum of Natural History in New York City. Her keen interest in our experiment and her willingness to share with others relevant parts of her vast anthropological knowledge made it possible for each group of students during the three years of the experiment to hear her. Since all of her lectures differed somewhat, the following section is a compilation from transcriptions of the recorded talks that Dr. Mead prepared especially for this book.

Part II. Cultural Contexts of Nursing Problems¹

There are a number of contexts within which the relevance of a systematic knowledge of culture can be discussed. I might discuss, as I have done before, what a nurse means in our own culture and start with your own professional position, what other Americans will expect of you, and how your own image of yourselves is shaped by the culture of which you are all a part. Your image is shaped by culture because you have been reared within it and embody it, each of you, in the special terms of your own constitution, type of mind, and particular life experience.

Or I might begin by discussing what kinds of experience lead to an understanding of culture, and the various ways in which you may have already started on such an understanding. When one grows up in a section of the United States where almost everyone has the same kind of background, the same religion, the same origin—Germany, the British Isles, or France, for example—and where there are no other groups who differ in national origin, physical type, or religious membership from oneself, then one tends to think of “foreigners” as very strange and different. They are people who live far away, speaking totally unintelligible languages and following “strange” customs. Let us suppose, instead, that one has grown up in a community where there are many kinds of people, and the members of each group keep some of the characteristics that they brought from the society in which they or their ancestors lived, so that some of what they do, such as the language spoken at home, the food eaten, or the way holidays are celebrated, is conspicuously different from what one’s own family and group do. Then the differences between one’s own customary behavior and that of these other groups may be seen as a question of what is “American,” or “right,” or “modern,” versus what is “foreign,” or “wrong,” or “superstitious” (the word we use to distinguish other people’s irrational behavior from our own).

This way of looking at difference becomes all the sharper if it is mixed, as it so often is, with questions of economic level, or of

¹ A guest lecture by Margaret Mead, Ph.D.

class difference. In a culture like ours in which what is "American," "right," and "modern" is so firmly tied up with a high standard of living—milk for the children, plenty of clothes kept very clean, separate beds in separate rooms—there are bound to be differences between those who, because they are recent arrivals from other countries or come from parts of the United States or Canada where very little education was available, make a poor living and must live in wretched housing, and those who, with knowledge of the country or a better education, have a higher standard. But because so many of us recognize that other people's differences are tied in with matters of hygiene, nutrition, privacy (matters on which all Americans, and especially those concerned with health and illness, make judgments), nurses may be less willing than most Americans to think and talk about differences. Almost always, these differences seem to mean that someone is being regarded as in some way ignorant, or superstitious, or inferior when compared with the American standard.

! So it becomes particularly important for nurses, whether they are dealing with patients in a hospital or an outpatient clinic, or as public health workers in an American community or overseas in some national or international technical assistance program, to take the further steps necessary to think of cultural backgrounds as involving differences about which understanding and appreciation rather than moral judgments are called for. The first step is the realization that we ourselves have a culture and that our ways of doing things seem as strange, irrational, and superstitious to members of other cultures as theirs do to us.

Let me give you a few examples. The preparatory conference that led to setting up the United Nations Food and Agricultural Organization met in the United States, and the American newspapers, applauding the intention to provide food for all peoples, came out with the headline, "Three square meals for everyone in the world." To us enough food is symbolized by three square meals a day, and for us it is true that three meals are necessary. During the war it was discovered that persons whose work shift required them to sleep in the morning and so missed the meal called "breakfast," did not get correct nutrition because impor-

tant foods such as orange juice and eggs belonged to breakfast and were not served at lunch and dinner. Our meal pattern is so arranged that skipping a meal may mean losing something essential to nutrition. If we were to try to get people who eat five meals to eat three, however, we might be depriving them of something they need. Or if we try to expand a two-meal-a-day pattern to three, we might be giving people too much to eat. There is nothing biologically right about three meals a day; there is considerable evidence that eating more frequently may be better, at least for some ages or temperaments or persons doing certain kinds of work. Without training in distinguishing what is biologically based from what is culturally patterned, there is great danger of confusing one with the other.

For a long time in this country nutritionists, who contend that meals ought to be properly balanced during every twenty-four-hour period, assumed that Italian children were getting inadequate diets, so they tried to introduce more milk desserts into these children's meals. What happened was that the children got too fat because they were already adequately nourished in a meal pattern that balanced properly over a week's time instead of each day.

As long as members of a profession, whether the profession is that of medicine, nutrition, or teaching, are not able to separate those things in their own behavior which are culturally patterned from recent discoveries about the biological needs of the human body for food, sleep, or the age at which a child can be expected to learn to walk or talk, they are handicapped in dealing with members of other cultures. In the matter of the number of meals a day, nutritionists had to recognize what our cultural attitudes were, if they were to be able to plan efficiently for members of other cultures to get the right food as measured by scientific knowledge of calories, vitamins, and minerals, and a desirable balance among proteins, fats, and carbohydrates.

It seems useful, therefore, to begin with the cultural setting of those problems which are uppermost in nursing care; and as the student nurse becomes more aware of them, she will be able to recognize, analyze, and deal with the differences that she meets

in patients from other backgrounds. This is a little like the way in which learning grammar in school helps one learn a foreign language. If you think a moment, you will realize that when you start to learn a foreign language you already know something about languages. You know what a language is, that there are different languages which are mutually unintelligible without translation or interpretation, and that what makes them different is a different vocabulary and a different grammar. You also know that in order to learn another language you will have to learn something about the "grammar," and you may expect to find that languages differ in the way in which they express such things as tense, case, and mode. When I go to work with a people who have no written language and who have never learned to think of their language as having grammar, as I do when I study a New Guinea tribe, I have to sit down with them and get them to form sentences for me so I can "make" a grammar of their language.

This is what an anthropologist does when he looks at every aspect of culture. It is harder to do than to look at a language, for here one is already prepared to expect other languages to be different, to need to be learned, and to require systematic study. But in such matters as those with which nurses have to deal—sleep, food, cleanliness, punctuality, response to pain, willingness to exercise, obedience to routine, modesty—the average person has not learned to look for a systematic something like a "grammar."

So let us look first at more examples from the field of nutrition. Here the data have been worked out best, and the subject is one with which all of you have had experience. If we talk about many of the conditions you have to meet in nursing, you have not yet personally experienced them. Some of them, like maternity, you may experience later. Others, like death, you can never experience yourself during your own professional career. This contrast, which faces doctors and nurses between the shared experiences, such as eating, sleeping, minor illnesses, toothaches, and the major experiences which are seldom if ever shared, like paraplegia, fatal accidents, child bearing, psychosis or dying, is an

important one to keep in mind. It is the shared experiences that become especially valuable in developing empathy across lines of differences whether of sex, age, culture, class, race, or religion.

In all nursing care, food regulation is important. You will be either keeping a patient's strength up, administering special diets, or planning for correct food for expectant mothers, young babies, or school children. If you are engaged in public health nursing, you may be concerned with an optimal level of nutrition for the whole community, as it gives greater resistance to disease, or raises the level of health in other ways, such as ability to work longer hours, or concentrate better at school.

If we look at American food habits, we will find that there are different kinds of habits in different parts of the United States; whether we eat yellow cornmeal or white, like beans or don't, eat the salad before, with, or after the meat. These are differences that everyone is conscious of; but there are also deeper and subtler differences that are more like "grammar" and less like mere differences in vocabulary. In the Northeast, the Middle States, and the parts of the Middlewest that draw on a New England tradition, there is a distinction between food that is "good for you" and "not good," and food that is "good" but "not good for you." Children are rewarded for eating foods that are good for them by being permitted to have a little food that is good. It is important also that the "good for you" foods be eaten before the "good" foods, and from this children learn many other things. They learn that foods for which you have to be rewarded are therefore not good, and that all acts for which you have to be rewarded, like washing your hands, brushing your teeth, going to bed quietly when told, taking a nap, not crying when your hair is washed, are in themselves unpleasant and undesirable. Similarly, they learn that the things used for rewards—candy, ice cream, movies, staying up a little later to watch television—are all desirable and in some way a little wicked.

It is this contrast between food that is "good" and food that is "good for you" which became the basis of much of our nutritional education in the United States. When these essentially New England puritanical attitudes were taken to the Southeast, where

there is a very different attitude toward food, they did not work. Tremendous amounts of money were spent in vain trying to spread better nutritional food habits. Because foods are not thought of in terms of morality in the South but instead in more social, personal terms, you can say "I don't like onions," or "Onions don't like me." The good mother recognizes the relationships between each of her children and the foods with which they are on good and bad terms. Where the *ought* in the North is to eat food that you don't like, and to teach others, if you are a nutritionist, how to learn to force yourself to eat food that you don't like because it is good for you, the *ought* in the South is to be attentive to personal preferences. Failure to recognize this fact meant that new information about nutrition which was scientifically based could not get through to southerners because it was couched in unacceptable terms.

During the war I heard of a striking example of how recognition and respect for cultural differences can promote the ends of health education work. A public health nurse in a well-baby clinic was trying to stop Mexican mothers from feeding their babies so many beans, and start them using more milk. Month after month she inveighed against the beans. Finally, in despair, she said, "Well, then, at least feed them the water in which the beans are cooked [in which some of the nutrients would have been preserved]." The babies began to show signs of better nourishment. When she said, "You see, the bean water helps," the mothers answered: "Oh, it's not just the bean water. When you stopped talking against our beans we started following your advice and began giving them more milk."

Once I asked a nurse in a French-Canadian community how she persuaded mothers to provide better food for their babies. I said, "Do you start by telling the mothers how much better the baby will be?" "Oh no," she answered, "I start this way. If the baby is fed better it will cry less. If it cries less the mother will get more sleep. If the mother gets more sleep, she will be better humored and the whole family will be happier." What would be an end for an average American—a better nourished baby—became, in a different cultural setting, a means to a better family life.

Now let us turn to the central point of nursing. Someone, because he or she is newborn, or has been injured, or is ill, or is on the point of giving birth, or is dying, becomes dependent upon others for care. As a result, we need to analyze both our own cultural attitudes and those of any other culture with which we come in contact concerning questions like dependency, losing and gaining autonomy, and receiving help from others, that help us form a picture of the conditions of birth, sleep, illness, and death. In many cultures, birth and death are thought of together. The same group of women who gather to bathe and dress the newborn, gather to bathe and dress the dead. Little distinction is made between the two kinds of helplessness, those who have just entered life and those who have just left it. Someone who is ill is often held in the arms of special relatives, rocked, cradled, crooned over like an infant, or prematurely wailed over as if already dead.

In our culture we have given a very special phrasing to the universalities of life and death. In the first place we treat childbirth not as a natural event of great significance but as an illness. We place the expectant mother in a hospital, otherwise assigned to the care of the ill, induce weakness and dependency in her by the use of drugs, straps, and soon isolate her from her husband and other children just as we isolate the sick and the dying. Again, under our dogma that the most important elements in nursing care are quiet, rest, and safeguard against infection, we separate the newborn infant from his mother, break up the essential rhythm of the first hours after birth, and let the father and brothers and sisters over fourteen years (a magical age set by various irrelevancies) look at the baby only through a glass window. This classification of childbirth with illness has a great variety of repercussions all through our culture, some of which we are now attempting to correct with such new practices as "rooming in," "self-regulated feeding," and inclusion of the father in prenatal training and in the delivery.

Just as the earlier style of maternity care in hospitals was based on new knowledge about infection, so this later style is based on new knowledge about emotional relationships between mothers

and their newborn, some of it learned from comparative studies of animal behavior, some from comparative studies of the ways in which other peoples, primitive and civilized, deal with pregnancy, childbirth, and breast feeding. At each stage as we make new scientific discoveries, we find that the attempt to use them differs from culture to culture, and that we need to be continuously aware of how a scientific discovery will be used in a given culture. Just as we earlier turned maternity into a duty, like eating the right food, women are now attempting to turn the new freedoms of giving birth to a baby without an anesthetic if there are no complications, or of breast feeding their baby if he and the mother flourish, into new *oughts*. As a consequence, women are developing extreme anxieties if they do not have "natural childbirth," fail to breast feed, and cannot manage "self-demand."

Unless we realize that matters of health in our culture are closely tied to duty and conscience—we ought to eat the right food, get enough vitamins, have enough sleep, take the right exercise, watch our weight, relax—we will fail to understand the kinds of anxieties that any changes in maternity behavior introduce. Childbearing generally in America is not an intrinsically rewarding, pleasurable experience in which a woman expects to take an immediate, day-to-day delight. Instead, it is a series of necessary, hygienic, difficult, and unrewarding activities which will culminate in a child who can then be enjoyed only to the extent that he grows, gains weight, learns to walk and talk, establishes good toilet habits, takes naps, plays in the fresh air, and goes to bed on time.

Next let us consider sleep, another form of dependency that every human being experiences which is part of the nursing-illness situation. Sleep has been called a "little death," and surrender to sleep may be felt to be something like dying. Many primitive peoples believe that the soul leaves the body during sleep, and forbid anyone to wake a sleeping person suddenly for fear the soul will not have time to get back into the body and death will therefore ensue. Sleep leaves one unprotected, open under conditions of violence to being killed, raped, robbed, as the case may be. Children respond to the dangers of sleep by insisting on

lights, parents nearby, special toys in bed; they may refuse to go to bed or go to sleep when they are anxious, with strangers, or in a strange place.

When someone is ill and being given nursing care, these attitudes toward sleep are reactivated, not only at night when natural sleep occurs, but during the day when weakness or drugs may bring on sleep at any time. The old habits of early childhood, also the adult habits of where, with whom, and under what circumstances it is safe and possible to sleep, all come into play. To members of some cultures, a hospital ward is frightening because they have never slept in the same room with a member of the same sex since childhood. Husbands and wives have perhaps shared a room for thirty years with never a night apart, and separation is traumatic and terrifying. To members of other cultures, being alone in a room may be an unbearable situation. Children in Spanish-American families, for example, sleep in one large room, with one bed for the boys and one for the girls; modesty and privacy are matters of separate beds not separate rooms. But many older people come from situations where they may never have undressed in another person's presence since early childhood.

Several years ago, 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 marriage, and to whom even temporary separation from the family is itself a trauma.

Our ideas about the value of quiet and rest as aids to recovery are likely to conflict with the emphases of other cultures in which the individual feels safe and loved only when there are many people about. Refusal to enter a hospital, failure to make a good recovery, and unaccountable postoperative depressions may all be due to the loneliness of the patient who is separated from family and friends. Moreover, we have carried over our ideas of the value of isolation, quiet and rest, not only to the parturient mother who is treated as if she too were ill, but also to the dying. Hospitals today are places where people die alone; yet in many cultural groups dying alone is the most terrible thing that can happen, both to the one who dies and to those who are left behind. Relatives have no way of knowing what the last moments were like or if words that trembled unheard on the lips of the dying might have been picked up if someone who loved him had been there. In most parts of the world it is still customary for the members of the family to gather around a deathbed.

Our present American refusal to deal with death is partly due to historical circumstances, particularly to the two world wars fought on foreign soil. Two generations have seen strong young men march away never to return, with the only attestation to

their death being a telegram from the War Department. Also, the whole emphasis on protecting children from traumatic experiences, which began in the early days of this century, has led to protecting them from the sight or even the knowledge of death. Many students of college age have never seen a dead body, never seen anyone die, never even watched at the bedside of someone who might die, never held a dead child in their arms. This means that when young Americans study medicine or nursing, the experience of death in the dissecting room or on a ward service at night comes to them in a dissociated, almost inhuman form, separated from all of the rituals which human beings have developed to make final separation meaningful and bearable.

Another circumstance that has contributed to our inability to deal with death is the enormous control within the past fifty years of diseases that were once killers. Death in early life has become so much rarer that where it was once regarded as natural that many children and young adults should die, now it seems as if each such death were an unforgivable and in some way quite preventable tragedy. The practice of medicine and nursing has become the practice of curing, rather than the alleviation of symptoms and the sympathetic smoothing of the path to death. The dying patient is treated as an anomaly that should not have occurred.

These standard American attitudes naturally come into conflict with those of many other cultures, and with those of persons whose religion demands a straightforward facing of the nearness of death. A nurse may be confronted with the problem of two patients in one room, one from the contemporary American secularized scene, who wishes to pretend until the very end that everything will be all right, while the other expects to receive daily Communion or be surrounded by weeping and wailing relatives. Only by an understanding of our own tendency to deal with death by denial—as we, in America, handle many other disallowed impulses and conditions—and by a sympathetic recognition of what death means in other groups, will the nurse be able to deal with such contrasts within a hospital population

without penalizing one of the patients or his relatives for having an attitude that is somehow less correct, praiseworthy, or admirable than the other patient.

This tendency to discriminate among patients, some of whose attitudes are closer to, or more congenial with our own cultural values, shows up sharply in attitudes toward the expression of pain and the response to pain. The dominant mode in American culture is an Anglo-Saxon stiff upper lip, a refusal to admit that it hurts, a matter-of-fact "well, if it's necessary to do something that hurts, go ahead and get it over with." This attitude toward pain is not, in fact, even characteristic of all parts of America. Ray Birdwhistell has demonstrated that in a single county in rural Kentucky one group of patients maintained a conspicuously stiff upper lip, while the other group "sagged" and actively announced how much they were suffering as an open bid for sympathy. In our hospital populations there are great contrasts among different ethnic groups: Italians protest volubly, Poles want the extent of their pain known and recognized and then want to maintain their imperviousness to it, while Eastern European Jews require of the sick and the suffering a sufficiently articulate statement of pain so that the visitor and patron can sympathize wholeheartedly. Patients from these different cultural backgrounds will behave quite differently and run the risk of being branded as childish, demanding, or lacking in self-control and self-discipline, when each group is behaving in culturally approved ways. Some individual patients, however, react against their own cultural backgrounds and overdo a kind of behavior that they imagine to be more generally acceptable.

As in response to pain, so in conceptions of the human body, wide differences are found. These conceptions are crucial in reporting on symptoms and responding to nursing care. During the past fifty years there has been a profound change in most Americans' feelings about the inside of the body. Formerly, the interior of the human body, like that of cupboards, closets, refrigerators, and women's handbags, was forbidden ground. It was rude to pry, for such things were expected to contain a variety of unpleasant, disreputable, and leftover objects. Today

all this has changed. Refrigerators are illuminated, clothes are hung up in plastic bags, handbags often are permeable to light, and in drugstore windows we see transparent body models showing how the different "systems" work. Instead of the image of a body with an inside that is repellent, we now have a body that is considered good as long as everything works. Moreover, we treat it much like a complicated machine about which we know very little and so must take it to a specialist to be "fixed" when necessary. What is more, we generally accept almost any attempt to fix it; an operation, prosthesis, or potent medication.

This treatment of the body contrasts sharply with views of the body as sacred because made in God's image, as inviolable, self-regenerative, or divisible into a good upper half and a bad lower half. The rituals of bathing and exposure, shaving, preparation for surgery, taking blood samples, enemas, cathartics, or emetics all encounter some one or other of these attitudes. Sometimes they become a threat, sometimes a too pleasant experience, occasionally an unbearable trauma.

When one looks, then, at the great variety of ways in which the culture of any given people may be expressed in their behavior and attitudes toward birth and death, sleep and rest, food and drink, pain and the body, the nurse may well ask, "How am I to encompass all this? What must I know in order to understand the newly arrived immigrant from Puerto Rico or Hungary, the sharecropper from the rural South and the Mennonite, who has lived for eight generations in Pennsylvania preserving an almost medieval way of life? If there is no chart for ready reference on which all of these matters are entered, and if, furthermore, our own American attitudes change from decade to decade, how is one to keep up?" This is a reasonable and fair question, and to answer it, I should like to return to the question of language. In order to learn a new language easily you need to know how to speak, read, and write, and to be conscious that what you speak and how you write relate to one language among many. Once this is clear, the way is open to learn any other language much more quickly and easily than learning to speak, read, and write as a young child. You know now about language, about grammar

and script; you have learned to learn, and so the second language comes far more easily.

This is true with culture, too, once you understand fully how much of what you do, feel, and think is neither natural nor right but is instead what you, as an American, have learned from other Americans. Then it will be fairly easy to learn, if you need it, a great deal about the culture of some other part of the United States, about people of another social class, or people of some national origin who still retain part of their foreign identity. Equally, if you want to learn not some special version of your own culture different from that in which you were reared, but a really different culture, you will find it relatively easy to do that, too. You might perhaps suddenly find yourself working among newly arrived Puerto Ricans or Mexicans, or on a foreign assistance mission to Iran or Indonesia.

But meanwhile, the even more pressing task is how to deal with cultural differences when you are not suddenly immersed in some foreign culture but instead are required to deal with a ward in which each patient has a different cultural background. This is the ever more usual situation which confronts a nurse today, and the composition of the ward shifts from day to day. Tonight it is a member of Jehovah's Witnesses who is recovering from an operation; tomorrow it is a Lascar sailor off a British ship, or a sharecropper from the Everglades, or a recently arrived Hungarian intellectual. Religion, class, language, nationality, all shift in an unending panorama. The nurse, already overburdened with duties more numerous than she can perform, cannot hope to become an encyclopedia of the food habits, modesty patterns, beliefs about birth and death, and attitudes toward medication of such a varied group. What she can hope for, however, is to learn, while in training or afterward in specially oriented study situations, what the nature of cultural difference is. She can learn enough about her own culture and her own place in it to recognize and allow for the special preferences and prejudices that she has acquired from her family, friends, and school. With this as a beginning, she can learn enough about some other cultures to feel what cultural difference is like. Then, whenever a patient

behaves in a way that seems strange, ridiculous, inexplicable, the nurse can stop and ask herself, and sometimes ask the patient, whether perhaps a different cultural background is responsible.

If you do this often enough, you will find that just as one develops an ear for dialect and after long listening, can place a speaker geographically, so one develops an ear for cultural differences. One begins to know when a piece of behavior is probably due to individual idiosyncrasy, when to some social class attitude, when to sensitivity about difference in skin color or hair form, to national background, to region, or to religious belief. All Catholics will cease to look alike to a Protestant as the differences which nationality make, come into awareness, and equally all Protestants will cease to be lumped together. Class will be seen as only a partially useful criterion when one compares persons from a small town with those from a large city and persons of German extraction, let us say, with those of Irish extraction. You will find that finally you have set up within yourselves a set of accurate discriminators which say, "Stop, watch, consider, and suspend judgment."

This does not mean that the routines of health as practiced in a hospital or a clinic should necessarily be changed to meet the cultural attitudes of a given patient. But if visiting hours cannot be relaxed for a young mother who has lost her baby, the nurse can recognize how she feels instead of judging her as demanding and unreasonable. If a patient stirs unhappily when exposed to the midnight sky ten stories above a park, the nurse can understand the reason instead of branding the patient as disturbed, uncooperative, or unreasonable. Although it is of great importance for us to be able to chart these cultural differences, probably the most important effects for nursing are in a way, a by-product: the change in the nurse's own attitude which makes it possible for her to realize more fully that whatever the race or creed or nationality of the patients, they are all, even as she is, members of the human race. Only when the knowledge of one's own cultural position has been fully understood is one ready to use a knowledge of difference as a way of according other human beings, who eat and speak and fear differently, full humanity.

Part III. Conclusion

Assignments for this part of the course were drawn from publications and the latest research findings on folk medicine and practices, attitudes toward illness and health, toward pain, mutilation, child bearing, and infant care in such diverse cultures as the Navajo, Greek, Zulu, Irish, Puerto Rican, and others. Several of the case studies in *Health, Culture, and Community*, edited by Benjamin D. Paul, were assigned to students for reading and discussion.¹ Not only do these cases convey useful social science concepts, but they are graphic illustrations of modern health and disease programs that often failed because the value systems and functions of cultures that differ from our own were not taken into account by the medical team or investigators.

Nursing students seem to find cultural learning both stimulating and useful. And as they learn that there are *patterned* differences among patients which may affect response to illness, they become more confident and relaxed in meeting new situations. But in guiding their learning in this area there are some necessary precautions which must be taken. Very soon, reports of situations relating to their work with patients are brought to class by the students for discussion. For example, one hears about "the young Swedish woman who is not ashamed about having her child out of wedlock," "the Orthodox Jewish patient who refuses non-kosher food," "the Chinese patient who believes his medicine is ineffective because it doesn't taste bitter." This "feedback" is to be expected and encouraged, for it provides us with opportunities for discussion of differences in values, customs, and attitudes among the various kinds of patients within our own Medical Center. It also gives students a chance to air some of their own feelings. Since they not infrequently select, consciously or unconsciously, problems about which they feel some guilt or ambivalence, one must move slowly to prevent traumatizing them. Extreme care must also be taken in discussion of ethnic and religious backgrounds in order that stereotypes are not developed,

¹ Paul, Benjamin D., editor, *Health, Culture, and Community: Case Studies of Public Reactions to Health Programs*. Russell Sage Foundation, New York, 1955.

and that generalizations regarding culture patterns leave sufficient room for taking into account the uniqueness of the individual.

In addition, it must be emphasized that interpretations of behavior, made from a single disciplinary approach or from one frame of reference, may obscure other significant factors or preclude correct interpretation. Neurological interpretations, for example, have been known to mask what was really a psychiatric problem and vice versa; and psychological interpretations have been known to mask a cultural problem. Likewise, a cultural interpretation may conceal an emotional problem. Typical of such an instance is the one cited by Dr. Theodora M. Abel. Dr. Abel reports that because she was brought up on the stereotype of Chinese mispronunciation of English, she had assumed that her inability to understand a Chinese patient whom she was treating was due to his difficulty in pronouncing English words. Eventually she asked him if his friends understood him when he spoke Chinese and learned that indeed they had complained of not being able to understand him when he was upset. Because she had at first been misled into explaining the patient's speech disorder on a cultural basis, progress in therapy with him had been slowed up.¹

The point we wish to make here is that initial enthusiasm over the discovery that there are cultural explanations for certain kinds of behavior may, as is often the case with orientation in a new subject, lead nursing students to see or to look for cultural points everywhere to the exclusion of other possible explanations. It is therefore necessary to stress the fact that while it is important to take cultural points into consideration as they affect the care, treatment, and management of patients and especially when they appear to be operating to the patients' disadvantage, cultural interpretations are not always required or indicated. Culture is but one of the behavior components to be considered and one that is not always more or less important than the others.

¹ Abel, Theodora M., "Cultural Patterns as They Affect Psychotherapeutic Procedures," *American Journal of Psychotherapy*, vol. 10, October, 1956, pp. 728-739.

Chapter 5

Subcultures and Social Class

NURSES WHO PRACTICE AND TEACH in regions or cities that are not characterized by large heterogeneous populations, such as are found in New York City, San Francisco, or Chicago, have asked, "Of what use is it to include the cultural aspects of health and illness in our educational programs if we don't have all these people from foreign countries in our hospitals?" These nurses usually are referring to communities or localities in which there are no large clusters of people whose customs, language, or physical appearance differ conspicuously from the majority of inhabitants. Their patient population, therefore, is viewed as being homogeneous.

What the nurses have not taken into consideration, however, is that even though the entire community to which they refer were composed of fourth-generation Americans, whose forebears all came from the same European country—an unlikely situation—there still would be differences represented by subgroupings of people determined by factors other than racial or ethnic origin; differences equally important to be aware of in nursing patients as the more easily identifiable racial and ethnic differences.

These subgroups within the larger culture, social scientists have termed "subcultures." In our own American culture, for instance, there are subcultures represented by the various geographic regions of the United States: the South, Northwest, New England, Southwest, and so on. Each of these regions is differentiated by certain idiosyncratic forms of speech, folkways, dress, foods and eating habits, politics, and prejudices. There are also the subcultures of religions and religious sects, each one having its own distinctive beliefs, symbols, and forms of worship which

reach into and are expressed in the lives of its followers. Similarly, age and sex groups, the several social classes, political parties, and occupational groups are distinguishable by their own peculiar values, points of view, and attitudes.

In addition, there are subcultures within subcultures: the family within the neighborhood, the executives within industry, the sorority within the university, the delinquent gang within the community, nursing within the hospital.¹ Each of these discrete groups has its own *modus vivendi*, unique sets of expectations, code of ethics, rituals, and special terminology. And in each, the participants acquire through interaction, and share in common certain interests, attitudes, and beliefs that are distinct from, and not shared by, the nonparticipants. An individual may be a member of many different subcultures at the same time, but he is inevitably influenced one way or another by his participation in each. It follows, then, that if we are to understand behavior, it is as necessary to take into account the subcultural differences that influence it, as it is to consider the larger cultures to which people belong.

It is of singular interest that while the health professions have for some time recognized that illness must be understood within the context of the patient's total environment, the influences of the subcultural divisions have been more often than not ignored. In general, the tendency is to lump under the blanket term "American culture" all behavior patterns, attitudes, and practices which, if classified according to subcultural groups, would reveal significant variations. Because of the underlying premise that in "American culture," or in the "South," there is homogeneity of food habits,² for example, many nutrition courses in nursing education completely fail to take into account the variety of different attitudes, beliefs, practices, and knowledge about food that do exist—and for different reasons—not only in various sections of the country, but within the same region or even county.

¹ For an analysis of the delinquent subculture see Albert K. Cohen's *Delinquent Boys: The Culture of the Gang*. The Free Press, Glencoe, Ill., 1955.

² Cassel, John, "Social and Cultural Implications of Food and Food Habits," *American Journal of Public Health*, vol. 47, June, 1957, pp. 732-740.

In considering the various subcultural divisions within a society, we must recognize that some have greater relevance for nursing and the care of patients than others. A knowledge of subcultural differences in food habits and preferences obviously has more importance for nursing than a knowledge, say, of our political differences. Others that could be examined with profit are the subcultural differences represented by regions, religions, age, and sex. Unfortunately, we could not give time in our course to all of these, so we chose to focus our attention on the social class system in the United States and the influences of class affiliations upon its members.

The concept of social class is especially relevant for nursing and the care of the sick, for both nurses and patients reflect their class affiliations in innumerable and distinct ways: their habit patterns, responses, preferences, and value systems; manifestations that are not always as discernible as those, for instance, that denote age and sex. However, in dealing with any single subculture it must be kept constantly in mind that, in the interaction between the individual and society, there are numerous subcultural variants operating simultaneously. In other words, social class is but one of the variables of an individual's social and cultural matrix, although as we shall see, it is very important.¹

SOCIAL CLASS

Social class has been defined differently by different social scientists,² but for our purposes it may be loosely defined as an aggregate of individuals who have similar sets of responsibilities, privileges, and status positions. In America social class is not the same as economic class, but refers to general behavior and attitudes of people according to the existing class levels of a community. Though economic factors are considered important determinants of social class, they do not account for all the behavior representative of the different class levels.

¹ Seward, Georgene, *Psychotherapy and Culture Conflict*. Ronald Press Co., New York, 1956, pp. 74-75.

² Pfautz, Harold W., "The Current Literature on Social Stratification: Critique and Bibliography, *American Journal of Sociology*, vol. 58, January, 1953, pp. 393-394.

American society is thought of as being divided into three major categories: the upper class, the middle or "white-collar" class, and the lower class, sometimes referred to as the "working class" or "lower-income group."¹ The actual number of subdivisions may vary, however, according to a particular community, its age, economic status, ethnic composition, and so on. For example, different regions have been classified by sociologists into four or five major levels, while other investigators, like Lloyd Warner, have made even finer distinctions. In his study of "Yankee City," Warner found six social layers. Each of these, in a sense, is a cultural entity with its own customs and standards of behavior. Roughly, they are the upper-upper class or old-line aristocrats of a community; the lower-upper or the newly rich; the upper-middle, including professional persons, executives, and owners of businesses in a community; the lower-middle, with its white-collar workers, tradesmen, and some highly skilled workers; the upper-lower, composed of skilled and semi-skilled workers; and the lower-lower, or laborers and unassimilated foreign groups.²

In the United States social classes are not set off from each other as they are in a caste system by any legal, religious, or official boundaries that prevent people from moving from one level to another. Nor are they as well demarcated as are the classes in many European countries. On the contrary, class lines in America are blurred and often overlap. In their attempts to

¹ When it is necessary for health practitioners to identify lower-class patients, the terms most commonly used are "working class" or "lower-income group." But neither of these terms is precise. For as Walter B. Miller has pointed out, "to call the lower class the 'working class' appears to imply that middle-class people are the nonworking class, an implication which is far from accurate, and neglects the fact that the bulk of the unemployed, in fact, come from the so-called working classes. Nor can class status be equated simply with income level, especially today. We are all well aware of the fact that a truck driver or plumber may make seven thousand dollars a year, while a grammar school teacher or social worker may make only thirty-five hundred or four thousand; yet the teacher follows a way of life all would identify as middle class, while the truck driver uses a set of speech patterns, a manner of dressing, a pattern of allocating his income which could be definitely identified as lower class." (Miller, Walter B., *Cultural Features of an Urban Lower Class Community*, unpublished monograph.)

² Warner, W. Lloyd, and Paul S. Lunt, *The Social Life of a Modern Community*. Yale University Press, New Haven, 1941.

delineate them, investigators have used various indices, the major ones being income, place of residence, occupation, and education. Movement upward and downward from one class to another is possible and does occur, though not so widely as is generally supposed. To give one example: among white American males, only about one-third of the sons achieve a higher occupational status than their fathers, while two-thirds of the white American fathers have sons whose occupational status is either the same or lower than their own.¹

In teaching nursing students, our interest in the American class system is not so much whether there are three, four, or six social classes, but that in each of them observers have found differences—some marked and some subtle—in the conditioning and standards of behavior, and in the responses, attitudes, and values that distinguish one group from another. What some of these are, and the implications they have for nursing, is our main concern.

In spite of the accumulating data on the important role class and class factors play in shaping our personality and life experiences, on the relationship of social class position to behavior, and even to illness, it is one of the subjects, as we indicated earlier, that is either ignored or sidestepped in nursing education and practice. There are two major reasons for this. In the first place, the term as popularly conceived, in contrast to sociological usage, has unfortunate connotations, and for most Americans, is emotionally provoking. It implies stratification, rank and status differences, inferiority and superiority, concepts that are inconsistent with the principles upon which democracy is based. It implies inequality in a society whose Declaration of Independence recognized "that all Men are created equal. . . ." This is the "ideal": a social system in which there are no classes, no ranks, no inequalities. But as various students of our society have demonstrated, it is an ideal which in reality does not exist, as evidenced by the numerous and sharp distinctions between the classes over a wide range of social activities and cultural phe-

¹ Gittler, Joseph B., *Social Dynamics*. McGraw-Hill Book Co., New York, 1952, pp. 149-150.

nomena.¹ Even the denial of differences, they point out, is given the lie by the scramble to "get ahead" and to move up the socioeconomic ladder. Be this as it may, open acknowledgment of class distinctions or classifying people into upper, middle, and lower classes is considered both un-American and undemocratic, and nurses no less than other people shy away from it.

Another reason that the existence of social class differences is muted or denied by nurses is their adherence (in principle if not always in fact) to the precept that in caring for the sick it should make no difference who a person is, or whether he is rich or poor. To recognize or speak of class distinctions, then, which for the unsophisticated has invidious implications, would be to run counter both to this precept and to the equalitarian ideology of American society.

But shutting one's eyes to class distinctions does not conjure away their reality; and nurses can no longer afford to do so any more than they can ignore the cultural differences related to ethnic backgrounds. Like their colleagues in medicine, as well as others in the health-related professions, they have the most personal and intimate contact with people whose class backgrounds differ from their own. To remain unaware of, or indifferent to, the impact of class conditioning on behavior—on one's own as well as on others—may seriously impair effective patient care.

In approaching the subject of social class with nursing students, a cautious approach is particularly essential. First of all, it is a complex subject with all the attendant dangers of oversimplification. Secondly, and for reasons that by now should be fully apparent, it is likely to create anxieties or feelings of hostility. Still, a knowledge of the American class system and of the cultural and motivational patterns of each is a necessary part of the professional nurse's training if she is to deal with problems of human relations and be proficient in the therapeutic situation. Not irrelevant, either, is the social class from which the nurse herself comes—an aspect of nurse-patient role relationship that

¹ See, for example: Myrdal, Gunnar, *An American Dilemma*, Harper and Bros., New York, 1944; Lynd, Robert, and Helen M., *Middletown: A Study in American Culture*, Harcourt, Brace and Co., New York, 1929; and Warner, W. Lloyd, *American Life: Dream and Reality*, University of Chicago Press, Chicago, 1953.

has not received the attention it deserves. Several studies of the social origins of nurses in the United States have indicated that by and large they derive from middle-class culture.¹ This does not mean that the nursing profession does not include those from the upper or lower classes, but that it is predominantly composed of nurses from middle-class backgrounds. It follows, first of all, that those who enter the profession will, to a greater or lesser degree, hold the middle-class values of our society. To the degree to which individual nurses are classbound or ethnocentric, they will assume that their points of view are essentially correct. Furthermore, they may even assume that these are both universal and meaningful for all patients.

Among the dominant middle-class values are emphasis on cleanliness, work, "busyness," punctuality, rationality, "respectability," independence, self-discipline, effort, and progress—the same values, for the most part, that are reinforced in the hospital milieu, where (if for different reasons) they are also regarded as "virtues." But these values are not necessarily given the same priority, or even, in some cases, given any priority by those in the upper or lower classes. The matter of cleanliness, for instance, which has been described as a middle-class obsession, is given less attention by the lower classes. Likewise, conformity to popular ideals and beliefs, which is emphasized by the middle class, is accorded less importance by the upper class, who place a higher premium upon individuality. When, therefore, the standards or values of the nurse and those of the patient come into conflict, or when there are divergencies between them in their preconceptions and goals, we are likely to have difficulties in communication, management, and interpersonal relationships. We saw, for example, in the case of Miss Miller, how the efforts of the rehabilitation team to prevent the onset of decubitus ulcers failed because of a conflict in definitions of modesty and moral behavior. From the team's point of view, examination of one's body in the mirror was entirely appropriate, but for the patient it was not.

¹ Hughes, Everett C., Helen MacGill Hughes, and Irwin Deutscher, *Twenty Thousand Nurses Tell Their Story*, J. B. Lippincott Co., Philadelphia, 1958, pp. 20–21; Reissman, Leonard, and John H. Rohrer, editors, *Change and Dilemma in the Nursing Profession*, G. P. Putnam's Sons, New York, 1957, p. 66.

Another important consideration is that regardless of the possibilities for mobility from one class to another, "the social system maintains cultural, economic and social barriers which prevent intimate social intermixture between the slums, the upper class and the middle class."¹ This being the case, it would be unrealistic to expect the average nurse or the entering nursing student to be familiar with the environments and the culture of patients from upper and lower classes. Moreover, because of differences in the conditioning and controls of her own social class, any nurse may feel uneasy or anxious with patients from another social class.

Students' Attitudes Toward Social Class

There are probably many different methods of introducing nursing students to the concept of social class and its implications for problems of health and illness. But within the context of our experimental course, we proceeded in the following if somewhat roundabout way. Some groundwork had already been laid. Beginning as we did with the comparisons of differences and similarities among other cultures, students were inevitably led to comparisons with their own. Having done so, they were then better prepared for further orientation in American culture and some of its subcultural differences.

Before starting an analysis of social class and social stratification, we gave the students an assignment that required, among other things, answers to the following question: "What difference do you think it makes to nurses if a patient is a child or an adult; young or elderly; male or female; a member of the wealthy upper class, or of the lower class?" At the time this assignment was given, students had had sufficient contact with patients and hospital personnel to have acquired either directly or indirectly some fairly definite opinions as to the differences in patients' behavior according to these categories. While most students prefaced their answers with statements picked up earlier in their preclinical training or elsewhere (such as "You can't generalize," "You can't put people into categories," "Each case is unique," "It depends upon the nurse versus the patient"), they nevertheless proceeded to characterize different types of patients according to

¹ Warner, W. Lloyd, *op. cit.*, p. 84.

behavior, attitudes, expectations, and specific nursing needs, simultaneously revealing in many instances their own personal reactions to each.

An analysis of their responses showed that while individual perception of patients varied, collectively the class ascribed to patients characteristics that fell into clusters or patterns. Also, as a group, they had recognized and agreed upon certain recurring differences and similarities in patients that rested on a subcultural basis. For example, concerning age, the class consensus was that a child is "helpless," "frightened," "needs to be protected," and "should receive explanations," while an adult patient "should be more self-reliant, mature, and responsible," "should cooperate," "can be reasoned with." Male patients, the nursing students agreed, were "less demanding and easier to care for," "could tolerate pain better," "often joke," "don't want to be dependent upon women." They were the ones with whom students were sympathetic and preferred to women patients. Female patients, on the other hand, were "fussy," "talkative," "more demanding," and "complaining."

Concerning patients in the different age and sex categories, students responded freely. For the most part, they ignored the word "nurses" in the question, "What do you think nurses feel . . . ?" and related the question directly to themselves. On the items referring to social class differences, however, they were wary and manifested considerable uneasiness. Most of them chose to respond in terms of what *other* nurses think. Here they put up defenses by falling back on the democratic thesis that it "should not make any difference to a nurse whether a patient belongs to the upper or lower class, or whether he is rich or poor." Also, responses were on a more subjective level and in many cases revealed strong reactions in terms of feeling tone and their own social class attitudes. In general, they equated private patients with upper-class patients. (Only six students admitted having had any contact with private patients; and five equated them with wealthy upper-class persons.) Yet, in spite of their lack of contact with private patients, whom they assumed would be members of the upper class, they had definite perceptions of such patients. These had been determined either from earlier

experiences or picked up from their contacts with graduate nurses. On this subject they had a number of stereotyped conceptions:

The upper-class patient is one who thinks he can pay for service or who, even though he is a nice patient, is the man who in business or professional life may be used to hollering at his subordinates.

One must be careful not to harbor feelings of aggression, especially since the wealthy might be used to much attention.

In the hospital routine, as in the corner drugstore, there seems to be a tendency to treat persons of wealthy, upper-social classes with more respect and to give them more consideration. However, the patient is the same, rich or poor.

They may be more demanding and expect more from the nurse because they're used to this sort of thing.

It should make no difference in the quality of care given, but one should be tolerant toward their demands and possible complaints. They, too, are in an unfamiliar, anxiety-producing situation.

The nurse may think that the wealthy upper-class individual will expect more care and will look down upon her as a servant.

Persons in this class usually have respect for the nurse. They generally have quite high intelligence and therefore explanations are easier. This can work adversely, though, as they can ask too many questions and are not satisfied with "half-truths."

I have not had contact with such patients. However, I should probably feel hesitant about counseling in any way someone above me on the social scale.

Upper-social-class patients treat you as though you were one of their house servants.

When with the upper social class there may be a feeling of resentment of subservient position.

Upper-social-class patients are polite, friendly, and slightly condescending toward a nurse.

Upper-social-class patients are inclined to look down on the nursing profession.

Typical examples of responses regarding the lower-class patient were as follows:

Most nurses expect lower-class patients to be grateful receivers of all services rendered. They are expected to be less demanding than upper-class patients and never to criticize any part of the hospital.

Usually they are more appreciative and less likely to complain about little things.

They usually have great respect for the nurse and awe of the doctor.

Some nurses think that lower-class people are used to less and minimum care should be enough. "She never had so much done for her in her life and still she complains," said a nurse.

On the whole members of the lower class may be less demanding. The nurse may have to be alert to their unexpressed needs and discomfort.

Nurses must treat such patients with just as much respect.

Lower-class patients are often very sensitive to any action on the part of the nurse which could be interpreted as a feeling of personal and social superiority.

The dynamics involved here are worth noting. First of all, we see that nursing students tend to think of themselves as middle class and as lacking in class consciousness. Moreover, they are voicing both the American ideal and the precepts of nursing when they claim that the socioeconomic situation of a patient should make no difference. In the second place, we note that while denying or attempting to ignore class differences, students do recognize their existence as reflected in their statements.

From these statements, the image of the upper-class patient appears as a spoiled, demanding, condescending person who may regard the nurse as a servant. In this built-in image we see what appears to be a projection of feelings of insecurity, inferiority, and hostility found among some members of middle-class groups toward members of the upper classes, rather than a factual portrayal of upper-class attitudes and behavior based on direct contact. On the other hand, the students' image of the lower-class patient is of a person who is more appreciative, respectful, and less demanding, toward whom they feel superior and more secure. Though they show a willingness to understand and work with lower-class patients, they seem to be less aware of the sub-cultural patterns of the upper class and manifest resentment toward those whom they consider members of it. Obviously, nurses who feel insecure with, or subordinate to, certain types of

patients, or who approach them in a patronizing manner or with an attitude of "tolerance," cannot hope to establish mutually satisfying relationships. In fact, such attitudes cannot help having an adverse effect on the interaction between the nurse and her patient.

When we presented our analysis of the responses to the students, they were not a little disconcerted by the fact that while protesting that patients could not be classified or typed, they had drawn quite definite distinctions in terms of expected behavior and attitudes, and even their own preferences.¹ This gave us an opportunity to consider differences in method and purpose of classifying and typing human beings as seen by the layman and by the student of human behavior.

As one participates in the social world, he is constantly faced with problem-solving situations. In terms of recurring experiences, he tends to expect some continuity of behavior from others as well as himself, and to make decisions on the basis of preceding solutions. Therefore, he begins to classify people or to put them in pigeonholes according to the role they play within the group. For the untrained, classification into types is usually for purposes of simplification. For example, a student is typed as "a grind"; a relative is described as "a black sheep"; a patient as "a malingerer." Such labels or typologies furnish a mental image of the individual and a set of expectations as to his behavior. The danger here, of course, is that not only is such typing often only stereotyping (the picture in one's head), but it is frequently used as an explanation of personality.²

The social scientist also classifies people. But he goes about it in some systematic fashion and for purposes of analysis. He may, for instance, identify certain social types that for him are merely models or "ideal" types. These are his methodological tools which he uses as a guide or as a basis of prediction and a *partial* explana-

¹ For an interesting discussion concerning medical students' preferences, see "Preferences for Types of Patients" by William Martin in *The Student Physician*, edited by Robert K. Merton, George G. Reader, and Patricia L. Kendall, Harvard University Press, Cambridge, Mass., 1957, pp. 189-205.

² Young, Kimball, *Personality and Problems of Adjustment*, 2d ed. Appleton-Century-Crofts, New York, 1952, pp. 240-252.

tion of collective behavior. They do not correspond to any given individual since no one person is said to embody the "ideal" type; but individuals may more nearly approximate one type than another. The classification of people into social types does not, it is important to stress, explain personality, nor does it become involved in the deeper aspects of motivation. What it does is to provide the social scientist with a method for analyzing human behavior and furthering his understanding of it. In so doing he is *not* implying a negative evaluation, nor is he making invidious comparisons between any individuals or segments of society.

Class Differentials and Patterns of Behavior

To introduce nursing students to the concepts of social class and social stratification, we began first by examining the family in a class system. From selected readings and lectures they see how the process of socialization of the child is influenced by the social class position of his family.¹ Students are exposed to distinctions between the classes in child-rearing practices, patterns of consumption, education, moral codes, and sexual conduct; to the differences in definitions of goals and aspirations, and in attitudes toward responsibility, independence, authority, work, and success. As we have previously indicated, our major interest in studying these differences is in order to understand the impact of class position on the behavior of people, and in *what* respect they are pertinent to the therapeutic relationship. Some of them will be briefly touched upon here.

One concerns class differences in child-rearing. In many nursing schools, the curriculum includes a course in early growth and development of the child; but rarely do such courses approach or consider with any appreciable depth the socialization process of the infant and child from either the social class or cultural framework.² In general, standard texts treat the subject in terms of

¹ Warner, W. Lloyd, *op. cit.*, chap. 4; Gittler, Joseph B., *op. cit.*, part 4.

² For cross-cultural insights into child-rearing practices students were referred to: Mead, Margaret, and Martha Wolfenstein, *Childhood in Contemporary Cultures*, University of Chicago Press, Chicago, 1955; Mead, Margaret, and Frances Cooke Macgregor, *Growth and Culture: A Photographic Study of Balinese Childhood*, G. P. Putnam's Sons, New York, 1951.

"norms" derived for the most part from studies of American middle-class families, while the variations in what are approved and acceptable practices and behavior by lower- and upper-class standards are seldom taken into account. It is not surprising, then, to find nurses and doctors, who by and large derive from middle-class backgrounds, disturbed or shocked by behavior which they perceive as "shiftless," "overdependent," "aggressive," "pretentious," or "uninhibited." Nor are the psychodynamic interpretations that are so often part of current health-team discussions of patients' behavior very useful in those cases where a sociological interpretation is needed.

For example, at a conference in a pediatric clinic, a doctor, nurse, and a social worker expressed grave concern over the "psychic damage" to a ten-year-old boy that was "bound to result" from the constant bickering and free expression of rage between him and his father, or between his father and mother. Such behavior among those in the middle classes, who are taught to inhibit or restrain their impulses, is regarded with disapproval. But this child and his parents came from "the wrong side of the tracks" where fighting and arguments were everyday occurrences. What the members of the conference did not realize was that among the lower classes it is more usual for children and adults to express their aggression both physically and verbally. Not only is such behavior sanctioned, but is expected by the members of the group. In this particular instance, then, it was unlikely that the child would be psychologically traumatized on this score, whereas a child from the middle class whose members strongly disapprove such behavior, is more likely to be.

Class differences in definitions of what is "normal" or "abnormal" with respect to sexual behavior are also possible stumbling blocks to the therapeutic relationship between health practitioner and patient. It is interesting to note that many nurses and doctors, particularly those who are trained in public health, are cognizant of the extremes in patterns of sex behavior in some primitive societies or foreign cultures. They are also likely to be fairly tolerant, at least on an intellectual level, of customs and practices which are indeed "different" from ours but which they

recognize are part of the culture or "way of life." But when it comes to sexual behavior within our own society, moralistic middle-class attitudes are likely to prevail. Consequently, we frequently find the behavior of a nonmiddle-class patient labeled "wrong" or abnormal, though it may be well within the normal limits of the class within which he was reared.

Many physicians and nurses who have been influenced by middle-class taboos about sex expression, tend to view persons in the lower reaches of the class system, where there is more permissiveness regarding child training and sex activity, as "deviant," "immoral," and even "animalistic." Young nursing students who come from sheltered middle-class homes are especially prone to hold these attitudes. They are somewhat surprised, therefore, as they begin to examine patterns of sexual behavior among the different classes to discover that:

Although there is a wide divergence of standards of sexual behavior acceptable to the lower, middle, and upper classes, the standards within each class appear to follow a set code. The middle class looks upon lower-class sex behavior as unmoral and "just like animals." These middle-class people do not realize that this behavior is as rigidly standardized as their own. If they did, many of the golden phantasies of the middle-class people about not giving a damn and living as they please "the way those people do down in the shanties," would have to find another locale. Fortunately for the self-respect and ego satisfaction of the middle class, there is little communication between the two levels on such subjects. For the middle class would probably be shocked to see that people of the lower class consider much of middle class sexual behavior and many of their attitudes as "dirty" and "unnatural."¹

The effect of social class position on patterns of adolescent behavior is not only relevant for nursing students, but it is understandably of intense interest to them since they themselves have so recently passed through early adolescence. By most persons in our culture, adolescence is assumed to be a period of considerable strife and "psychological conflict" and a "natural" part of the growing process; a premise upon which a good deal of guidance and counseling of students is based. In guiding their learning on

¹ Warner, W. Lloyd, *op. cit.*, pp. 90-91.

this subject, we found especially fruitful *Elmtown's Youth*.¹ This study highlights the diversity of behavior that is exhibited by adolescents in the different social classes, such as differences in dating practices, patterns of recreation, conceptions of "right" and "wrong"; and concludes with the revealing observation that the important thing about adolescence is the way people in our society regard it. Balancing this class analysis with cross-cultural studies of attitudes toward adolescence, such as *Coming of Age in Samoa*,² and "Cultural Backgrounds of Female Puberty,"³ serves to rearrange students' perspectives toward themselves and toward patients who are in their own age group.

Useful for nurses also is an understanding of different class attitudes toward work and money; toward spending versus saving for a rainy day, as well as how such attitudes determine what people buy and their motivations for buying.⁴ In the field of public health, as Dr. Simmons has pointed out, health precepts are formulated in terms of dominant middle-class values. These assume a future of orientation that may not apply to lower-status people. Emphasis is on planning ahead, budgeting, deferring gratifications for long-run goals, and saving for the future. Those in the lower classes who do not entertain much hope for a better future are inclined to give priority to the satisfying of immediate rewards and needs.⁵ When these two sets of values come into conflict communication may break down, and plans of action for health prevention or a medical care program are disrupted. Meanwhile, tensions are engendered in the members of the health team by their failure to understand what seems

¹ Hollingshead, August B., *Elmtown's Youth*. John Wiley and Sons, New York, 1949.

² Mead, Margaret, *From the South Seas: Studies of Adolescence and Sex in Primitive Societies*. William Morrow and Co., New York, 1939, pp. 1-304.

³ Abel, Theodora M., and Natalie F. Joffe, "Cultural Backgrounds of Female Puberty," *American Journal of Psychotherapy*, vol. 4, January, 1950, pp. 90-113. See also Montagu, M. F. Ashley, "Physiology and the Origins of the Menstrual Prohibitions" in *Anthropology and Human Nature*, Porter Sargent, Publisher, Boston, 1957, pp. 194-202.

⁴ For an illuminating discussion on the application of the social class concept to advertising and merchandising, see Packard, Vance, *The Hidden Persuaders*, Pocket Books, Inc., New York, 1958.

⁵ Simmons, Ozzie G., "Implications of Social Class for Public Health," *Human Organization*, vol. 16, no. 3, 1957, pp. 9-10.

by their standards to be "irresponsible" behavior; exasperation and disgust is their reaction to the patient who "didn't have enough money saved up to pay for his medicine though he was able to buy a TV set."

THE RELATION OF SOCIAL CLASS TO PROBLEMS OF ILLNESS

Thus far we have attempted to bring into focus some of the distinctions between the value systems and characteristics of the different social classes of America, and to show that attitudes and behavior as influenced by class origins or membership are as important to consider in nursing as are those that are influenced by particular cultures. We now ask what are some of the more specific problems of health and illness that may be influenced by social class factors. Until recently, medical science has not evinced much interest in the social factors in illness, nor have social scientists been particularly concerned with the role that these might play in illness. To be sure, quantitative analyses have been made of the relationship between socioeconomic status and life expectancy, infant mortality, and frequency and duration of illness. But aside from analyses of this kind, more research has been focused on the possible relationships between the individual's personality structure or his psychological and physical characteristics, and certain diseases or predispositions to them, than on the possible correlations between social class or social status and specific problems of health and illness. An examination of the literature, however, reveals that in the past decade or so this lag is being gradually overcome.¹

An increasing number of studies is showing significant class and status differences with respect to a variety of phenomena that are particularly relevant for those interested in the multiple stress and multiple causal aspects of illness. To mention only a few, there have been studies concerned with the relationships between class differences and family reactions to crisis; class differences and conceptions of marital roles; class differences in family stability, divorce, family rituals, and even funerals. Other studies

¹ See, for example, the studies listed in Harold W. Pfautz's "The Current Literature on Social Stratification: Critique and Bibliography," *American Journal of Sociology*, January, 1953, pp. 391-420.

have been concerned with social class and old age, fertility and social mobility, the drinking mores of different classes, and social status and social change in illness.

It will be noted, however, that there are as yet few studies that have been devoted to the relationship of social class to a particular type of illness or disease. Of these, two different studies, one dealing with chronic physical illness, the other with mental health, were particularly pertinent for nursing students. Important because it recognized the social factors in chronic disease and psychological invalidism, was the study by Dr. Ruesch and his collaborators.¹ In the course of this research project, 123 outpatients and 64 inpatients with chronic diseases were studied with relation to convalescence and delayed recovery. Complete medical, psychiatric, and sociological "workups" were done on all patients. Seventy-five per cent of the patients with delayed recovery came from the lower-middle class, as opposed to a total of only 28 per cent lower-middle class in the general population. (Four social classes were used as a basis for this study.) This, the authors suggest, may be related to the fact that doctors and medicine carry prestige for the lower-middle class:

Since these same people look up admiringly to doctors, it seems safe to assume that this admiration might in turn induce them to seek contact with physicians and medicine as much as possible. This conclusion is supported by a previous study of ours on head injury. In a series of acute head injuries, accident-prone people and those with speedy recovery derived primarily from the lower class, but those with prolonged symptoms were primarily from the middle class. Lower-class people hate hospitals and everything that has to do with authority. They do not admire doctors and they are not willing to spend one day longer than necessary in the hospital. . . .

. . . In delayed recovery the incidence of [social] climbers is much more frequent than that of the decliners. This fact might support the theory that delayed recovery and psychosomatic diseases are conditions affecting middle-class people and climbers, as contrasted with the conduct disorders affecting primarily the lower class and decliners.²

¹ Ruesch, Jurgen, and others, *Chronic Disease and Psychological Invalidism*. University of California Press, Berkeley, Calif., 1951.

² *Ibid.*, pp. 164-165.

Another important piece of research relating to a specific illness was that conducted at Yale University by Dr. August B. Hollingshead, chairman of the Department of Sociology, in collaboration with Dr. Frederick C. Redlich, chairman of the Department of Psychiatry. It concerned the relationship of social class membership to the various types of psychiatric disorders. Included among the many facets of this extensive study are correlations of social class and the kind of therapy that patients receive, as well as the length of time spent in the hospital.¹ On one occasion, our students had the opportunity to hear a report by Dr. Hollingshead on still another aspect, namely, class factors in the cost of psychiatric care. Because this lecture served to upset many of the students' traditional preconceptions and assumptions, and because we think it has great value from the point of view of methodological procedures, we present it as Part II of this chapter.

Part II. Class Factors in the Cost of Psychiatric Treatment²

Today I shall discuss selected aspects of the project we have had under way in the New Haven community since 1950. This project is an exploration of interrelationships between social stratification and psychiatric disorders. In a single period of fifty minutes, it is possible only to give you an overall view, and then focus upon one or two aspects of it. First, I will outline the project and then concentrate upon a single aspect, namely, how much is spent on the medical care of a mental patient during a single course of treatment.

Viewed overall, this project has three parts. First, we had to know who was a psychiatric patient. We defined him as a person who was in treatment or under the care of a recognized psychiatrist on a specified date. The date we used was December 1, 1950. We then took a census of psychiatric patients from the New Haven community who were in treatment at that time, whether in private practitioners' offices, clinics, or in state, private, and

¹ Some 25 papers resulted from this research prior to the recently published volume, *Social Class and Mental Illness*, John Wiley and Son, New York, 1958.

² A guest lecture by August B. Hollingshead, Ph.D.

Veterans Administration hospitals. We counted both ambulatory and hospitalized patients.

It is a well-known fact in psychiatric practice that because of the stigma attached to mental illness in our culture, some people leave their homes to avoid having their friends and associates, or anyone outside the immediate family, find out that they are psychiatric patients. Therefore, we went as far north as Montreal, as far south as Florida, and as far west as Kansas, and points in between, to locate patients. We went to New York, Boston, Providence, and to every practicing psychiatrist in Connecticut. After long and careful searching, we located 1,963 persons who were psychiatric patients and also residents of the New Haven community.

The second part of this project involved a careful study of the social system to determine if there were, in fact, classes in the community. The New Haven community probably has been studied as carefully as any city of 250,000 population in the United States. Studies have been carried on there for well over a half-century by various kinds of social scientists. These studies are in general agreement that the community is stratified. We built upon the work that had been previously done. In addition, we drew a 5 per cent sample of the community's households; then we interviewed each one personally with the aid of a schedule. The purpose of the 5 per cent sample was to enable us to make comparisons between the general population and the psychiatric patients.

We gathered information on the age and sex structure of the population, income, behavior patterns—such as the clubs persons belonged to and their participation in community organizations. We were concerned with the radio programs they listened to, the television programs they viewed, if they had a television set. We were interested also in the reading matter that came into the home. So we asked what newspapers and magazines were read, and if comic books were read, which members of the family read them. We were concerned also with home ownership, the structure of the family, and so on. The data from these interviews were coded and placed on International Business Machine cards.

The third operation was to stratify both the patient and the control population. We stratified the population by use of my *Index of Social Position*, which uses three items. The first is the social evaluation of the residential area where the family lives. My colleague, Dr. Jerome K. Meyers, mapped the entire community. The second factor in the *Index* is the occupation of the head of the household. This is scaled according to seven types of occupations that range from the highly trained professions and large business operators, such as presidents and vice presidents of banks, to unskilled workers. The third factor is the education of the head of the household.

Education is classified by a seven-point scale that ranges from a graduate professional degree, which we give a scale-score of 1 to a scale-score of 7 for a person who has had seven grades of school or less. I will give you a brief idea of educational rating: a graduate professional degree, M.A. or M.S. in education, or an M.D., or Ph.D., or LL.B. (we do not differentiate between them), receives a scale-score of 1. For an A.B., or B.S., the scale-score is 2. From 1 to 3 years of college receives a score of 3. A high school graduate is assigned a scale-score of 4. From the tenth through the eleventh grade the scale-score is 5, from the seventh through the ninth it is 6. Schooling to the seventh grade is scored as 7.

These three items of residential area, occupation, and education are combined by a statistical procedure known as a "regression equation." There are weights that I am not going into here that are involved in the scores we compute from the data. From our qualitative and historical study of the community, as well as the analysis of the participation patterns of the people, we came to the conclusion that the population can be divided into five major social classes. Our preliminary data had indicated the presence of that number and now we have the data to demonstrate the validity of our original assumption. Remember, I told you a moment ago that we asked about every piece of reading matter that came into the homes of the 3,559 households in our control sample; the radio programs they listened to; the television programs that they viewed; and so on. To test the validity of our assumption that there were five classes, we examined 50

mass communication variables that are common to our society: such as *The New York Times*, *New York Herald Tribune*, *New York Daily Mirror* and *New York Daily News*. These newspapers are all available in New Haven as well as the local ones. In addition, we used *Life Magazine*, *Time Magazine*, *McCall's*, *Woman's Home Companion*, *Harper's*, *U.S. News and World Report*, and so on. About 99 per cent of the households owned radio sets, and over 80 per cent of the families, at the time we interviewed them, owned television sets.

The question we were interested in was briefly this: Was there a relationship between people's scores on the *Index of Social Position* and their behavior with respect to the newspapers they read, radio programs they listened to, or television programs they viewed? By the use of our factor analysis, we found that behavior patterns were not only highly intercorrelated with score positions on the *Index of Social Position* but the intercorrelated scores formed five patterns. This is comprehensive evidence that the community as represented by the behavior of the people follows patterns we designate as classes.

TESTS OF THE HYPOTHESIS

Class I. This stratum is composed of well-to-do families whose wealth is often inherited and whose heads are leaders in the community's business and professional pursuits. Its members live in residential areas generally regarded as "the best." The adults are college graduates, usually from famous private institutions. Their social life revolves around private clubs, cliques of families, and exclusive organizations of one kind or another. Almost all gentile families are listed in the local social directory, but few Jewish families are so listed. Three per cent of the population are in Class I.

Class II. Adults in this stratum are almost all college graduates. The men occupy high managerial positions; many are engaged in the lesser ranking professions. These families live well but there is no substantial inherited or acquired wealth. Social life tends to revolve around the family, church organizations, and clubs. Fewer than 5 per cent of the families are listed in the social directory. Nine per cent of the community's population are in Class II.

Class III. This stratum includes the vast majority of small proprietors, white-collar office and sales workers, and a considerable

number of skilled manual workers. Adults are predominantly high school graduates, but a considerable percentage have attended business schools and small colleges for a year or two. They live in "good" residential areas. Their social life tends to be concentrated in the family, churches with less prestige, and lodges. Twenty per cent of the population are in Class III.

Class IV. This stratum consists predominantly of semi-skilled factory workers. Its members have finished the elementary grades but the older people have not completed high school. However, adults under thirty-five have generally graduated from high school. Residences are scattered over wide areas. Social life is centered in the family, the neighborhood, the labor union, and public places. Its members comprise 50 per cent of the community.

Class V. Occupationally, Class V adults are overwhelmingly semiskilled factory hands and unskilled laborers; most have not completed the elementary grades. Families are concentrated in the "tenement" and "cold-water flat" areas of New Haven. Only a small minority belongs to organized community institutions. Social life takes place in the family flat, on the street, or in neighborhood social agencies. Eighteen per cent of the population are in this stratum.

Once we had completed examination of the class structure of the city, we were ready to test three hypotheses. First, we postulated a significant relationship between an individual's position in the class system and the prevalence of treated psychiatric disorders in the population. Our second hypothesis assumed a significant relationship between class position and the kind of psychiatric disorder that a patient exhibited. Third, we postulated a significant relationship between a patient's class position and the kind of treatment he received.

To test the first and second hypotheses, the patients were compared with the general population. The sample of 1,963 patients contained both sexes, extended over a wide age-range, and came from the five social classes. The same was true of the general population. We then took the population of each class and standardized it according to total population of the community. After we had made corrections for differences in the age structure of the patient population in comparison with the total population, we expressed our findings in terms of age- and sex-adjusted

rates per 100,000 of the population. Classes I and II had to be combined because there were not enough patients in Class I to analyze the data by age and sex, marital status, race, or ethnic background, religion, and other factors of interest to us. In our basic test of the hypothesis about prevalence of mental disorders, we found that Classes I and II had a rate of 553 mentally ill members receiving psychiatric care per 100,000 population; Class III had a rate of 528, a little lower; Class IV had 664 patients, and Class V had 1,668 per one hundred thousand. In short, the rate in Class V, adjusted for age and sex, is more than three times what it is in Classes I and II. If you ignore class, the rate per one hundred thousand is 808 patients. We conclude that there is a significant relationship between a patient's position in the class structure of the community and whether or not he is being treated by a psychiatric agency.

Hypothesis two, you will recall, postulated a significant relationship between class position and type of disorder. First, the neuroses: in Classes I and II the rate per one hundred thousand was 360; in Class III it was 237; in Class IV, 146; and in Class V, 163. In short, the higher the class the higher the rate. A fundamentally different picture emerges for psychotic patients. Here we find the following pattern: in Classes I and II, 200 psychotic patients per one hundred thousand; in Class III, 291; in Class IV, 518; and in Class V, 1,504. The rate for psychotic patients between Classes I and II, and Class V has a differential of 1 to 7. The relationship is distinctly inverse: the lower the class, the higher the rate.

Something must be said about rates for schizophrenia because 58 per cent of our psychotic patients were diagnosed as schizophrenic. In Classes I and II, the rate per one hundred thousand was 111; in Class III, 174; in Class IV, 300; and in Class V, 895. In this group of disorders the differential is of the magnitude of approximately 1 to 9. Here again we find an inverse relationship: the lower the class, the higher the rate of treated morbidity.

The third hypothesis postulated a significant relationship between the treatment a patient receives and his class position. Without giving figures, it can be said categorically that *where* a

patient is treated and *how* he is treated shows a significant relationship between class position and every type of psychiatric disorder. *Where* patients are treated was defined at the beginning of the lecture: to wit, in private practice, private and public hospitals, and clinics. By *how* patients are treated, we mean the principal type of psychiatric therapy administered to them: one of the psychotherapies, organic therapy, or simple custodial care.

COST OF TREATMENT

Now I shall focus the discussion on expenditures for treatment and how the costs of treatment are related to class status. The cost data in the seven tables we shall talk about are limited to 392 patients, who were being treated in four different types of psychiatric facilities: private practice, private hospitals, clinics, and state hospitals. Of the 392 patients, 117 were receiving treatment from private practitioners. They represent a 50 per cent stratified random sample of all persons who were being cared for by 24 private practitioners on December 1, 1950. The number of patients in private hospitals on that date was too small either to sample or to give statistical reliability. Therefore, all patients in selected private hospitals on the first of December, as well as all persons who entered these hospitals from the community between December 2, 1950, and June 30, 1952, were included. We had to add to the psychiatric census figures because there were only 37 patients enumerated in all of the private hospitals on our census day, and some of them were a good distance away. Co-operating hospitals were willing to give us access not only to patients' clinical records but also economic records. All cases treated in three clinics on December 1, 1950, were included in the series. The cases drawn from the state hospital represented a 10 per cent random sample of patients from the community hospitalized on December 1, 1950.

Our findings on interrelations between class position and direct dollar expenditures for a single course of treatment for mental illness apply to four types of treatment agencies: private practitioners, private hospitals, clinics, and state hospitals. Note that our figures on costs are for a *single course of treatment*. Other medical

costs are not included here. For example, if a patient was treated in private practice and later referred to a mental hospital, we do not include what was spent before he entered the hospital. We discovered that the mean dollar expenditures patients or their families make in a single course of treatment with private practitioners are associated very strongly with class status. This is apparent from an examination of the data summarized in Table 1, which shows how sharp are the differences from one class to another.

TABLE 1. MEAN PER PATIENT EXPENDITURES ON A SINGLE COURSE OF TREATMENT WITH PRIVATE PRACTITIONERS, BY CLASS

<i>Class of patients</i>	<i>Number of patients</i>	<i>Mean expenditures</i>
I	13	\$6,202
II	17	4,137
III	38	1,505
IV	49	368
	117	\$1,079

To understand the differences shown in Table 1 in the average amounts patients or their families spend, we must realize that these figures reflect the ways class status is linked, on the one hand, to what classes go to which practitioner; and on the other hand, to the therapeutic orientations of the practitioners. The psychiatrists who furnished us data on their charges to patients represent treatment orientations that range from classical Freudian psychoanalysis to empirical eclecticism without any specific theoretical orientation. There is a marked relationship between the type of practitioner and the size of the bill he submits to his patient. Psychoanalysts treat their patients three to four times a week for two, three, or four years, and sometimes longer. The patient pays an agreed-upon fee that ranges from \$15 to \$40 for each fifty-minute period. An eclectic psychiatrist sees his patients from fifteen to thirty minutes perhaps once a week, for a month, two months, possibly for as long as six months, and he charges them \$10 to \$20 for each visit. The therapeutic orientations of

practitioners are correlated in turn with the class status of their patients.

The patients of the psychoanalysts are all in Class I and Class II: 81 per cent are in Class I, and 19 per cent are in Class II. The analytically oriented practitioners see patients predominantly from Classes II and III: 27 per cent are in Class II, 33 per cent are in Class III. Only 11 per cent are in Class I, and a mere 9 per cent are in Class IV. Patients of the eclectically oriented practitioners show a distinctly different distribution: 84 per cent are in Class IV; 14 per cent are in Class III; and 2 per cent are in Class II. These figures show that Class I patients spend their money on psychoanalysis for the most part. This is a long expensive form of treatment, as the mean expenditure of \$6,202 reveals. Class II patients tend to patronize analytically oriented practitioners, who see them two or three times a week for a year to fifteen months; the resulting mean expenditure is \$4,137. Class III patients divide their patronage between analytically oriented and eclectic practitioners. They are not seen as often as the Class I patients and their mean expenditure is \$1,505. The Class IV patients are treated predominantly by eclectic practitioners once a week or less often, for twelve to fifteen weeks, and their mean expenditure consequently is only \$368.

We shall turn now to the private hospitals and see if they follow somewhat the same pattern. One hundred and six patients cared for in private hospitals were followed from the time their treatment began until they were discharged. One patient was still in treatment when the field work ended on March 1, 1956. Seventy per cent went to the hospital on the advice of a physician, the remainder were sent by a psychiatrist who had them in treatment before hospitalization. Expenditures for their illnesses before they entered a mental hospital and after their discharge are not included in the computations presented in Table 2.

The figures in Table 2 are based exclusively upon the amount paid to the private hospitals and hence represent only partial costs of these illnesses. The definite inverse relationship between class position and mean dollar expenditures on a single hospitali-

TABLE 2. MEAN PER PATIENT EXPENDITURES ON A SINGLE PRIVATE MENTAL HOSPITALIZATION, BY CLASS

<i>Class of patients</i>	<i>Number of patients</i>	<i>Mean expenditures</i>
I	23	\$3,265
II	20	1,682
III	33	1,264
IV	31	831
	107	\$1,646

zation is highly significant. This association results from the operation of two class-linked factors: first, the length of time patients are hospitalized; and second, discount practices in private hospitals. These practices, however, produce opposite effects. The longer a patient remains in the hospital, the larger the bill unless the time factor is neutralized by a larger discount. With these points before us, we shall present data to demonstrate how class status is related to the length of time patients remain in private mental hospitals, to the frequency with which discounts are given them, and the size of the discounts they receive.

The data summarized in Table 3 reveal that hospitalization in Class I is longer and variations in the length of time are greater than in Class II. Class II patients stay longer than the Class III patients, and their stay in the hospital is more variable, as shown by the standard deviation. Class III patients are in the hospital longer by 37 per cent than the Class IV patients, but there is no difference in distributions around the means. Two conclusions emerge from these data: the higher the class the

TABLE 3. MEAN NUMBER OF DAYS THAT PATIENTS ARE PRIVATELY HOSPITALIZED, BY CLASS

<i>Class of patients</i>	<i>Number of patients</i>	<i>Mean number of days</i>	<i>Standard deviation in days</i>
I	23	138	114
II	20	57	34
III	33	43	20
IV	31	27	20
	107	61	43

longer the patient remains in a private hospital, and the greater are the differences in length of stay within the class. Clearly, a patient's class status is linked to the length of time he remains in a private mental hospital.

Now we turn to the second point about financial arrangements and discounts. Financial arrangements between "the front office" and a patient's family are highly confidential. Therefore, who receives a discount and how much are, in front-office terminology, "delicate subjects." Departure from quoted fee schedules are made for a number of avowed reasons. To quote from some of the administrators who grant discounts, the reasons include: "inability to meet the full schedule" (a posted schedule of the hospital), "professional courtesy," "to help the patient's recovery," "for business reasons," "an interesting case." There are also further explanatory reasons. No hospital administrator was willing to state that a patient's status influenced the patient-hospital relationship; nevertheless, a definite relationship exists between class position and those who receive discounts and in what amounts. These conclusions are supported by the data presented in Table 4.

TABLE 4. DISCOUNTS IN PRIVATE MENTAL HOSPITALS, BY CLASS

<i>Class of patients</i>	<i>Per cent of patients receiving discounts</i>	<i>Per cent of bill discounted</i>
I	57	30
II	25	21
III	21	16
IV	7	2

The discount system operates to the distinct advantage of Class I. Interestingly, only small differentiations are made between Class II and Class III, both in the percentage of the patients who received discounts, and the proportions of the bills that are discounted. Class IV, in comparison with Class III, is treated in a more singular manner than is Class I when compared with Class II. You can see this by merely looking at the

percentage of patients who received discounts and the percentage of the bills that are discounted.

The frequency and the size of discounts could be attributed to the length of time patients remain in hospital rather than to class status. To determine if class status were a significant factor rather than the length of time patients remained in hospital, the data were analyzed by covariance procedures with the number of days patients remained in the hospital controlled.

TABLE 5. AVERAGE DAILY COST OF PRIVATE HOSPITALIZATION, BY CLASS

<i>Class of patients</i>	<i>Adjusted mean payment per day*</i>	<i>Standard deviation</i>
I	\$23.76	\$7.37
II	29.66	5.87
III	29.88	5.92
IV	31.11	5.11
	\$105	\$6.04
F (3,102) = 2.690 $p < .05$		

* The means were adjusted after a covariance analysis was made with the number of days in treatment controlled.

The data in Table 5 show that the Class I patient pays significantly less for his hospitalization than the Class II, III, or IV patient. In short, the analysis summarized in Table 5 demonstrates that the observed mean differences in daily costs result from class position rather than the length of time patients remain in hospital. What Table 5 does not show is that Class I patients began to receive discounts after the first week, and in an appreciable number of cases from the "hour of their admission"; the customary \$50 to \$75 examining fee was waived. Class II and III patients do not begin to receive discounts until their families are pinched by the financial drain of the illness. The rare Class IV patient who receives a small discount does not have it applied to his bill until he is ready to leave the hospital and not until he has almost begged for it.

An ironical aside relevant to the large discounts granted to the higher classes is the linkage between class status and the kind of

therapy prescribed for patients. Approximately 93 per cent of the persons in Class I receive analytic psychotherapy, but only 19 per cent of those in Class IV, who are treated predominantly by electro-convulsive therapy. Analytic psychotherapy is a slow, time-consuming form of treatment, but it is believed to be effective in cases where this treatment is indicated, the therapist is well trained, and it is acceptable to the patient. A psychiatrist rarely sees more than 12 patients a day by this method, whereas electro-convulsive therapy is rapid and inexpensive and one psychiatrist may treat 40 to 50 patients. Moreover, the latter is a controversial form of therapy with very narrow indications.

The contrast between who is prescribed what therapy, both from the perspective of class position and the cost to the hospital, is too great to be ignored. We may infer that private hospitals are oriented toward Class I patients, but they are maintained in good part by the high-paying, low-cost Class III and Class IV patients who stay only a few weeks. To use a metaphor, private hospitals are designed for the carriage trade but they are supported by the "shock box." Exceptions are institutions where only psychotherapy is carried out. However, practically no Class III and Class IV patients are treated in these hospitals. A private hospital's patients are selected on a class basis just as are those of a private practitioner. Then they are treated according to their status.

The cost for treatment in a clinic has two sides: how much the patient pays, and how much the treatment administered to the patient costs the clinic. The participating clinics have a fee schedule that ranges from nothing to \$10 per visit. Each patient's fee is determined by the size of the family's income, and the number of persons supported by it. The responsible heads of the clinic do not expect the patients to support the clinic with their fees. The fee is paid, or set, simply to help defray some of the costs; often it appears to be set more for psychological than economic reasons. The mean charge for each clinic visit ranges from \$2.02 in Class III to \$2.10 in Class II, so there is no difference. Class V has to be treated separately as only four patients were carried beyond the intake and diagnostic interviews. Only

two paid for their visits, 25 cents each. When Class V is ignored, there is no association between class position and the fees the patients pay. On the other hand, the amount of money the clinics spend on the average patient is related to class status. This is clear from the data in Table 6. The gross cost of a patient to a clinic was calculated by multiplying the number of visits he made to the clinic by the mean cost per visit. Then the amount the patient paid was subtracted from his estimated gross cost to determine his net cost to the clinic. Let us turn to Table 6 and discuss our findings.

TABLE 6. GROSS AND NET TREATMENT COSTS PER PATIENT IN CLINICS, BY CLASS

<i>Class</i>	<i>Number of patients</i>	<i>Mean gross costs per patient</i>	<i>Mean amount patients paid</i>	<i>Mean net cost to clinic</i>
II	11	\$467	\$77	\$390
III	29	246	42	204
IV	24	110	18	93
V	4	49	1	48
	68	\$270	\$44	\$226

The clinic's net mean estimated expenditure on Class II patients is almost twice as large as it is for Class III patients—\$390 versus \$204. Class III patients, in turn, cost the clinic more than twice as much as the Class IV patients—\$204 versus \$93. Finally, the Class IV patients cost the clinic almost twice as much as the Class V patients—\$93 versus \$48. The interrelations between class status, gross costs, the amounts patients pay, and net costs are functions of the way the different classes utilize the treatment facilities available. The average Class II patient receives almost twice as much treatment as the average Class III patient; he personally pays more for it but he costs the clinic proportionately more because he stays in treatment longer. The same principle applies to Class III in comparison with Class IV, and particularly to Class V in comparison to Class IV. The net result of the difference between the length of time patients are treated within the clinic and class position is this: Class II patients receive the most therapy and Class V patients the least. If we consider that

clinics are established primarily to help lower-status patients who presumably need help very badly, this is, in the words of a psychiatric colleague, "a startling finding."

Finally, a word about expenditures on the 100 patients in state hospitals. These patients are almost exclusively public charges. The state sends bills to families who are able to pay all or part of the computed mean daily cost of hospitalization; but relatively few families are billed. Of those who receive statements, only a small percentage pay the bill. Therefore, for present purposes, we will assume that the public bears the entire cost of state hospital care. The computed cost per patient-day for each year the patients have been hospitalized was obtained from the state comptroller's office. This figure was then multiplied by the number of days in a given year each patient was hospitalized. However, the computation of the cost of a single course of treatment in a state hospital was complicated by the fact that 54 per cent of the patients enumerated in the psychiatric census on December 1, 1950, were still hospitalized on March 1, 1956. Sixteen per cent had been discharged, and 30 per cent had died in the hospital. In view of this situation, we analyzed the data in terms of how much had been spent on the patients' present hospitalization up to the time of their discharge, their death, or to March 1, 1956. The results of this analysis are summarized in Table 7.

The mean expenditures on each patient's hospitalization given in Table 7 show two things: maintenance of mental patients in a state hospital is expensive, and Class V patients are far more expensive than patients from the higher classes. Since no class differences exist between computed mean daily hospital costs, the

TABLE 7. MEAN PER PATIENT EXPENDITURES IN STATE HOSPITALS UNTIL DISCHARGE OR DEATH, OR UNTIL MARCH 1, 1956, BY CLASS

	<i>Classes II and III</i>	<i>Class IV</i>	<i>Class V</i>
Discharged from hospital	—	\$ 6,296	\$10,728
Died in hospital	\$ 1,926	15,866	12,306
Still in hospital	22,865	16,487	28,549
<i>N</i> =	6	46	48

mean aggregate costs shown in Table 7 must be the product of differences in the length of time patients in each class have been hospitalized. When the data were examined to test this conclusion, we found that the Class IV patients who were discharged spent an average of five years in a hospital before their release, while Class V patients spent twelve and one-third years before moving back into the community. One Class III patient who died in the hospital had been there eighteen months at the time of death. The deceased persons in Class IV and V had been in the hospital from ten to thirteen years when death came. Patients still in a hospital when the field work closed had been there a long time. The mean number of years by classes was: Class III, eighteen years; Class IV, thirteen years, and Class V, twenty-two years. On the basis of the low percentage of discharges experienced during the sixty-four months that these patients were followed, it appears safe to infer that patients who have been hospitalized continuously, as these have been, are not likely to be discharged in appreciable numbers. These patients have been an expense for many years, and they will continue to have public and private funds expended on their care for indefinite periods in the future. Even the few who have been discharged may return to the hospital. The only patients whose costs can be computed definitely are those who have died. Their accounts are closed.

To recapitulate what has been said: The data in Tables 1 through 7 are focused on the direct expenditures that were made by patients, their families, and the public for psychiatric care during a single course of treatment in four types of psychiatric facilities: private practices, private hospitals, public clinics, and state hospitals. Cost figures were gathered on 392 patients. The data presented demonstrate that the costs of treatment are linked with class status in each type of psychiatric facility. In private practice the higher the class, the greater the mean per-patient expenditure. In private hospitals the higher classes spend more than the lower classes because they are hospitalized longer. However, the mean cost per day is significantly less for the higher classes. This is attributable to invidious discounts granted high-status persons. In the clinics, the fees paid by Classes II, III, and IV are not significantly related to class status. On the other hand,

the cost to the clinic of treating patients is related inversely to class status. The clinics spend eight times as much treating each patient in Class II as they do in Class V. This differential results from the varying amounts of treatment administered to patients in these classes.

Public expenditures on patients in state hospitals are related to class position. This results largely from differences in the way these hospitals are used by each class. In Classes II and III, patients are sent to them as "a last resort" and usually only after families have exhausted their resources in private facilities. Class IV uses the state hospital as a treatment center or as a place of custodial care. It is the one psychiatric facility available to Class V persons who have become so distressed that they must be separated from the community. Ordinarily these persons are not wanted by their families, and they are viewed as dangerous to society if not to themselves. The sequel to rejection by the family and isolation from the community is long-term custodial care. Thus, although the state hospital is a minimum-cost institution on a per-day basis, it is a maximum-cost institution in the long run because it functions in large part as a "dumping ground" for chronic cases. In each type of psychiatric facility, the data presented demonstrate that class status influences direct expenditures on a single course of treatment.

Part III. Discussion

In this chapter we have endeavored to show some of the implications the concept of social class has for nursing as well as some of the difficulties inherent in dealing with it. Certainly the democratic and equalitarian philosophy and aims of our society upon which we are not only nurtured but strive to preserve, make it difficult even for those in the health professions to acknowledge and examine objectively the reality of class differences. But the reality of cancer, tuberculosis, or mental illness is equally hard to accept in a society dedicated to life, health, and the pursuit of happiness. Yet their existence is not denied. In the efforts to improve the care of patients and to prevent, cure or allay disease and pain, no component or possible relationships can afford to be

overlooked or by-passed, distasteful as some might seem to be. If human behavior in its totality is admitted to be an important aspect to consider in dealing with problems associated with illness, all the factors which condition it must be taken into account.

It is true that with respect to class factors there is still much that we do not know; and there are still many areas that deserve systematic study. One that holds particular interest for us has to do with nursing. It will be recalled that there were definite attitudes, feelings, and expectations on the part of nursing students toward lower- and upper-class patients—the import of which we suggest has ramifications worthy of study. For example, it would be valuable to know to what extent, if any, differential treatment of patients by nurses is related to class and status position. If, as other studies have indicated, the qualities considered necessary for therapeutic relationships, such as mutual trust, sympathy, respect and so forth, vary with the social distance between the health practitioner and the patient,¹ we would expect to find significant differences in quality of interaction and quality of care.

Other items for research are: the effect of social class differences on patterns of interaction between nurses and patients in specific teaching or interviewing situations. In what way, for example, are teaching and learning affected when the patient is upper class and the nurse lower class, or vice versa? Are middle-class patients more cooperative in interviewing situations with middle-class nurses, lower-class nurses, or upper-class nurses? If, as it now appears, the trend in nursing education is to give more attention to instruction in teaching and interviewing patients, research on these aspects should be profitable. From our own observations made over the past twelve years in several hospital and clinic settings, as well as those made in physicians' private offices, we would hypothesize that class and status positions are not only significant in the establishment of relationships between the nurse and the patient but are important factors in the eventual outcome.

¹ Simmons, Ozzie G., *Social Status and Public Health*, Social Science Research Council, Pamphlet 13, New York, May, 1958, p. 17; "The Clinical Team in a Chilean Health Center" in *Health, Culture, and Community*, edited by Benjamin D. Paul, Russell Sage Foundation, New York, 1955, pp. 325-348.

Chapter 6

Psychosocial Aspects of Physical Disability and Rehabilitation

THE CONSIDERATION OF PSYCHOSOCIAL ASPECTS of physical disability and rehabilitation occupied an important part of our course of study. Today members of the health professions are generally agreed that any disease or disability has its psychological concomitants. But in the efforts to understand, manage, and rehabilitate patients, it is not enough to know this as an isolated fact. Little is added to understanding by such statements as, "These people (meaning, for example, those who have peptic ulcers, congestive heart failure, multiple sclerosis, or impaired hearing) have psychological problems." What exactly are these psychological problems; how did they arise; how can they be recognized; in what ways can they be alleviated? These are the questions to ask, and if possible, to answer.

The amount of knowledge and literature on the psychosocial aspects of different types of illness and physical handicaps grows increasingly larger, and in designing our course we made no attempt to cover it. In the limited time at our disposal (only one-third of the allotted thirty hours could be devoted to this important subject), our major aim was to provide students with some analytical and conceptual tools and to develop their ability to apply them. We buttressed the lectures and discussions with selected reading lists through which the students could become acquainted with the range and scope of source material and recent research findings,¹ and which they could continue to use

¹ For example, Barker, Roger G., and others, *Adjustment to Physical Handicap and Illness: A Survey of the Social Psychology of Physique and Disability*. Social Science Research Council, Bulletin 55 rev., New York, 1953.

as they advanced in their training and nursing careers. To encourage continuing use we supplied instructors with bibliographies from which to make class assignments. It not infrequently happened, however, that the students themselves introduced the instructors to pertinent literature.

The psychosocial theories and concepts that can aid in the understanding and care of the physically disabled may be broad or specific. Some apply to "sick people," or to "patients in a hospital," or to patients requiring short-term care or long-term care. Others apply to specific categories of disability, such as the chronically ill, the blind, the facially disfigured, the aged, and so forth. Not only is the number of theories and concepts that might be useful for nursing students sizable, but their selection requires a balancing of divergent demands and needs: what preparation have the students had; at what stage are they in their clinical experience; what are they least likely to get in other courses; and what are some of the problems that need immediate attention.

Among the theories and concepts selected for consideration were those having special relevance to the kinds of patients whom students described as "problems" and about whom they were frequently puzzled, frustrated, or discouraged; patients who "do not behave like adults"; patients who "don't want to help themselves or don't try"; patients who "refuse to look at their disfigurement"; patients who "lack motivation for, or refuse to cooperate with, rehabilitation programs and seemingly want to prolong their state of incapacitation"; patients who "overreact emotionally to minor disabilities."

THE ADULT PATIENT

Prime consideration was given to some of the psychological aspects of hospitalization of adults. As we have mentioned elsewhere, our first-year students' expectations of the adult patient were that he should act like an adult; be reasonable, mature, responsible. A patient who fails to meet these expectations may be accused of "acting like a child" and treated accordingly. What is frequently overlooked, however, is that whether the patient is overtly behaving like an adult or like a child, his feel-

ings about a hospital and all it signifies are those of a frightened child. This has been clearly demonstrated by Ernest Dichter in "A Psychological Study of the Hospital-Patient Relationship."¹ Of the patients studied, it was found that reactions of adults to hospitals, regardless of intellectual or economic level or specific hospital experience, were as irrational as those of a child.²

Feelings of insecurity and fear were universal, and the patients tended to regress to a child's dependency and helplessness. This fear, Dichter is careful to stress, was not, as it is so often assumed, simply that of dying or of injury even when openly expressed. There was also fear "that involved specific infantile insecurities and responses." To find oneself suddenly in a situation and environment over which one has no control is feared by the adult patient as much as death. The patients Dichter studied showed this basic insecurity by being irritable. They complained about the hospital coffee, about bills, the routine, boredom, and personnel—complaints which some hospitals had unsuccessfully tried to remove by changing routines, diets, and so on. But these complaints, depth-probing of patients indicated, were merely "surface peevess" that were rationalizations and substitutions for entirely different basic emotional needs. Feeling frightened and alone, most of them sought a symbolically reassuring parent. They found comfort in an image of the doctor as a "father," of the nurse as a "mother."

At the same time, and according to different stages of their hospitalization, they reacted strongly against real and implied threat to their individuality and adulthood. Being treated like children only seemed to increase their feelings of helplessness. They wanted to be taken care of. Indeed, the study seemed to indicate that "*there is no such thing as 'too much' care. It is the quality rather than the amount of the care the patient is wary of. It is the attitude rather than the procedures themselves to which he reacts.*"³ While seeking assurance and attempting at the same

¹ *The Modern Hospital*, vol. 83, September, October, November, and December, 1954; vol. 84, January and February, 1955.

² *Ibid.*, September, 1954, vol. 83, pp. 53-54.

³ *Ibid.*, pp. 54, 136.

time to protect their mature individuality, the combined emotional need of patients seemed to be "care for me but also respect me."

DYNAMICS OF REHABILITATION

We next examined some of the sociological and psychological dynamics of rehabilitation. Today the concept of rehabilitation is an integral part of medical and nursing care. Theoretically, it means no longer waiting until the patient has been in the hospital for weeks or months or discharged before concentrating on a specially designed rehabilitative program to help him improve and adjust to his condition. "Rehabilitation begins as soon as the patient is admitted to the hospital" is the current attitude. Hence the treatment given a patient admitted because of tuberculosis, for example, includes teaching that will enable him to adjust faster and better to his disease, help to accelerate his recovery, and prepare him for his future life on being discharged. Likewise, the patient who has a colostomy is taught, as soon as his post-surgical condition allows, to apply, remove, and care for the necessary equipment to which he must now become accustomed.

Much time and energy by doctors, nurses, and related personnel are given to the planning and carrying out of rehabilitation programs for patients. These may include surgery, physical therapy including hydrotherapy, prosthetic aids, occupational therapy or vocational training, speech training, and so forth. Not only is the aim to rehabilitate the patient physically but to return him to his job and to society as a contributing member.

Complications, delays, and even failures in achieving these aims are not infrequent. A patient who should improve more rapidly does not; another whose function has been sufficiently restored refuses to return to his job; and still another who has only a minor disability refuses to accept or adjust to it. When such problems arise, members of the rehabilitation team may attribute them to failure on their part to stimulate motivation in patients. Or, conversely, they may attribute the difficulty to lack of motivation on the patient's part and may seek explanations in

terms of personality characteristics ("He's just plain lazy") or lack of intelligence. In others, lack of motivation may be attributed to what is erroneously concluded to be a personality disorder that requires psychiatric attention.

The ability to take care of oneself within the limitation of one's physical condition, and the attainment of physical, economic, and psychological independence to the greatest degree possible are the major aims of rehabilitation as it is currently defined. This emphasis has led to a patterned way of thinking about motivation and to the development of techniques for increasing it. Today patients are encouraged, far earlier than formerly, to get out of bed, bathe and feed themselves, and take exercises, since it is recognized that such measures are not only important for recovery but for the prevention of possible complications.

Simultaneously, these measures are utilized to hasten psychological rehabilitation by making patients self-reliant and independent. This is the accepted rationale, which, unfortunately, is sometimes exploited in order to avoid giving the care that should be given. Patients who cooperate are usually rewarded with praise and more reassurance. Lethargic or depressed patients are prodded or "cheered up." Those who are physically able to cooperate but do not, are sometimes scolded and perhaps even threatened with the withdrawal of certain privileges. This is the common sense method of approach. It often works but the frequency with which it does not work and the reasons it does not, have been the focal point of considerable psychological and sociological research.

Factors That Contribute to the Delay or Failure of Rehabilitation

Every person who becomes disabled will react to his disability as he would to other forms of stress or life crises, according to his particular personality structure. Many of his feelings and attitudes, however, will be a reflection of the values of his family and the society in which he lives. American culture places a high premium upon a healthy body and physical attractiveness. One need only think of the advertisements in magazines, on the radio,

and on television to recognize the social and economic importance attributed to these qualities.

Conversely, people who are physically weak, deformed, or unsightly to look at are devalued. They are frequently viewed with pity, curiosity, or awe. Because of stereotyped personality traits imputed to them, they may be feared or avoided. Even in this age of scientific enlightenment and widespread education, certain superstitions and folk beliefs are still extant regarding particular diseases and disabilities and their genesis. Some are thought to be socially stigmatic or a punishment for some wrongdoing, as the often-heard phrase, "What have I done to deserve this?" will attest. Congenital anomalies in particular are not infrequently imputed to maternal impressions, "God's punishment," or to the unfaithfulness of a parent.¹

Major problems in the adjustment to physical disability, then, are sociological in nature as well as physical. Social participation, employment, prestige, role and status, interpersonal relationships, and a variety of cultural activities may be affected or altered. Reaction patterns are virtually thrust upon the disabled person. Given a subordinate or minority status and devalued by others, his self-esteem suffers; he feels set apart, perhaps inferior, ashamed, resentful, and even unworthy. Under such pressure the psychic damage from which he is bound to suffer may have far greater consequence than the physical impairment.

In the attempt to rehabilitate patients, then, these social and psychological facts must be taken into account. For even though function may be restored or adequate substitutes found for it, and the patient's daily life resumed, his adjustment is not complete if he remains psychologically crippled.

Body Image. A subtle factor in the problem of care and rehabilitation of the physically disabled is that termed "body image."² This is the mental picture one has of his physical structure and appearance. It is a concept that has been of considerable interest to psychiatrists and psychologists but is less well understood;

¹ Macgregor, Frances Cooke, and others, *Facial Deformities and Plastic Surgery: A Psychosocial Study*. Charles C. Thomas, Springfield, Ill., 1953, chap. 3.

² Schilder, Paul, *The Image and Appearance of the Human Body: Studies in the Constructive Energies of the Psyche*. International Universities Press, New York, 1950.

ample, are greatly determined by the attitudes of his parents and the society in which he lives. How a child has been conditioned with regard to bodily functions and the social and psychological connotations they come to have for him, will influence to a marked degree how he reacts in later life to a malfunctioning organ. Early acquired attitudes toward cleanliness, self-control, manliness, and so forth take on added meaning; and fear of soiling, being punished, or shamed may become a focus of concern.

How one perceives his body, then, may account for feelings of guilt, disgust, shame, and other reactions during a hospital experience. These are sometimes misjudged by others as irrational or overemotional. A patient who refuses to have a blood transfusion or to undergo surgery or to look at his scar is not necessarily "stupid" or "stubborn" but is simply unable at the time to accept or to integrate a change in his body image. The need to keep the body image intact and inviolate may retard recognition and acceptance of a mutilation, as was illustrated in the case of Mrs. Dietrich at the beginning of this book. For others, preservation of the integrity of the body image may be of greater importance than the prolongation of life.

A patient was advised to have a ureterostomy (surgery to produce an external ureteral fistula) because of malignancy of the bladder. At a team conference the patient's negative emotional reaction and his resistance to surgery were viewed by the surgeon as exaggerated and unreasonable. "When I explained to him what had to be done," the surgeon said, "he started crying. 'What are you crying about?' I asked him. He stopped for a while, but later he was crying again. I think there is something wrong with his mental processes." Another staff member said, "When I went to see him his knees were shaking. He cried and acted just like an adolescent girl. I've never seen anything like it." Finally, the patient said to a staff member: "What kind of man is it that wears a bag on his leg?" Then she added, "You know, I discovered that his crying and shaking were not because he was afraid, or even afraid of the operation but because he felt that he would no longer 'be a man.' "

The patient was Italian-born and sixty years old. He had been informed that the operation would mean that he would no longer be able to void normally; that he would have to wear a rubber bag. In spite of efforts to convince him of the advisability of a ureterostomy, he refused to give his consent. He submitted instead to a partial resection which meant that the malignancy was not completely removed. His prognosis consequently was not favorable. He would, however, for a time at least, be able to maintain his body image. For him this had greater importance than the magnitude of the pathological findings.

The concept of body image may be a factor that accounts not only for differences among patients in their responses to the same degree of physical impairment, but in the time required for adjustment; phenomena that are frequently puzzling. Yet if the medical personnel understood that much psychic energy and time are needed for some individuals to integrate a new image of their body, it becomes clear, for example, why one hemiplegic is more difficult to motivate than another. Similarly, a knowledge of psychosocial and cultural differences in the meanings attached to excretory functions can aid in understanding why a particular colostomy patient is "overly fastidious" and another—to the exasperation of the average nurse—"doesn't even try to keep himself clean."

Depression. Depression is a common reaction to amputation of a body part, cerebral vascular accident, loss of sight or hearing, or some other impairment. A period of mourning, similar to that experienced after the death of someone loved, is not infrequent.¹ At such times, a patient may recall all the things he was once able to do which will now be denied him. Grief and despair pervade every waking moment. While for each individual the disability will have different meaning, there normally is an overwhelming sense of loss and perhaps a wish to die. Some even think seriously of committing suicide.

¹ For a good discussion of the meaning of loss see Dembo, Tamara, and others, "Acceptance of Loss—Amputations" in *Psychological Aspects of Physical Disability*, edited by James F. Garrett. Office of Vocational Rehabilitation, Series No. 210, pp. 80-96. Undated.

Doctors, nurses, relatives, and friends ordinarily attempt to help counteract or reduce depression by various methods. They try to cheer the patient, point out how much worse off others are than he is, how much he still has to live for, what others who have had similar handicaps have been able to achieve. Some may avoid the subject entirely in an effort to make the patient temporarily "forget" his situation. Others may even be tempted to offer false hopes in a situation they regard as desperate. When these attempts fail, all are likely to feel discouraged and troubled, and anxieties are mobilized. Yet reactive depression is a normal phase of the rehabilitation process, and, as others have pointed out, it may be a necessary phase.¹ Obviously, for those patients whose periods of depression extend beyond normal limits or those for whom suicide might be a possibility, psychiatric help is definitely indicated. Indeed, no manifestation of depression should be viewed lightly. Nor should there be a lessening of attention to those who seem not to be depressed. In an effort to meet the expectations of others or to conform to hospital routine, an occasional patient gives the illusion that he is not depressed. This may mislead doctors and nurses into believing that he is taking his misfortune in his stride. Other patients manifest depression by an appearance of marked elation.

Dependency. After the onset of a disability a patient needs time in which to recognize and accept the reality of his situation. During this interim period that lasts longer for some patients than for others, much depends upon the manner in which he is handled by the rehabilitation team. Getting patients to accept and adjust to their disability and to regain, within limitations, their physical and psychological independence is the driving force of the rehabilitation team. But to facilitate this process and to motivate the patient accordingly, the aims and goals of each must be compatible. If the focus of the team is upon getting the patient to use his crutches, to learn to speak again, or to return to his home and job, while the patient's goals and needs lie in

¹ Menninger, Karl A., *op. cit.*, pp. 8-17; Cholden, Louis S., *Psychiatric Aspects of Informing the Patient of Blindness*, American Academy of Ophthalmology and Otolaryngology, Instruction Section, Course No. 221, 1953.

another direction, the rehabilitation process cannot get under way. Failure may be due to concerted efforts to help patients help themselves too quickly. In so doing, the dependency needs of many patients are not taken into account.

Where nurses' or doctors' own feelings about dependency reflect the negative social connotations of our competitive society, they are inclined to have a depreciatory attitude toward any behavior that is labeled "dependent" or "overdependent"—terms that tend to stigmatize. Besides patients from those cultures where dependency is not equated with weakness of character, there are those who must not only accept but be encouraged to accept a certain amount of dependency upon others in the period following the onset of a disability. This is a necessary step for many a patient in the process of coming to terms with his situation realistically. Obviously, the periods of physical dependency that may be necessary, differ according to the degree of disability. For those who are severely and permanently disabled acceptance of dependency is mandatory and much help is needed to cushion the shock. But even for those whose physical condition permits, forcing independence too rapidly may create psychological blocks. To scold them for leaning on others and for having dependency needs is only to add to the humiliation from which they are already suffering. There are also patients who should be allowed to regress now and then, though they are ostensibly regaining both physical and psychological independence, without being made to feel that they are failing themselves or the staff. Such periods of regression should be regarded as necessary plateaus during which essential consolidation of gains is taking place. Positive interpretations of dependency should be made on these occasions and should be utilized to give extra support and understanding, and to prevent patients from pushing beyond their capacities or from becoming discouraged.

A patient who denies that he is dependent on others, when in fact he is, or who tries to conceal his needs by doing everything possible for himself, only delays psychological adjustment to his condition and his environment. He requires a different approach from the staff. Instead of aiding and abetting his denial by exces-

sive praise of his courage and initiative—a device that only serves to postpone the day when he must face his disability realistically and accept it—members of the rehabilitation team should tactfully help him re-evaluate his concept of dependency and to view it rather as a salutatory asset.

The Physician's Attitude Toward Disability. Another barrier to rehabilitation, but one not always recognized, may be more directly related to the doctor than the patient. Sometimes, unfortunately, the patient is not informed of the nature or extent of his disability because of the meaning this particular type of disability has for the physician. If it has special symbolic or emotional importance for him, he may be unable to handle the situation objectively. Unwittingly, therefore, he may prevent patients from facing their problem and beginning rehabilitation.

A surgeon in charge of a tumor clinic had an iron-clad rule never to inform a patient that he had cancer. The surgeon also instructed his staff that neither by word nor expression should they reveal the fact. His stated reason for never informing patients of the diagnosis was expressed in these words: "I am not going to have any of my patients jump out of a window because I tell them they have a cancer! It happened once and it won't happen again."

Such an inflexible rule can operate to the serious disadvantage of a patient, as it did in the following instance. A woman had undergone a resection of the left mandible (lower jawbone) for a malignant tumor. Subsequently plastic surgery was done for cosmetic purposes, and hence she was interviewed by the writer in the course of the research project referred to earlier.¹ Members of this project had been forewarned of the surgeon's rule. In answering such routine questions as "How did you happen to undergo plastic surgery?" the patient explained that she had had a cancer. When the interviewer inquired, "How do you know; did the doctor say so?" the patient replied that the doctor had told her she did not have a cancer, but from the symptoms, from what she had read, and from other clinic patients she had talked with, she knew she had had a cancer.

¹ See p. 24.

Some months later the surgeon appealed to us to try to persuade his patient to come back to his clinic immediately for a checkup. She had ignored a number of requests to do so and in her case recurrence of cancer was almost inevitable. At our next interview with her the subject of a checkup was broached. The patient explained that she had not returned to the tumor clinic because she was afraid of what the clinic doctors might find. She had begun to have recurring symptoms about which she was extremely apprehensive. She said, "But when I get nervous I keep reminding myself that the doctor assured me I did not have cancer, and then I go out and have a few beers." Though the patient suspected the truth, she now utilized the authoritative-ness of the surgeon's statement to give her courage and to help her believe what she wanted to believe. Furthermore, she used it as an excuse for not returning to the clinic and facing what she feared. The project workers do not know what happened to this patient, for she subsequently failed to keep her appointments with them.

Still another barrier to rehabilitation is the physician who refuses to admit either to himself or to the patient that there is no hope for further improvement through any means that he knows of. Such an admission, to him seems a reflection on medical science and his professional competence. Rather than presenting the patient with the true facts, he becomes vague and evasive. Unwittingly, he fosters false hopes by allowing continued visits to his office or alluding to possible medical discoveries in the near future. Aware or unaware of his real reasons for his actions, he rationalizes his actions on the grounds that it is better if patients do not lose hope. The end result is that the patient is prevented from accepting his disability and beginning the process of rehabilitation.

For the most part, motivations for shielding patients from painful truths are humanitarian. The profession of medicine is dedicated to the relief of suffering, and if, by withholding the truth, additional and unnecessary suffering can be avoided, it is considered justifiable. On the other hand, at times it is more humanitarian to inform the patient of the true facts. An ophthalmologist

knew that a patient who had lost the sight of one eye would lose that of the other eye in three to six months. He did not divulge this information and admonished the nursing staff against doing so. Yet, as one of the nurses observed, "Think of how this time could be used by the patient to prepare himself for total blindness! He might begin to learn to read Braille or to do many things which would give him a head start in adjusting more quickly to his handicap."

This doctor's motive was, of course, best known to himself. But it has been observed by Dr. Louis S. Cholden that the ophthalmologist whose special interest is the conservation and preservation of sight, often reacts emotionally to its loss in his patients or others. The physician may have so close an identification with a patient, Cholden suggests, that he feels as if he himself were losing his sight. This might explain some of the instances that were encountered "in which the doctor did not tell the patient he was blind, but postoperatively had the nurse inform the patient."¹

Hence, the "humanitarian" motive may be employed as a rationalization for a course of conduct that in the long run is not to the patient's best interest. Moreover, it may also be used as a means of avoiding painful self-analysis and perhaps more painful decisions.

The foregoing examples concerning physicians were selected because they point up sharply the direct cause-and-effect relationship between the practitioner's attitudes and feelings and the rehabilitation of patients. The implications for nursing, however, should be clear. Certain types of disease or disability may have equally strong emotional connotations for the nurse, and, therefore, consciously or unconsciously influence what she feels and does for the patient.

MINOR DISABILITIES

In considering the psychosocial aspects of physical disabilities, there is another area that we attempted to explore with students. It will be recalled that among the situations they described as "problems" were those involving patients who "overreacted

¹ Cholden, Louis S., *op. cit.*

emotionally to minor disabilities." What is a minor disability depends, of course, upon who is defining it. But used loosely, it can be a misleading term. In a large general hospital, where there is a wide range of acute and chronic illness and disability that can be classified according to degree of severity and complexity, students are quickly exposed to such relative terms as "major" and "minor," "serious," "critical," and "mild." Such labels provide a kind of measuring rod for making medical and nursing decisions.

It is not surprising, then, that nursing students tend to measure patients' needs, and their contributions to patients, on the basis of comparative severity of physical conditions or degree of helplessness; and to attach less importance to the care of patients with relatively benign physical disturbances, regardless of the significance of these disturbances for personal well-being. By the same token, they are disappointed when assigned to the eye, nose, and throat service, where they consider the surgery to be "less dramatic than in general surgery." Even their emotional responses toward patients appear to be influenced, though not exclusively, by the degree of physical handicap. A patient with a minor ailment is likely to be patronized, and if he complains about it, he may become an object of disdain or contempt.

From an analysis of students' responses at the beginning of the course to the kinds of patients toward whom they said they felt the greatest warmth and tenderness and toward those whom they felt the least, we were able to formulate a composite of two modal types. According to these types, one might expect to receive from the students the greatest amount of "tender loving care" if he was a "helpless new-born," or perhaps a "double amputee who though dying, was courageous and appreciative of the nurse!"¹ Conversely, only a modicum of attention could be expected if one was a "middle-aged upper-class woman with a minor disability about which she complained!"

Obviously, such extreme responses are not typical of the majority of nursing students; and our report to them of the modal

¹ The positive feelings of first-year nursing students toward helpless patients are partly related to the fact that the students' self-images are gratified by patients who allow them to see themselves in the role of the professional nurse.

types is received with a mixture of shock and amusement, yet not altogether with disbelief. It serves, however, to illustrate three important points we wish to make: (1) that the usefulness of the nurse to a patient can be measured only in terms of the individual patient, not in relation to other patients; (2) that while patients with "minor" problems may not be physically incapacitated, they often have psychological needs that should be taken into account; (3) that even what is referred to as "minor surgery"—an erroneous term if one believes that for most patients no surgery is minor—can be psychologically traumatizing.

For further elaboration of these conclusions and to impress upon students their importance, Dr. Lester L. Coleman, a noted otolaryngologist who is attending physician at the Manhattan Eye, Ear and Throat Hospital in New York City, was invited to speak to the students. His studies of the role of fear in such common operations as tonsillectomies has added so greatly to our insights, that his lecture is presented as Part II of this chapter.

Part II. Psychological Implications of Tonsillectomy¹

For many years in the practice of medicine, I have noted with growing concern the increase in the number of patients who come to my office overwhelmed with fear and anxiety completely out of proportion to the severity of their illnesses. Minor, relatively insignificant disease seems to catapult many of them into an emotional tailspin by the propulsive force of their unreasoning fears.

Physical complaints or illness usually motivate the patient to come to the doctor's office, and the newer drugs and techniques of today make it easier for the patient to recover. Yet I note that while the actual physical disease is being controlled, there is frequent subtle evidence of fear and anxiety. This fear may be far more destructive and devitalizing than the disease itself. Sometimes it seems to dominate his behavior long after the illness has been conquered. This anxiety is not characteristic of any one sex or age or of any one occupational, social, ethnic, or religious group. The timid, the stoic, and the stalwart seem to be equally

¹ A guest lecture by Lester L. Coleman, M.D.

affected by an overlay of fear about the illnesses they have or, more often, think they have. There may be variations in the intensity of the anxiety and the ease with which it can be alleviated, but no one appears to be completely free from it. Patients—children, adolescents, and adults—are afraid, just afraid. Their fears as well as their illnesses determine how quickly and how well they will be reestablished in their schools, jobs, or homes.

Fear in itself is an illness. The fear that we physicians observe in our offices is actually a communicable disease. It is not transmitted by germs or by viruses; it is transmitted by humans to humans, sometimes unwittingly, sometimes in error, and sometimes purposefully. It seems to flourish in epidemic form in this harassed twentieth century and has slowly insinuated itself into every facet of our civilization. Fear of all diseases—heart, cancer, tuberculosis, arthritis—fear of cataclysmic destruction by atom bombs, fear of economic upheaval, even fear of the consequences of smoking, all become a never-ending bombardment against our inner security.

If we were to believe all the distorted, fear-provoking statistics spoon-fed to us through every medium of communication, this is what our destiny would be like: By 1968 one out of every five of us would be dying of cancer while one out of twenty of us would be in a mental institution. We probably would be visited from time to time in the hospital or asylum by one of our children, a victim of cerebral palsy or polio, while our second child would be at home, ill with rheumatic fever. The third child would, under these circumstances, be forced to go to his psychoanalyst alone. Mind you, this could only happen if we were fortunate enough to have escaped the ever-compounding effects of heart disease, tuberculosis, arthritis and cigarette-smoking, and if we had not been previously destroyed by Fourth of July or Memorial Day accidents! Now combine this picture with the new fear of the atom bomb, economic upheaval and total war, and perhaps only then can you appreciate the impact of fear and anxiety in our day-to-day existence!

If we were to follow the dictates of all the fear-provoking propaganda, our day would be something like this: We would

awaken and go straight to the bathroom. We would look in the mirror to see if our gums were bleeding. We would investigate our complexions and eyes to make sure that they were clear. Then we would look closely at our tongues to check that they were not coated. Women would feel their breasts for "lumps." The urine would be examined to be sure that it did not have an unusual color. The skin would be inspected for rashes. The heart rate would be counted. Finally, we would take our temperatures. Then we would make elaborate preparations to assure ourselves that we would not slip and fall in the shower. After we emerged safely from our shower, we would be prepared to live another day, fairly certain that we would be free of physical ailments until the next day. That is, if we were cautious at intersections, kept "regular," and cut down on cigarettes. Preposterous, isn't it! Yet there are literally thousands who follow these dictates of fear with a religious fervor, hoping that their day-to-day existence will continue uninterrupted despite the propaganda that makes them an inevitable "one out of five."

The alleviation of fear and anxiety by the nurse and by the physician is easily as great a contribution as any therapeutic technique that we are capable of using. Should you and I, the combined medical team, fail to recognize that fear and anxiety are far more devitalizing than the disease that actually presents itself, then we will only deprive ourselves and our patients of the true benefits of medicine.

Let us consider, for example, the fear and anxiety that are so often the accompaniments of an operation that is generally considered "minor," and which hundreds of children undergo each year. Here is a golden chance for us to convert what can be a psychologically traumatizing experience into one of growth and accomplishment. In most instances tonsillectomy represents the first and only admission of the child to a hospital and is the first painful separation of the child from its home and security. The effect of this precipitous dislocation of the emotional security and happiness of the child is the basis for our study. The universality and frequency of the operation have made many of us lose sight of its potential in affecting the emotional adequacy of the pa-

tient. The data that we have accumulated both from our own experience and, more significantly, from that of established neuropsychiatrists, are terrifying evidence of distortions in adult personality directly traceable to improperly handled childhood surgery. For personal substantiation you need but inquire into the recollection of your own tonsillectomy or inquire of your friends who will pour out revelations that are often distressing in magnitude. The fact that one may have forgotten the experience in no way minimizes its traumatic significance. The analytic student might even claim that this very amnesia is part and parcel of the blockading pattern so responsible for adult neuroticisms.

Let us arbitrarily create a typical composite of the preoperative and postoperative story of a tonsillectomy. (It could be that of any operation: the removal of teeth, the repair of a hernia, corrective surgery for a clubfoot, or the straightening of eyes.) Note how closely your own personal experience, with time and space variations, fits into this story. Note further that, although the details may vary, the character of the impact is constant and becomes more clearly defined in retrospect.

The child is first brought to the otolaryngologist by a terrified parent who has for some time been resistant to the possibility of an operation. Since the operation is an elective one, all conceivable rationalizations have been used to avoid subjecting the child to surgery. When the child arrives at the doctor's office, usually under protest, examination is made by the otolaryngologist who sincerely tries to develop a pleasant relationship with him. Failure to establish this rapport can sometimes be traced to a lack of understanding of his inner terror. We must not forget that often the child who is seemingly well behaved is the very one who is suppressing the greatest fear. All surgical indications being present, an operation is advised, a date set, and arrangements for an apparently casual experience for the child are thought to be complete.

Except in the rare instances where parents and surgeon are attuned to the importance of careful psychologic preparation, the stream of injustices to the child now begins with a frightening

impetus. The child is given the impression that on a particular day a new and interesting experience will take place. At this point there are limitless variations to the parents' pragmatic lie. A visit to a relative; a new toy; or unlimited ice cream in a hospital may be part of the unplanned approach. Even worse, perhaps, is the "wonderful surprise" approach which melts into terrifying nothingness when the child first realizes the obvious trickery.

The child's right to fantasy cannot be denied. His anticipated joy becomes a dream with a rude awakening when he finds himself on the designated day suddenly confined to a hospital room, certainly far removed from the scene of his imagined pleasure. Strange, serious, white-robed people are milling about him. Just as he is becoming aware of the series of tricks that led to this incarceration, he is immediately undressed and at a confusing time of day placed in bed. This magnifies his sensation of capture. Add to this the picture of the drawn and tense mother who is wondering whether her decision is right and who is already chastising herself with guilt for inflicting all of this on the child who seems to look so particularly healthy to her at this moment. It is exceedingly difficult for any of us to comprehend the true impact of such terror, confusion, and disappointment for the child, and evaluate its disastrous sequelae. There is the immediate resentment at having been lied to and tricked into a situation. Then there is the painful distrust the child suddenly feels for the parent, a distrust which may well negate all the previous support and protection and kindness offered by the parent. Years of compensating kindnesses are often necessary to "buy back" the altered relationship.

It is most unfortunate that at this time of the child's greatest need the parents are least qualified to offer solace and comfort; rather, they reflect by appearance and gesture their own personal apprehension and concern. We must remember the parents' concern is not only concern for the child but a reemphasis and a revivification of the pain of their own childhood tonsillectomy. The fact that their own experience may have been blockaded or entirely forgotten up to this very time makes the combination of recollection and reality even more severe for mother and child.

Deprived of his breakfast with no adequate explanation, the child is now subjected to the further indignity of rectal temperature taking and preliminary injections. These, coupled with disappointment and pain, are too many insults for him to accept gracefully when improperly prepared.

Now we are ready for the next exciting chapter. Without preliminary warning one or two persons, the operating room attendants or nurses, gentle and kind but at best strangers, pick up the struggling child and whisk him away from the mother to an unknown destiny. His entire life has been attuned to that vague yet definitely all-encompassing thought, security. Here, then, is a sudden precipitous break in a relationship between child, mother, family, security, and dependence. At this particular moment there is no reason why the young child can anticipate ever being returned to his parents. The purpose of this separation has not adequately been described, nor has he been given sufficient substantiation of the fact that the separation is to be but a temporary one. The implicit trust of the child in the parents and the belief that in their presence no harm will befall him can be unalterably shattered at this moment.

Can we possibly project ourselves into that terrifying moment when first this child enters a strange white-walled, instrument-filled operating room? Before he can fully accommodate himself to this picture, a new terror descends upon him. He is now again undressed, overpowered and restrained, and anesthesia begun. Do we who have witnessed this struggle adequately appreciate the effect that this moment of terror has upon the impressionable child? He leaves his conscious state struggling against uncontrollable forces, with a great awareness that parents and life have deserted him. The temporary although significant struggle between the conscious and the unconscious during the early stages of anesthesia is tantamount to the experience of death. Up to this point the child has not had one single bit of evidence that he will ever return to life and to the normal relationships that preceded this ghastly experience. Is this cataclysmic happening compatible with all the training and preparation and infinite investment in our children's destiny and security? It is always particularly

interesting to witness at this point the orderly who feels personally insulted when the struggling child does not acquiesce more gracefully to force and anesthesia.

Is this pattern of emotional reaction typical of all children? Psychiatrists and experts in child behavior problems tell us that it may well be considered usual and expected. There are some few children who are so emotionally well oriented as to experience this trauma without immediate or even eventual alterations in behavior. There are others who fail to show any early effect of the experience but subordinate it, only later reflecting its real emotional significance; witness the frequency with which adults recount with various degrees of emotional intensity every detail. It is true that the child may go to the hospital willingly, but let us not be deceived by this apparent calm and submissiveness of the child.

It has been fallaciously noted that the timid or even obstreperous child can best be managed in the hospital when the parents are not present. Therefore, we arrive at the naive deduction that a hospital stay with parents barred is highly successful. But for whom? Perhaps for the efficient administration of the intricate hospital routine, but certainly not for the emotional balance of the sensitive child. We dare not accept his apparent docile resignation as a true index of the emotional state of the child. Inner and suppressed fear must not be mistaken for acceptance of a painful situation. Overwhelming terror often makes vocalization impossible. What chance has a four-year-old against the all-powerful, white-robed army that surrounds him?

Because of administrative procedure, one major hospital insists on the following: A child is brought to the hospital the afternoon before the operation and the parents immediately dismissed. No contact between parent and child is permitted for forty-eight hours until they are reunited on the second morning. A smile of welcome is hardly compensation for the horror of the child's experiences. The parents' complete ignorance of actual details does not minimize the import of this severe emotional trauma to the child. One child, in her anguish, epitomized the whole nightmare by the surprising statement to her father who

called for her, "I thought you didn't want me." Review the significance of this painfully poignant statement, and note the mounting connotations of the whole discussion.

The immediate or delayed reaction to this surgical procedure may be one of many alterations in behavior: family antagonisms, negativisms, night terrors, hostilities, phobias, obsessions, or other psychoneurotic manifestations. The impact of tonsillectomy may be but the trigger mechanism that is disastrous to an already sensitized personality. Since this procedure can be anticipated, the damage can be remarkably reduced with comprehension, education, and planning. Inasmuch as the medical and emotional happiness of the child may be predicated on this single experience, the preservation of stability falls directly in our province. It is distinctly the responsibility of all physicians, nurses, and personnel involved in the ultimate health of the patient to become more aware of the psychosomatic aspects of disease if we are to maintain the emotional integrity of the child entrusted to us. Were we able, in all instances, to avoid imposing a tonsillectomy on a child, the ideal would be attained. However, since there are specific indications for this important operative procedure, we must devote ourselves to both the surgical and emotional aspects of the problem.

The established criteria for tonsillectomy vary but slightly with each school of otolaryngology. To these must be added the significant indication of an optimum age for operation. The exact age may vary somewhat with each child, but the common denominator should be the child's ability to understand the necessity for the operation. It is a decided misconception to believe that the child of one or two years tolerates an operation better because "it doesn't know what is going on." The very use of the word "it" indicates failure to recognize the fact that the one- or two-year-old "it" is a functioning organism subject to psychic trauma. The emotional dependence of this age group is even greater since there is no conscious awareness by these young children of other than home experience. Therefore, their need for sustained security may be even greater than in the older group who are able to adjust more easily. The further difficulty with

children under three-and-a-half years is that they are as yet unable to verbalize their fears.

Preoperative and postoperative preparation is the responsibility of the surgeon. The responsibility of the nurse is to help maintain the patient's emotional stability. Psychic trauma must be as significant a surgical consideration as hemorrhage or infection. The warmth and understanding that the nurse offers to the child (and to the parents) can prove to be a most vital supporting contribution during this period. The child must be approached on an honest basis with a sincere effort to obtain a tangible hold on his trust and confidence. No matter what the psychologic structure and background, the child can be approached and his friendship earned by patience, kindness, and understanding. Time is the one significant variable in establishing the patient-doctor relationship. Every extra moment previously spent in establishing a gentle friendly relationship is rewarded, from the point of view of the surgeon, by the child's trust at the time of his departure for the operating room and in his quiet acceptance of the anesthesia. The established faith only later becomes manifest in the sustained doctor-patient relationship, important but not really as significant as the unaltered child-parent relationship.

To obviate the psychologic pitfalls associated with tonsillectomy, the following salient steps are recommended:

1. The child must be given a calm, forthright, and honest explanation of the reason and need for the operation. He can be told that he will have fewer colds and consequently more time for his favorite play activities. There should not be any idealization of the postoperative joy that follows. It must be explained that a certain amount of pain is one of the unavoidable but tolerable aftermaths.

2. The child must be spared the tension and anxiety reflected by the attitude of the parents. Discussion of the operation should be limited to times when the child is not present until purposeful exposure is desired. It is suggested that the four- or five-year old not be told until a day or two before the operation.

3. The element of surprise and confusion should be avoided. A simple but recognizable picture of a hospital, operating room,

and white-gowned nurses can be described. The picture can even be made pleasant by adequately explaining the need for white and cleanliness.

4. The reason for anesthesia to spare the child pain during the operation needs to be explained. Assurance that the forced sleep is of short duration, is very comforting.

5. The presence of one or both parents during the immediate preoperative and postanesthetic period is essential, and the constant presence of one parent during the entire hospital stay is the greatest single contribution to the maintained security of the child. The use of toys and affection as ingratiating techniques differ from parent to parent but each generally knows what methods work best.

6. The separation of the child from the parents should be recognized as one of the most traumatizing of the entire experience. These terrifying and destructive few moments can be materially attenuated if the physician himself calls for the child and escorts him to the operating room. Armed with an already established patient rapport, the doctor can make the child-family separation more tolerable, even though basically difficult. A strange operating room attendant serves no pacifying or soothing function at such a time.

7. The child should be permitted to manifest overt hostility during the postoperative period. From his point of view an injustice has been done him. Pain has been imposed on him; he feels unnecessarily hurt. There is no apparent pleasantry or compensation for the entire unhappy experience. It is a natural tendency to insist that the child remain quiet and not voice his objection or cry for fear of irritating his throat. Actually, such suppression is so fraught with subsequent psychologic danger that he must be permitted to vocalize his objection to this imposed annoyance.

This realistic portrayal of the emotional aspects of tonsillectomy is not meant to be pessimistic or foreboding, nor is it meant as a reflection on an operation which is health-restoring and constructive, when such need is indicated. Rather, this portrayal is meant to illustrate and emphasize the fact that many

childhood and adult neuroticisms can be traced to poorly planned tonsillectomy and other elective surgery.¹

Part III. Life Situations and Illness

A final topic for consideration which is useful for nursing students is that dealing with the patient whose physical complaints are primarily related to social, psychological, or cultural stress—a relationship that has been well established.² Pressures from life situations may become of such magnitude that one reacts to them by developing a whole series of somatic symptoms. Regardless of the etiology, the physical symptoms are no less real for the individual, and if he is not aware that they are emotionally induced, he goes from doctor to doctor in search of relief. In such instances, if the physician makes no attempt to familiarize himself with those aspects of a patient's life that may be stress-producing, he is likely to involve the patient in medical and even surgical procedures that are unrelated to the real problem. These facts are clearly illustrated in the following case history.

A man, thirty-four years old, of Italian-born parents, consulted his family physician with the following complaints: loss of eighteen pounds in weight over a three months' period; pains in his legs; dyspnea and gasping when walking upstairs; moist and tremulous hands; and feelings of exhaustion. He was referred to a chest specialist, who x-rayed his chest and reported the findings as normal. He was next examined by an orthopedic surgeon who found no evidence of any relationship between the mild poliomyelitis which he had had at the age of three and his present complaints.

¹ Readers who are interested in exploring Dr. Coleman's thesis further are referred to an article and a book from which this lecture was adapted: "The Psychologic Implications of Tonsillectomy," *New York State Journal of Medicine*, vol. 50, May 15, 1950, pp. 1225-1228; and *Freedom from Fear*, Hawthorne Books, New York, 1954.

² See Wolff, Harold G., "Life Situations, Emotion, and Bodily Disease" in *Feelings and Emotions*, edited by Martin L. Reymert, McGraw Hill Book Co., New York, 1950, pp. 284-324; Wolff, Harold G., *Stress and Disease*, Charles C. Thomas, Springfield, Ill., 1953; Alexander, Franz, *Psychosomatic Medicine*, W. W. Norton and Co., New York, 1950; Hinkle, Lawrence E., Jr., and Wolff, Harold G., "The Nature of Man's Adaptation to His Total Environment and the Relation of This to Illness," *American Medical Association Archives of Internal Medicine*, vol. 99, March, 1957, pp. 442-460.

Since his breathing was difficult, he was next referred to an otorhinolaryngologist, who found that he had a deviated septum with marked nasal obstruction and a chronic sinusitis. Because there was also a slight external deviation of the nose, the patient was referred to the plastic surgery clinic for surgery. As part of the routine for research and screening purposes, he was seen by the social scientist although his operation had already been tentatively scheduled.

The facts of the patient's medical history were thoroughly reviewed. Then he was asked directly, "What is it that you are most worried about?" He replied with a grim smile, "Well, I'm in a jam. Frankly, I think a lot of this has to do with worry. I haven't slept for the last four weeks. There are a lot of obligations that I have to meet in order to avoid criticism."

The patient was a clerk who had been gambling for the past twelve years. He had incurred heavy losses which he was trying to "cover" by borrowing, and gambling again in a desperate effort to recover his money. He had been pressed by the bookmakers to pay his debts, and was forced to borrow money from his brother, who had criticized him severely for his recklessness. He also borrowed money from the credit department of the office in which he worked and was afraid of losing his good standing, possibly his job as well, if he did not repay his loan promptly.

One of his chief worries was centered around his wife. He tried to conceal from her not only his debts but his gambling as well. He wished to confide in her but since she had once had a nervous breakdown, he felt she could not tolerate any emotional shocks. He also dreaded having his parents learn of his troubles as this would incur their strong disapproval. He began to lose his appetite and could not sleep. His weight fell, he felt weak and developed a number of somatic symptoms which further aggravated his concern over his health. He feared he would not be able to hold his job, and therefore might be unable to meet his financial obligations. The more he worried, the more his physical symptoms increased. He became depressed, irritable and unsociable, withdrawing even from his wife and children, which caused him to feel intensely guilty. Recently he had contemplated suicide.

There seemed to be little doubt that the patient's physical complaints were psychogenic, and that an operation on his nose would not only fail to relieve his distress, but might conceivably add to it in terms of physical trauma and additional expense. It was suggested that treatment of the psychiatric condition was of predominant importance, and the operation was cancelled. The

patient was gratified by this decision and stated, "For the first time in years I've been able to unburden myself. What hurts me more than anything is that I have had to fight this all alone." When asked if he had told his story to any of the doctors, he replied, "No one has asked me about my feelings or if I'm worried about anything. They have only given me tests and vitamins. I realize now that this operation wouldn't solve my problems."

He was then referred to the psychiatrist for treatment of his anxiety and the psychosomatic complaints, and for the purpose of uncovering, if possible, the underlying causes of his gambling. Psychiatric examination revealed that the patient's father was affectionate but very strict with his children, and constantly preached to them the importance of moral values and economic security. He emphasized careful planning for the future and avoiding risks. He abhorred gambling, especially betting on horses. He allowed the patient, his oldest son, very little freedom of choice in social activities, and would not permit him to study law because he thought such a profession was economically hazardous. The patient, who was deeply attached to and dependent upon his parents, was highly sensitive to their criticism. He was obedient and submissive to them until the age of eighteen when he began to rebel inwardly against his father's domination but remained outwardly compliant. He particularly resented his father's interference in his relationships with women and his choice of a profession.

For the next four years he tried making his living at various jobs that his father did not approve of. At the age of twenty-two he finally surrendered to his father's wishes and entered the civil service. It was at this time that he began to gamble. He was faintly aware that his gambling represented in part a rebellion against parental authority and an assertion of independence, and that it was necessary to keep it a secret from his father. Initially his gambling consisted only of cardplaying, usually for low stakes, and he rarely lost more than two dollars at a time. However, his repeated losses spurred him to play for higher stakes.

It is of interest that the consistency of his bad luck was no deterrent; he gambled recklessly almost as if to punish himself unconsciously for disobeying his father. He stated that he believed one's losses and gains would eventually be equalized. Though he was losing money he was aware of the fact that he derived a certain satisfaction from betting which he could not explain since in all other respects his life was "upright" and conforming. When his parents eventually discovered his card-playing, he turned from cards to horses and bet on them secretly for many years. When

the "bookies" eventually threatened him for the remaining sums he owed them, he became "paralyzed with fear" and even contemplated suicide. He saw no way out of his difficulties and began to feel that the possibility of being sent to jail would almost be a relief, "for then my problem would be out in the open." He developed a severe anxiety state. When his failing health became serious, he was finally forced to seek medical attention.¹

In this patient we are dealing with a severe anxiety neurosis, secondary to a reality crisis brought on by compulsive gambling. Failure to recognize the basic problem delayed the essential treatment for over three months, which intensified his psychosomatic manifestations. The factors that produced the anxiety state were largely sociological and psychological. Outwardly a conformist who prided himself on being a good son, husband, and father, as well as a reliable employee, the fear of losing his status in all these categories proved overwhelming to this patient. The family disorganization, for which he felt responsible, produced in him enormous guilt-feelings. Since he could not confide in anyone in his family, without fear of incurring severe disapproval, he began to isolate himself from them and escape into illness. Because of the deduction each payday of part of his salary, he saw his family deprived of necessities, the true reason for which he was unwilling to reveal. Essentially a dependent person who needed support and encouragement, he felt completely helpless and isolated and could not face alone the prospect of four additional years of deception, economic deprivation, and fear of discovery. As he was devoutly religious, he had further conflicts over the moral implications of his behavior. He would have welcomed going to jail as his due punishment, or escaping from responsibility through severe illness; failing these, he even contemplated suicide. The reason he gave for not killing himself was that he felt this would only intensify the suffering of his family. His fear that he could not hold his job any longer because of his physical symptoms

¹ This case history was first published in *Psychosomatic Medicine* (vol. 12, September-October, 1950, pp. 285-286) as part of an article entitled "Screening Patients for Nasal Plastic Operations: Some Sociological and Psychiatric Considerations" by Frances Cooke Macgregor and Bertram Schaffner. It, together with the discussion that follows, is reprinted here in substantially the same form, with the permission of Paul B. Hoeber, Inc., publisher of the journal.

eventually led him to seek medical help. Since one of his complaints was difficulty in breathing, and his psychiatric difficulties were not yet recognized, he was referred to the plastic surgery clinic and scheduled for surgery.

The patient had two long sessions with the psychiatrist, the first primarily for diagnostic purposes and the second for interpretation and planning for long-term management. The psychiatrist explained the relationship between the patient's anxiety and his physical symptoms, tracing its origins in his ambivalence toward his father, with the need to be independent and the fear of losing his father's approval. He also interpreted the compulsive nature of the gambling. He tried to modify the patient's attitude toward his job, pointing out the desirability of the security of a government position in his particular situation. Thereafter, the patient was followed for the next twelve months by the social scientist. While her function was not intended to be therapeutic, her original contacts with the patient had provided him with his first opportunity to talk out his problems; this afforded him tremendous relief.

Within one month after the initial interview, the patient's depression and anxiety had decreased markedly; he stopped gambling and felt better able to assume his financial obligations. He no longer had the physical symptoms of dyspnea, though he still complained about weakness in his legs on payday. The tension between him and his family subsided and he began to resume his role of husband and father for the first time in six months. Eight months later, his demeanor was markedly changed: he appeared calm, more controlled, and extremely relaxed. He had gained twenty pounds. By steady payments he had decreased his debt by \$400. He had also been able to admit his plight to his wife who took a sympathetic attitude toward him. He said, "I now have a different outlook on life. Now when I'm broke I don't get panicky and think I have to do something drastic; I just wait for my next paycheck."

CONCLUSION

In presenting students with the kinds of illustrative material just cited, we are careful to stress the fact that it is neither ex-

pected of them nor desirable that they should attempt to become amateur psychiatrists or psychologists. The hazards from quasi-therapists of any kind are, or should be, well known. Many people have deep-seated anxieties, and for the most part are able to live with them. It is not the function of the nurse to attempt to uncover or to treat such anxieties, though she should certainly be alert to their existence and their possible relationship to the patient's illness.

More appropriately, the nurse should be prepared to recognize the "situational" anxieties that are generic to the fact that the patient is in the hospital because he is sick or is to have an operation, and also that he may be worried about his family, his job, or other matters. Needless to say, hospitalization can accentuate or add to the patient's life problems and anxieties; and it is this superimposed stress that the nurse should be equipped to alleviate or lessen. She should be able to deal intelligently with this particular segment of the patient's problem—his pain, fright, and worries—and to do so from the time he enters the hospital to the time he leaves. She should find satisfaction in the contributions she can make to his comfort by helping him feel less frightened and helpless.

Focusing on goals of this order in nursing education would, it seems to us, place in proper perspective the functions of the nurse. If this were done, less time might need to be spent in trying to reduce frustrations of students who feel that *they* should have been able to do more about the kinds of problems that should properly be reported to the social worker, psychiatric nurse, or psychiatrist. For most patients the complexities of their lives are not eradicated within the hospital. Yet encouraging nursing students to use the methods and tools of psychiatry—which are only half-learned and hence can be used but amateurishly—only creates greater frustration because they do not see the results they think they should obtain. More serious is that in attempting to apply psychiatric techniques to patients who have deep-seated problems, harm rather than good may result. If psychiatric treatment is indicated, it lies within the province of the psychiatrist.

If we warn students of the dangers inherent in attempting to take on the role of psychologist or psychiatrist, why do we present

them with some of the concepts and principles discussed in this chapter? Our contention is that since nurses today are enjoined over and over to *listen* to the patient, they should be sufficiently knowledgeable and free from emotional blocks to *hear* what he is saying. This is quite different from listening with an ear that is not tuned in on the same wave-length. While listening without a trained ear may conceivably have some therapeutic value for the patient, an untrained ear, by hearing only part, blocks off important avenues of communication.

In addition to emphasis upon listening to patients, an increasingly important part of nursing education today includes instruction in how to teach patients and their families matters of diet, medication, exercise, the care of the new-born, and so on. Teaching is an essential skill demanded of professional nurses as physicians find themselves progressively less able to cope with more and more patients. Successful teaching, however, requires that the nurse be able to recognize and deal with situations complicated not only by language and educational differences, but a multitude of other and more subtle factors that can, unless perceived and understood, obstruct her efforts. But the nurse can neither listen to patients who need to be listened to, nor teach patients who need to be taught, if and when she is reacting to them in a manner reflected by such statements as the following:

I feel angry toward the extremely emotional individual who magnifies minor problems into major crises.

I feel frustrated when I see that a patient's physical or mental problems are insurmountable by me because such a situation seems practically hopeless.

Teaching a patient who does not want to learn, is very trying.

I feel angry when a patient who has convalesced completely still refuses to do anything for himself.

No matter how technically proficient she is, a nurse cannot fully realize the goal of total patient care so long as she and the patient are at the mercy of her own emotionally undisciplined reactions.

In sum, then, it is our experience that nursing students' awareness of some of the sociological and psychological dynamics involved in adjusting to illness or disability is essential for the following reasons:

1. If the reasons for patients' reactions and behavior are better understood, more intelligent care can be administered.
2. Psychological insights into one's own emotional reactions and attitudes toward disability are as essential in working with the sick as is the need to understand what the disability means to the patient.
3. Though the nurse may not be sufficiently trained to analyze and interpret the more complex psychological mechanisms involved, the knowledge that one or more of them may be operating, can help to alleviate or reduce her own feelings of frustration, guilt, or failure.
4. If she realizes that in those situations that demand time and patience she need not take heroic measures in order to fulfill her role as a nurse, she may shift her energies to concentrating on short-term goals and find satisfaction in attaining them. This is of particular importance for the young nursing student who tends to become impatient or discouraged with those who have long-term illnesses, but who will be faced in the future with an increasing population of aged and chronically ill.
5. With sufficient knowledge and awareness to recognize a complex behavioral problem or deep psychological disturbance, she will know enough not to try to handle it but to bring it to the attention of the proper agencies or medical personnel.

Chapter 7

Authority

THUS FAR IN THIS SECTION of the book we have largely dealt with social science concepts that have particular relevance for understanding the behavior and attitudes of patients. But effective patient care requires more than this. It is also contingent upon—indeed, sometimes at the mercy of—the kinds of interpersonal relationships that exist between staff members. Therefore, if the nurse of the future is to provide increasingly better care and to derive optimal satisfaction from her work, it is of prime importance that she be able to function effectively and find satisfaction in working with her superordinates, her peers, and her subordinates. This may greatly depend, however, on the way the nurse feels about, and reacts to, the authority system within which she must function.

In the inflexible organizational structure of the hospital (and even perhaps in the more flexible one of a public health agency), the nurse will inevitably be in a position of authority with heavy and varied responsibilities, while simultaneously she will be responsible to authorities above her. Such essential restrictions demand certain special aptitudes and qualifications. Among the most important are flexibility of personality, a high degree of self-insight and inner security—in order both to exercise authority and to accept it—and the ability to work with doctors, other nurses, and auxiliary personnel, in different status positions. Not all nurses are so fortunately equipped, and those who lack these qualities frequently find themselves tense, dissatisfied, and drained of energy. Worse still, the care of patients, either directly or indirectly, is adversely affected. If this is to be prevented, nursing

education must provide an understanding of the dynamics of interpersonal relations and intrapsychic dynamics.

While most students enter nursing with the stated motivation of "wanting to work with people," their image of themselves as nurses is one of caring for patients and being in charge of them. During their first months in nursing school, however, they find themselves more involved in interpersonal relationships with those in positions of authority to whom they are directly responsible, namely, their nursing instructors, head nurses, and supervisors. Accepting and fitting into the authority system of the hospital with all this entails is, for a great many students, one of the major problems confronting them in the collegiate nursing school, especially during their first year.

In rather stark contrast to their experiences in college, where supervision and authority of instructors seldom reach beyond the classroom, nursing students are under constant observation and supervision. Time not actually spent within the classroom or in studying is devoted to learning through practicing in the wards. Schedules are inflexible, rules and procedures rigorously enforced, and mistakes regarded with gravity. Under the ever-watchful eye of head nurse, instructor, or supervisor, not only is the student's performance carefully noted and evaluated, but also her appearance, personality traits, and attitudes.

In many professions such supervision would be unpalatable; but just as it has been traditionally recognized and accepted as a necessary and integral part of medicine, psychiatry, and social work, so it has in the nursing profession. Both theoretically and practically the supervisory functions of the nurse are designed for the care and protection of the patient, as well as to protect other nurses in their professional role. According to seniority and hierarchical position, which presumably reflect education and competence, both power and authority are increased vertically upward from staff nurse to heads of departments, and ultimately to the doctor and hospital administrators. Students, of course, are at the bottom of the ladder since they have no authority unless it be delegated to them.

While the role of supervisor in nursing is not supposed to be that of inquisitor, nor is being supervised regarded as demeaning, the uninitiated student or the insecure graduate may think so. Her ideas may, unfortunately, be reinforced by contact with an authoritarian type of supervisor or educational system.

It is generally assumed that the very nature of nursing as practiced has traditionally attracted to it many women who seek and find security within a power system in which there are the strong—the hospital and the doctor—and the weak—the patients and the students. To what extent the emotional needs and attitudes of such nurses are basically characteristic of the authoritarian personality as others have described it, and to what extent they are the result of the rigid conditioning undergone in many hospital training schools, is not entirely clear.¹ Nevertheless, in their large reliance upon middle-class ideals and authority, these nurses demand, both of themselves and others, a type of conformity that is not always rational. Indeed, it is sometimes compulsive and irrational. Rigidly schooled in obeying and carrying out orders, in checking impulses to rebel, or to question or to use their initiative in working out alternate solutions, they are likely to be intolerant of other nurses who do not rigidly adhere to the rules.

At a staff meeting, supervisors were seeking assistance in handling what they termed a “problem of discipline.” It concerned a floor nurse whose behavior they regarded as inappropriate and unprofessional. For one thing, she was “too chummy with the doctors,” whom she frequently joined for coffee and cigarettes. One day she had been found sitting on the edge of a patient’s bed in friendly conversation, with her cap off! On another occasion she was discovered participating in a family party in a patient’s room, eating ice cream. With the performance of her nursing duties, the supervisors could find no fault. She was both efficient and prompt. She was extremely popular with patients, doctors regarded her with high esteem, and she got along

¹ See, for example, Adorno, T. W., and others, *The Authoritarian Personality*, Harper and Bros., New York, 1950; and Flowerman, Samuel H., “Portrait of the Authoritarian Man” in *Outside Readings in Sociology*, edited by Edgar A. Schuler and others, Thomas Y. Crowell Co., New York, 1952, pp. 111–118.

well with students and aides. She was not so friendly with the other staff nurses. In spite of her proficiency as a nurse, her demeanor suggested to the supervisors a disregard for conformity and professional conduct. This they found untenable. How to handle this situation, that is, "correct her behavior" or discharge her, was their problem.

Compelled as the authoritarian type of nurse is to submit to some higher power, she too is inclined to insist that those below her, particularly nursing students and patients, also submit. If she is unable to run the risk of being different herself, she not only is intolerant of but feels threatened by the nursing student who is too intellectual, too vocal, or shows too much imagination and independence of thought.

Reactions of Nursing Students to Supervision

Supervision and instruction, when in the hands of nurses of this kind, arouse considerable frustration and conflict in nursing students, and in some instances may produce psychological damage.¹ Equally harmful is the fact that those very qualities in the supervisors to which the students so strongly object, such as constant criticism, exactingness, and rigidity, are not infrequently perpetuated by the student herself upon graduation. Caught in the same power system and with similar personality needs and difficulties, she too may use the nursing student in turn as a target for her own anxiety, resentment, and hostility.

The autocratic nature of supervision, which in the past was considered a necessary function, is today viewed by an increasing number of nurses as archaic and unsatisfactory both to staff and supervisors. Moreover, many persons concerned with nursing administration believe that the role of supervisor as practiced in many hospitals must be drastically changed. Among the changes envisaged, and which are already being successfully initiated in some hospitals, are those that emphasize skill in interpersonal relations in working with staff. It must be noted, however, that

¹ For example, see Wyatt, Frederick, "Guidance Problems Among Student Nurses," *American Journal of Orthopsychiatry*, vol. 17, July, 1947, pp. 420-422.

clinical competence for the position of supervisor is a prerequisite both for maintaining the respect of the staff and for success in working through the process of interpersonal relations.

Obviously, in the education and training of a nurse, close observation and supervision of students are mandatory, not only for the protection of the patient but for the staff and hospital and for the student herself. Before nursing students can become fully cognizant of this fact and can accept it, however, many of them pass through a period of rebellion and resentment. If these destructive feelings cannot somehow be worked out before they are firmly entrenched, the prospective nurse is likely to become overly sensitive and to view *all* supervision as carping and motivated by the desire to find fault.¹ As a defense, some withdraw emotionally and intellectually. Though they make up their minds to "stick it out," they see their graduation as the fulfillment of an unhappy commitment which they do not wish to pursue further. A few even go so far as to leave school with the excuse, "I am sick and tired of being followed around like a high school girl." Others, who are just beginning to examine their own biases and prejudices, may find it more convenient to revert to their long-held attitudes which they see reinforced by the rigid and intolerant nurse. But whatever they do or think, they develop definite ideas and reactions to the authority system as it operates in training and practice.

At the completion of their first year in the Cornell University-New York Hospital School of Nursing, students in our course were requested to write their answers to two questions. (This assignment clearly revealed their feelings about supervision and prepared the way for class discussions of authority and authoritarianism.) The questions were these: What situations in working with patients or staff have you found most troubling professionally and/or personally so far? What situations have you found most satisfying? Among the situations most frequently cited in

¹ Many graduate nurses have reported to the writer that when informed that a head nurse or supervisor wishes to see them, their first thought is, "What have I done now?" Even an experienced head of a department, when told that an administrator wanted to see her as soon as possible, said, "Oh God, what have I done wrong?"

answer to the first question were those involving supervision and relationships with their superiors. Typical responses were:

It is unfortunate that we as nursing students must contend with staff members who have no respect for the fact that we are women with college backgrounds and intelligence; that we have the ability, maturity, and willingness to learn to accept professional responsibilities. I see no reason for the slurring remarks by doctors about our capabilities, nor for nurses to treat us like children. Why should we be given duties which do not further our knowledge in the nursing profession? Although I am ready to accept the task of damp-dusting and cleaning, I feel that this time should be spent in establishing better rapport with my patients and in reading their charts. When work on the floor is completed, I am sent around to clean trays, carafes, doilies, and so on.

When a head nurse continually follows nursing students around and criticizes every small detail, it becomes extremely difficult to do a good job. This produces strain, physically and mentally.

I have usually found it impossible to make suggestions for improvement without apparently incurring wrath or resentment. My position on the medical ladder is such that I do not dare voice objections. I also feel that such actions on my part would be reflected in my progress reports and in the attitudes of those more experienced than I am.

I was told not to ask so many questions which were not pertinent to my role as a "bed-pan pusher." This bothered me personally and professionally.

The student is made to feel that she is not an individual but just another nonentity working toward the gilded goal of getting the work finished efficiently and thoroughly so that the staff may leave the floor at the designated time.

A situation in which I feel extremely inferior is when I'm "called down" by a supervisor in front of a patient or another nurse.

A troubling thing about my first year was that most of the time I felt as if I were being treated like a six-year-old.

In reply to the second question, it was interesting to note that situations that students found most satisfying were those involving their relationship with specific types of patients, while examples of satisfying relationships with staff were noticeably lacking. In a

class of some seventy students, only four cited examples of satisfying or constructive relationships with staff.

My most satisfying experience in nursing occurs when I have been given a certain responsibility and have carried it out with confidence and dexterity. It is pleasant to have my head nurse assume that I have completed my work and have done a good job. She waits for me to report to her, instead of checking on me first. This helps me feel that others think of me as a responsible person.

I have found that the most satisfying part of nursing as a student has been on weekends when the staff really accepts us as needed members of the team and gives us a good amount of responsibility. This makes me feel more like a nurse doing an important job. We are given a chance to use initiative and think out our own problems.

When a patient has begun to ask me what I think about a problem I suddenly become confused. I find that asking a graduate or my head nurse usually helps.

I have a sense of satisfaction when I really feel that I am a member of the team. I mean when a doctor speaks to me as if I am a nurse, not just an ignorant, green student, completely lacking in responsibility or knowledge of nursing. Or when a nurse leaves me in charge of a patient who requires the utmost in comprehensive care, and is seemingly confident that I can do the task well.

The reactions and attitudes of first-year nursing students toward authority and supervision during this phase of their training program are not altogether surprising when viewed in relation to adolescent experiences and their total approach to nursing at this time. For, as is characteristic of their youth, they wish to be nurses quickly, and on their own terms. With a minimum of experience they judge the different services according to their needs and satisfactions. "A good service to work in," they say, "should not be too busy, like pediatrics and surgery; it should not be depressing like neurosurgery." Working with the chronically ill is "boring" because they can see no rapid improvement, and patients stay "too long" in the hospital. Yet in the ear, nose, and throat service, patients "don't stay long enough, and we don't get to know them." As for patients in general, they

should be “appreciative” of the nursing student; they should not know more than she does about their illnesses, and the student should be in full control of the situation. As for supervision—! Many of the attitudes are reflections of the professional immaturity and inexperience of the students and become considerably altered as they advance in their training program. But their feelings about supervision cannot be rationalized away so easily, for as one instructor of first-year students put it, “The way it has been, the needs of the instructors were met, not the needs of the students or the patients. We tried to fit all nursing students into a pattern that suited nobody but us. It’s ourselves we have to fight, not the students. Because we’re so regimented and autocratic, we can’t give an inch of leeway to somebody who doesn’t conform right down the line.”

The Supervisor's Position

The position of the nurse who supervises first-year nursing students—or more advanced students for that matter—is not always without difficulties. It is perhaps unfortunate, from an educational point of view, that nursing students learn their nursing procedures by working directly with patients. Clinical practice with people who are sick can go only so far. A point is rather quickly reached when the patient must be protected against error, faulty judgment, inept handling, and fatigue. The nursing student who is eager to practice new procedures and try out what she has learned may not always be aware of this fact. Nursing students are seldom aware either of the variety of other demands made upon supervisors, particularly in those institutions like the Cornell University-New York Hospital School of Nursing, where many also function as clinical faculty members. As instructors they are responsible to the School of Nursing, and as supervisors they are responsible to the medical and nursing administration. In addition, therefore, to teaching duties, they also have certain responsibilities in relation to staff orientation, to building service, pharmacy, laundry, record room, business administration, auxiliary staff department, x-ray department, and

numerous other ancillary services and departments.¹ Through the head nurse and other staff members, each supervisor is also responsible for the care of approximately 30 patients on her floor.² At times, understandably enough, "getting the work done" takes precedence over all else. Only when, as part of their senior experiences, nursing students are put in charge of a ward do they begin to gain some understanding of the complexity of a head nurse's or supervisor's job, and even this experience is usually limited in time and scope.

The professionally mature supervisor is not threatened by the occasional hostility and arrogance of nursing students, but recognizes and accepts those reactions as manifestations of the learning and maturing process. The insecure supervisor who is inclined to be authoritarian, however, may, as we have indicated, add to and perpetuate the initial reactions that students have toward authority.

If the hospital environment is to be optimally therapeutic for patients, it must be a peaceful one. As other studies have demonstrated,³ disharmony and tension created by poor interpersonal relations among staff members may have psychological and social repercussions that can aggravate sickness or delay recovery. To no less a degree misunderstanding and tension between nursing students and their supervisors may also adversely affect patient care—a fact that is recognized by perceptive students.

To clarify more fully the concept of authority and the necessity for supervision, we invited as guest lecturer, Dr. Bertram Schaffner, a New York City psychiatrist and psychoanalyst who was well qualified through his writings and experience as con-

¹ Since this text was written more appointments have been made to full-time supervisory positions for nursing service. Those with dual appointments, therefore, are released from many administrative duties. In addition, a plan of supervised clinical practice is under way whereby a fixed amount of time each week (15-16 hours) of student activities are *entirely* educationally oriented. During this time assignment of patients is made by the clinical instructor and guidance of student activities is directly under her.

² This would be the equivalent of one full-time supervisor having responsibility for sixty patients.

³ For example, see: Schwartz, Morris S., and Alfred H. Stanton, *The Mental Hospital*, Basic Books, New York, 1954, pp. 342-400; Dichter, Ernest, "A Psychological Study of the Hospital-Patient Relationship," *The Modern Hospital*, vol. 83, September, October, November, and December, 1954, and vol. 84, January and February, 1955.

sultant to many organizations to speak on this subject.¹ We reviewed with him, in advance, some of the common problems of nursing students as well as those of nurses in supervisory capacities. To this particular lecture, we especially invited all staff and faculty members. Because the subject of authority in the nursing milieu is emotionally charged, it must be handled with great delicacy and by an expert if discussion in a mixed group of nursing students and staff is not to aggravate rather than ameliorate the situation. Even during this particular lecture there were occasional giggles and other manifestations of nervousness or embarrassment, sometimes from students, sometimes from supervisors. And once there was applause by students when a particularly pertinent grievance of theirs was recognized by the speaker as legitimate. By the time the lecture was over, however, there was a noticeable lessening of tension. Both nursing students and faculty members participated actively and freely in the question and discussion period that followed. This seemed to clear the air still further; the members of each group were apparently more able and willing to see the other's point of view. When word of Dr. Schaffner's lecture spread, there were numerous requests from various nursing services for the tape recording we had made. The lecture is presented as Part II of this chapter.

Part II. Authoritarianism and Defense Mechanisms²

We cannot imagine life without authority and yet we are constantly having problems about authority. In recent times the world has had to cope with the authoritarianism of Nazi Germany. Much time is spent thinking about dictator states; much time and effort are spent in promoting the right kind of leadership. People continually worry whether there will be enough leaders and also whether they will be the right kind of leaders. Since our nation originally grew out of a rebellion against authority and a distrust of it, we, perhaps more than any other country in the world, dislike the word "authority."

¹ Schaffner, Bertram, *Fatherland: A Study of Authoritarianism in the German Family*. Columbia University Press, New York, 1948.

² A guest lecture by Bertram Schaffner, M.D.

One of the largest problems in American family life today is suggested by the question: How much authority should fathers have; how much should mothers have; how much authority should children get? People from many other countries say about Americans that we lack authority in dealing with our families and our children. On the other hand, we have established and maintained certain types of authority just like any other country. We have police; we have traffic lights. In our Army and Navy we have the same kind of powerful defense authority as other countries. In many of our churches we see the usual strong authority system, as we also see it in our schools and in every hospital.

Perhaps one might ask, why do we permit authority in the Army, Navy, churches, and hospitals in contrast to the rest of our culture when on the whole we tend to resent and fight authority, distrust it, or set up elaborate checks and balances to see that it does not become too powerful. It has occurred to me that in matters which are very serious, involving those of life and death, we want a strong authority. Clearly the Army and Navy have to do with protection from danger and with matters of life and death. So does every hospital. These are areas where mistakes are more costly than in any other, and where we both require and tolerate the strictest discipline.

How does authority begin? Is it something that human beings invented merely as an abstract, philosophical concept, or is there some basis for authority in biology, in human nature? I think that you as nursing students probably see the answer in your everyday lives more than other people since you see human beings from the minute they are born. You see what really helpless creatures babies are. There is nothing that babies can as yet do for themselves. Without authority, that is, without somebody responsible for them, without somebody who knows what to do and is able to do it, these babies would not survive. Authority, or rather a person in authority, is essential to life.

If, for example, you watch children as they are emerging from the helpless stage of infancy through the first year of life, the second, the third, it is not difficult to discern their natural, usual, and happy dependence upon authority. If you have watched children learning to walk, you have no doubt noticed that they

turn toward the person in authority. They do not instinctively "hate" or "distrust" authority. Their first attitude toward it is very warm. When one is small and helpless, when one has no idea what the world is all about, it feels good to have someone there who knows. It is also good to have an authority on hand who can teach you what you need to learn, can stop you if you are going to hurt yourself and knows how to comfort you when you are unhappy.

I go into this detail because, with our cultural dislike, distrust, and even suspicion of authority, we tend to forget that we generally like the right kind of authority. We are used to thinking of ourselves as hating all authority in line with slogans like "Give me liberty or give me death," which seem to imply that authority and liberty are not simultaneously possible. However, looking once more at the beginnings of human life, there need be no contradiction between authority and freedom. In the first stage of life the helpless infant cannot exercise freedom. At that point, the mother, nurse, father, or doctor who is in charge of the child must take responsibility and do almost everything to or for the child. The good nurse, mother, or father gradually learns that it is not necessary to do everything for the child.

The good authority begins rather early to give the child liberty. For example, at feeding time it lets the child find his own way to bring food to his mouth—perhaps it only hands the child a spoon. In my experience with mealtime behavior, children quickly want to take over, to hold the spoon in their own hands. As I view it, a good authority is likely to let the child do it whenever he is ready. The authority relinquishes part of the responsibility and gives the child the opportunity to practice what he is now becoming capable of. There need be no essential contradiction between what the good authority needs and what the child needs. Of course, some nurses, mothers and fathers are impatient, and cannot wait while the child awkwardly brings the spoon to his mouth. Some become worried for fear the child will not get enough to eat, and may take the spoon away from the child. Some worry too much about laundering clothes and wiping up the floor, to be able to let the child learn in his own natural way.

At this point I should like to introduce the word "authoritarian." By "authoritarian" I mean the poor authority; I reserve

the word "authority" for the good one. One important quality of the good authority is that he defines situations. It is important for children to know what life is really like. Their own ways of looking at events, their frames of reference, are limited. An authority is necessary to a child in order to explain and define situations. For example: "This is the way we do things"; or, "This is not the way we do them"; "If you do this, such and such will happen"; "This will probably take you a certain length of time"; "That is a mistake but it's not a calamity"; or, "Yes, you just hurt yourself but it is not dangerous." This kind of teaching and support which brings the past experience of the older person into the learning of the child is a vital function of authority.

There is also the necessity for the setting of limits—often an unwelcome function—yet a benevolent, healthy function of good authority. When I, as a psychiatrist, listen to the common difficulties of my patients, they often tell me that their problems stem from the fact that limits were not set for them and from their subsequent inability to limit themselves. They say, "I can't stop myself. I know what I'm doing but I can't keep myself from doing it." How do such problems come about? Often the parent has had some difficulty in telling the child, "This is as far as you can go." All children need this information and limitation. We need to learn not only to express our emotions but also at some point to master them before they master us. An authority must not only provide a child with what he needs, but at times also say to him, "I know you need this but I'm not able to give it to you"; or, "I don't think it is really in your best interest to give it to you, therefore, I will not."

This is an unwelcome aspect of authority, but extremely important for mental health. We human beings will be refused many, many times during our lifetime. I can hardly imagine anyone living through a day without hearing "No" at least once and more likely several times. If we are to live in reasonable comfort we need a healthy reaction to the word. The authority in early life should accustom us to refusals and give us the feeling that a refusal is a natural thing to have happen without its necessarily being a reflection against us. If some suffering comes

with the word "No" (it always does, no matter how much we get used to it for we never come to like frustration), we learn that this suffering does not last long and that we can survive it, then we will have received most valuable basic training from the authority.

Unfortunately, many persons in positions of authority are uncomfortable about saying "No." Some feel they are unkind when they refuse. Others realize that to say "No" is in their own interest but feel selfish about refusing for that reason. Hence, they are inconsistent in their use of the word. For example, they may refuse at first but if the child presses long enough they may give in. This makes the child uncertain and he may ask himself, "Did mother mean 'No' or didn't she?" For children with this kind of confusing training the word "No" will give much trouble in interpreting adult directions. "When should I stop? If mother says 'No' does that mean I should keep on pushing until she says 'Yes'? If she gives in and says 'Yes' will she then be annoyed with me? Will she be angry because I pushed her so hard?" These are typical questions that arise when an authority has been worried, unsure, or inconsistent about saying "No."

Throughout history and in most groups that we know of, people have been somewhat uneasy about the use of authority. Some have gone too far, becoming domineering and requiring abject obedience. Some could not bear the use of authority at all. There seems to be no instinctive understanding of the exercise of authority; it seems to have been developed through experience. Most societies, families, and organizations eventually set up some system of rules for the exercise of authority. Then that ugly word "discipline" comes in. When people are not sure of their own authority, of methods of using it, or of getting others to respect it, they often resort to external measures to enforce authority. This usually creates problems, since the very persons on whom one is tempted to impose discipline are frequently those least able to accept authority. Hence, the situation becomes worse.

Let us now examine the relationship of the authority figure to another person, whether it be between parent and child or between supervisor and nursing student, in order to understand

how difficulties arise. In the first place, in viewing his father or mother, a child is likely to feel that the parent is absolutely right; that he really knows everything he is talking about; that he is correct in his opinions of the child. Such attitudes may unfortunately persist into adult life. Many of us continue to have problems with authority because we still look at authorities as we did when children, before we could yet see them as mere human beings trying to do the best they could—often right, sometimes wrong, with all sorts of feelings and confusions like our own.

This quality of knowledge about adults, children do not have. The normal child in his helplessness and frustration usually misconstrues the adult as having no difficulties or problems. Therefore, when a parent is irritated, perhaps for an understandable reason, the child is not likely to understand that the parent is going through some painful experience of his own. The child will frequently conclude, "My mother and father are very angry and that hurts my feelings very much. I don't feel very good toward them now, and in that case they cannot feel good about me. They must have a poor opinion of me, too. Maybe they consider me very bad since ordinarily they smile." This, of course, may not be the meaning of the parents' irritation at all. It may only be that they are tired or under a strain, which the child does not comprehend. Especially while the parent is angry, the child is unlikely to know that he may ask questions to find out the reason. He is much more likely to be busy thinking about what the parent's anger means in relation to himself. "What is wrong with me now? Why did this happen? Did I cause it?"

This type of reaction is often the true cause of difficulties when dealing with authority. For example, when a nursing student is spoken to by her supervisor, she often has questions in her mind such as "Will I learn this? Will I do this well? Is there any danger of my failing? Is my judgment good? Can I tell you that I don't know how to do something? Do you approve of me? If I think you are wrong, will you let me tell you so? Do you want to help me in this or are you interested only in seeing that the work gets done? Will you be patient with me while I try this out or will you criticize me severely if I do it awkwardly?"

Students in all fields, not only in nursing, react to authority quite seriously. It would be difficult not to react in this way. In the first place, the authority has power not only to help, to teach, to assist, but also to give marks and to "flunk" one. Although a student may be grateful to a supervisor or teacher, she may also be somewhat afraid. Whatever a teacher says is usually taken too much to heart. If the supervisor is aware of this, she may reassure the student with, "You are doing fairly well. I don't think you need to be afraid"; or, "Yes, this was a mistake. Despite its consequences, don't think there is anything strange about the fact that you make mistakes; everyone does. The only reason for mentioning the mistake to you is to help you avoid it next time."

Many of us react to the comments of a supervisor much as we reacted to the criticisms of our parents. If we happen to be persons who took criticisms well in the past, we may have little trouble with those from supervisors. It is a different story if we react to criticism with feelings of "You don't like me or think I'm any good. I always make mistakes. I must be hopeless. I can't learn anything. You don't want to help me. You think I'm all wrong; you don't understand how hard I'm trying. You don't care about me, only about the hospital." Unfortunately, such reactions are not uncommon; actually, everyone has some of them. Even while we are learning a lifetime profession and are primarily interested in obtaining security in our knowledge, we still worry about our adequacy as persons. Even if we know our work well, we are still vulnerable to comments about our competence. "What does the supervisor really feel about me? I would like her to like me as well as to think I'm good." So run the ideas that keep bothering us.

As I have indicated, nursing supervisors are also people. What are some of the problems that arise in their minds? What might they worry about while teaching? We can assume that as supervisors they will have not only the academic subject-matter on their minds, but also their responsibilities to the school and the hospital. They probably wonder, "How do the nursing students feel about me? Do they think I am a good teacher? Do they think I have good judgment?" Often the authority has to be firm and

criticize others even though she does not wish to do so. It is not easy to be firm, particularly if you surmise that others may dislike you for it. Many a supervisor with good ideas of what she wants to convey may be unnecessarily worried when she has to tell students about mistakes, or has to set down absolute rules. Many a supervisor knows that she should be respected for her knowledge and for the kind of person she is, but she may not be sure that she is respected. She may wonder, "Do other people see me as having these qualities or do I have enough of them to earn their respect?" Such supervisors may ask for too much respect. The problem is not that the students are unwilling to give it but that the supervisors themselves feel an excessive need. Similarly, not all supervisors know their own worth and sometimes they seek a feeling of worth through the responses of their students, just as students often try to get supervisors to indicate how good they are.

Some supervisors are so overburdened with a tremendous number of things to do that they become impatient. It is necessary to understand their frequent and perhaps excessive hurry which does not allow them to give their students sufficient time to learn. They may even criticize students for slowness in learning. Actually, they often have to deal with too many people and may therefore not have time to study individual differences and discover which nursing students learn one kind of thing more easily than others, or which students need special help in a particular area. It is very easy for a busy supervisor to think of all students as alike. Naturally, this is not true, any more than all supervisors are alike. A typical problem in most teaching is inadequacy of time and too many students per instructor.

Occasionally, a supervisor has so much anxiety of her own that she fails to recognize that the nursing student in front of her is also worried. This experience again is typical of people in general—because of our own worries we are less perceptive about those of others, just as a worried student is unlikely to notice that her supervisor does not feel well.

Supervisors, too, may have a problem about being questioned. Often students dislike being questioned because they feel they may have to admit ignorance. If one has had a good authority

figure early in life, he may have learned that it is safe to reveal what he does not know, since help will be forthcoming rather than punishment. Unfortunately, many people have previously been punished for not knowing something and so find it difficult throughout their lives to acknowledge ignorance in any degree, however small. Naturally this applies not only to nurses but to most adults, including supervisors and teachers. The good teacher should be ready to admit she does not know and ought to be comfortable in saying, "Now, I really don't know the answer to that but it's something I can look up and tell you later." The teacher who is uncomfortable about having her ignorance exposed may, in her worry or her irritation about it, criticize the student. Students, therefore, might well bear in mind that not all teachers are able to admit comfortably, "I don't know."

Supervisors have as much need to succeed in their work as do the students. When one of them is depressed or feels she is failing, she may press students to accomplish too much too fast, although the latter may in fact be doing well. She may even understand this but if excessively worried about her own success, may find herself driven by her own feelings into driving others.

The greatest confusion may be caused by that occasional teacher who, for reasons that are not apparent to herself or others, uses threats or shame as methods of teaching. Many persons tend to react with fear to such methods and hence they perceive the teacher, parent, elementary school instructor, or nursing supervisor as being more powerful and dangerous than she really is. Because of our own fear, most of us do not know how to deal with such a person. We are likely to become very angry and feel like quitting the job or attacking the individual, although our heads tell us that this will not solve matters. The first step in understanding such situations is to remember that when someone reaches the point of threatening, shaming or frightening others, it is usually because of his own disturbed and unhappy feelings. His sense of weakness or powerlessness is generally the cause rather than the actions of other persons. When he feels threatened because something does not work out well, he may resort to a show of strength or coercion which is not genuine. For that very

reason, it is not effective, it merely expresses desperation. At such a time, the parent, teacher or supervisor usually needs reassurance, patience, understanding. If we realize this fact, we can often become calm ourselves and no longer feel in danger from the authority figure. We may eventually be able to ask what triggered the severe reaction, and possibly prevent its recurrence.

Before closing this talk, I have been asked to make a few comments about personality and behavior reactions to authoritarian figures. Some reactions are conscious and overt, some are unconscious and hard to detect. They are usually classed under the name of "defense mechanisms," since the authoritarian behavior is typically experienced as unsafe for the individual and his self-esteem, and therefore, both behavioral and psychological methods are used to offset the expected danger.

The commonest and easiest reaction to identify is that of *open anger* against the authority figure. It is usually described as defiance, rebellion, disobedience, discourtesy, or insubordination. Open anger may make it look as if the student feels strong, equal or even superior to the authority, or lacking in respect. Upon closer inspection of the student's feelings, though, it often turns out that she feels markedly inferior, has been stung by a sense of insult or injustice because of the authority's words or tone of voice, and has wanted to protest. However, her actual deference toward and fear of the authority figure have not lessened at all. Precisely because they are still there, she makes the protest to the authority in a nervous, awkward, and offensive way.

The same combination of deference, fear, and anger toward the authority leads some students to *identify* with the authoritarian personality. This is rarely a conscious process. Fellow students often observe it while it is taking place, although the student herself does not realize it. It is not the same process as the strategy in the old saying, "If you can't lick them, join them," which requires considerable personal strength. It is rather an obedient response to the convincing tone of the authoritarian which leads the student to take it for granted that the teacher is actually right. Hence, the student feels herself clearly in the wrong, and will not be in the right or accepted and approved until she has become *like* the authority figure. Often authority

figures are imitated because of sincere, freely given admiration, and not because of fear of disapproval. Unfortunately, authoritarian figures tend to cause students unconsciously to identify with and imitate them. This happens as the result of a psychological security operation within the student because of her fear. She may even take over qualities and traits that she dislikes in the authoritarian figure.

When a student has been afraid to show openly her dislike of, or anger at, the authority, opposition still typically finds a way to manifest itself, though usually in a manner disguised even from the student herself. It would be a mistake to regard opposition as always conscious and voluntary. Many students cannot bring themselves to conscious disobedience; therefore, the opposition they show must express itself unconsciously. Common examples are forgetting, neglecting, overlooking, shirking, leaving things unfinished, arriving late, and so on. (To be sure, there is also natural lateness, natural forgetting, but we are speaking here of such behavior when it arises from covert hostility.) Hidden anger may also manifest itself subtly in frequent criticism, destructive innuendo, "disgust with the whole setup," or unfounded complaints. "Griping," as it is commonly called, helps to discharge some of the annoyance and irritation that could not be expressed directly to the authority herself.

Anger, while highly unpleasant, is usually short-lived compared to the *anxiety* which the authoritarian figure arouses. Anxiety is not equivalent to fear or apprehension, but is the disagreeable tension experienced in association with lowered self-esteem and self-criticism. It can become acute when an authoritarian figure has been highly critical, impatient or threatening. It manifests itself on the one hand in restlessness, awkwardness, muscular tremors or stiffness, slowness in comprehension and in reaction to events, but also in hypersensitivity and increased reactivity to the behavior of others. Defense mechanisms against the disagreeable experience of anxiety usually take the form of flight rather than of fight.

Most noticeable are "absentmindedness," increase in unintentional errors, confusion and disorganization, decrease in the usual ability to deal with situations. The nursing student herself may

feel a strong need to escape, to be anywhere else but in school or at work. Frequently a strong depressive mood overcomes her, although she may not know why she feels as she does. "Discouragement" and "nervousness" are the typical emotional complaints of the anxious person. In some cases the physical manifestations of anxiety may predominate, such as difficulty in sleeping, loss of appetite, tightness in head or throat, in fluttering heart. When anxiety and discouragement become great enough, reactions of apathy are likely to appear. The student goes through the motions of what she should do but in an indifferent or uncooperative manner that expresses the feeling, "You cannot hurt me any further. I know I am not good enough; I just don't care any more." When discouragement turns into real despair, the student may give up attending classes. With complete sense of failure she may decide to change professions and to withdraw from school.

In conclusion, a few words about the more desirable authority figure. How might we describe the goal of the good authority in the nursing world? This is surely of interest to all students who will one day function as authorities to others in many ways. The primary goal of the good nurse and teacher of nursing is to impart to her students her own knowledge, to teach them the competencies they need, to preserve and promote their sense of capability, to share with them the awarenesses she has acquired in the course of living and working with others. She endeavors to help students cope with the professional and personal problems that they are likely to meet in the course of following their profession. She tries to foster their self-confidence and self-respect and teach them to be tolerant toward and mindful of the self-esteem of others. In addition to acting as an instructor to students, she also attempts to free them to get along without her in the future, just as the successful parent teaches her children self-reliance. Thus they will emerge from her schooling with both adequate professional preparation and a sense of self-confidence. And lastly, through her example, the good authority figure in the nursing world teaches her students to become satisfactory authority figures for other students who will come after them.

Chapter 8

Value Judgments

WE NOW TURN OUR ATTENTION to some of the factors that interfere with the objective evaluation by staff of the personality and social behavior of patients. In the hospital setting evaluation of a patient's condition is regarded as an essential part of medical and nursing care. Except for psychiatric patients, it is primarily concerned with physical aspects—observation of physical signs and symptoms, results of doctors' examinations, laboratory tests, clinical records, and reports by consultants, nurses, social workers, or others who may be involved in the care of the patient. Objectivity, specificity, and precision of information are of signal importance. But where evaluation is carried over into the area of personality and behavior—as it frequently is—the same degree of accuracy and objectivity is singularly lacking.¹ Here may be found pronouncements, analysis, interpretation, and speculation without either the requirements of training or substantiating evidence.

Although supporting evidence is required before labeling a patient as critically ill, syphilitic, or tuberculous—medical assessments resting with the physician—his “personality” may be labeled by anyone, from doctors to nursing aides, on the basis of little more than some salient and little-understood aspect of his behavior. Opinions, very often influenced by individual biases, assumptions, and background rather than statements based on fact, are likely to be freely exchanged and as casually accepted. These may be offered formally at staff conferences or at nursing team briefings, or they may be exchanged informally between

¹ With the increasing emphasis on the “whole patient” and the “team” concept, more attention is being given to the evaluation of personality and behavior. When the team includes psychiatrist, social scientist, and social worker, the approach to behavioral data is as objective as the physician's approach to his clinical data.

staff members in the halls, at the nurses' station, or in casual conversation over coffee. Since patients are not likely to die because of an incorrect evaluation of this kind, misjudgments are not regarded as of any particular consequence. Unfortunately, however, the consequences may be more serious and far-reaching than is generally recognized.

LABELS APPLIED TO PATIENTS

Perhaps the most common label applied to patients, and by which they are identified and referred to by staff members, is that of "good" or "bad." These are terms within the hospital milieu that have specific meanings and are behaviorally defined. They are so usual that they amount to a stereotyped expectancy. Neither of the terms refers to moral qualities, nor are they evaluations of a patient's physical organism or performance; for example, "His eye looks pretty good," or "He had a good night." A "good" patient in this context is one who conforms to the medical regime designed to make him well: the prescribed treatment, medication, diet, rest, nursing care, the rehabilitation program; and he does so without questioning and without resistance. He does not complain unless it is absolutely justifiable. He does not make inconsiderate demands of doctors, nurses, or aides. He is "cooperative" and "reasonable," qualities usually equated with being "intelligent." He makes an effort, at least, to be a "good sport," tries to help himself and works at getting well. He shows appreciation for what is being done for him.

The "bad" patient, on the other hand, is one who is "difficult" or "uncooperative." He is likely to argue against or resist the required treatment. He questions everything that is done for or to him. Worse still, he may "know more" about his disease or illness than the doctors and nurses. He is "emotional" and is likely to complain loudly or continuously or both. He finds fault with the food, is inconsiderate of staff members and other patients, and is a constant "bell ringer." He seldom shows any gratitude toward those who try to care for him.

The behavior of patients affects the attitude—both consciously and unconsciously—of staff members toward them. The good

patient, by his appropriate accommodation to hospital routine, is regarded with approval. He is referred to as "an intelligent patient," "a real stoic," "a sweet person," and so forth. He is rewarded by the respect of the staff. Nurses, doctors, and aides find him a pleasure to care for and they are likely to "socialize" with him if they have the time. The "bad" patient, however, is regarded with disapproval. He may be referred to as "a chronic complainer," "a crock," "a pest," "a personality problem," "a neurotic." Although he is administered to according to his physical needs, he is likely to be avoided if this can be done without consciously jeopardizing his medical and nursing care. The frustration and resentment his behavior generates (as interpreted by the staff) do not endear him to them.

The characterizations that a patient acquires may or may not have validity, but they can and do play a significant part in the attitude of the staff toward him, and in the subtle and not so subtle differences in the care he receives. Unfortunately, the training and ability of doctors and nurses to assess physical needs do not ipso facto qualify them to judge patients' personalities or to interpret their behavior. This fact seems to be no deterrent, however, for assessment of patients is a daily occurrence and undertaken with apparent assurance. In contrast to the objective and impersonal manner in which clinical judgments are made, personality judgments are frequently subjective, impressionistic, and value-laden. It is here that the need for training in the social sciences and their methods is strikingly revealed.

COMMON SOURCES OF ERROR IN JUDGING PERSONALITY

Judging personality or "sizing people up" is a conscious or unconscious activity in daily social intercourse. It is also one in which many people consider themselves expert. A judge may pride himself on being a good reader of character; a teacher, on being a good judge of children; a doctor, on his ability to size up patients. By long experience and trial and error, they may, indeed, become very proficient. Others, however, delude themselves and fall prey to common sources of error. The ability to judge others, as Gordon W. Allport has pointed out, depends

upon a number of qualifications, the sum total of which few people possess.¹ Moreover, "the problem of understanding people is always a problem of *partial* understanding. We may understand one another *relatively* well, but never completely."²

In a hospital where maximum care and rehabilitation are dependent upon understanding the whole patient, erroneous judgments may have far-reaching effects. Personality assessment based on preconceptions, superficial observations, flash impressions, and so forth can have consequences that are incompatible with the major objectives of total patient care.

One of the most common sources of error in judging others results from the utilization of stereotypes for classifying or putting people into categories. In the earlier discussion of typologies we pointed out that stereotypes have the social function of serving as guideposts for purposes of identification and expectations. "Prima donna," "egg-head," "neurotic" are labels that, when applied to people, provide us with a mental picture in an instant, and is as quickly followed by attitudes, opinions, and expectations, depending upon how we react to the particular term. But labels are also oversimplifications that may paralyze the process of judgment. While it has been contended that stereotypes do contain some truth, as accounted for by the fact of their occurrence and widespread acceptance, studies have demonstrated that they can also develop without a grain of truth.³ Whether or not there is a reality basis for any one of them, the fact remains that they can affect and distort perception.

Another source which interferes with judgment is prejudice. This concept has been defined as "A prejudgment concerning a person, a group, or a situation such that one is unable to make an objective evaluation. It is a socially predetermined attitude, and one held without regard to the actual facts."⁴ As countless studies

¹ Allport, Gordon W., *Personality: A Psychological Interpretation*. Henry Holt and Co., New York, 1937, pp. 513-516.

² *Ibid.*, p. 499.

³ Klineberg, Otto, *Social Psychology*. Rev. ed. Henry Holt and Co., New York, 1954, pp. 485-486.

⁴ Reuter, Edward Byron, *Handbook of Sociology*. The Dryden Press, New York, 1941, p. 144.

have shown, prejudice is learned.¹ It may be learned from a variety of sources: from parents, friends, or teachers, as the result of an accretion of experiences or of a single traumatic experience. One may be prejudiced in favor of something or against something. In the hospital, a nurse or physician may be prejudiced in favor of pediatric patients or prejudiced against wealthy, upper-class, middle-aged women. In general, prejudice is thought of in terms of negative prejudgments. In this context, it is a phenomenon that is likely to arise from a dislike of those who are regarded as being "different"—unlike oneself or the group to which one happens to belong. It may be directed toward those who belong to minority groups or to a different social class, toward those whose moral codes or religions differ from one's own, or who are physically handicapped or have a particular disease. Where it exists, the affective reaction may be such as to block all rational inferences, making impartial judgment impossible.

Another pitfall in the scientific assessment of personality is the snap judgment. This may be made on the basis of rapid impressions determined by a single feature or characteristic. For example, the shape of a nose, manner of speaking, way of dress, or color of skin may suggest a trait that interferes with the process of judgment. These are items that claim an observer's attention to the extent that they overshadow and prevent the perception of surrounding cues. Any one of these may be what Allport calls "anchorage points" from which no judgment is allowed to drift.² Depending upon the observer's past experience, social attitudes, and biases, a personality image is formed of the individual and he is likely to be assigned those traits and characteristics with which it is assumed he is endowed.

A striking example of the unreliability of first and rapid impressions was demonstrated by the following study.³ An experiment

¹ For an excellent analysis of this process, see Allport, Gordon W., *The Nature of Prejudice*. The Beacon Press, Boston, 1954, pp. 285-339.

² Allport, Gordon W., *Personality: A Psychological Interpretation*, p. 484.

³ From the interdisciplinary project, "The Psychosocial Aspects of Facial Deformities and Plastic Surgery." This particular study entitled "Exploratory Study into the Reactions of Non-Disfigured Individuals Toward Photographs of Individuals with Facial Deviations" was conducted by Rita F. Post and submitted in partial fulfillment of the requirements for a master's degree.

was designed to test immediate reactions of a group of nurses to a series of photographs of persons with varying degrees and kinds of facial deviations; and to determine, among other things, what psychosocial and cultural components influenced their reactions. No additional clues, such as dress, occupation, and so forth were given to the group. Forty-five nursing students who had had three months of training but as yet no contact with patients, and eighteen graduate nurses who had had experience in the surgical wards of the hospital were the subjects tested. Informed that the study was to determine how well persons from different occupations and with different educational backgrounds can judge personality from photographs of people's faces, they were instructed to record their spontaneous impressions as each slide was exposed for several seconds.

One hypothesis was that since the nursing students had had less experience with illness and deformity than the graduates, they would find the photographs more disturbing and consequently: (a) would be more likely to carry over the negative feeling derived from perception of the deformity to character traits; (b) in trying to place greater social distance between themselves and the deformed would be more likely to project aggression as a trait of the deformed; and (c) would have a greater tendency to put these people into cultural stereotypes. Three aspects of the findings are worth noting here. One was the lack of any significant difference between nursing students and graduate nurses either in emotional affect or in judgment of character traits. It was also shown that the degree to which disfigured faces conform to cultural stereotypes appears to be the most important factor in determining unfavorable responses to them. If a face conforms to a widely accepted stereotype, the range of judgments in regard to the individual's personality is extremely limited.

The following examples are typical of the kinds of judgments made entirely on the basis of impressions received from viewing the photographs of the faces.

In response to a picture of a forty-year-old woman with a malformed jaw: "She's a tough baby"; "from the shape of her

mouth she seems to think she knows it all, and the world be damned"; "disillusioned, despairing, snarling"; "contempt of the world and herself"; "probably an alcoholic"; "dope addict"; "probably associated with the underworld."

The picture of a man aged twenty-nine with strabismus and a saddle nose elicited the following comments: "This guy looks like the real criminal type"; "looks like a boxer from the shape of his nose"; "looks ignorant; reminds me of a pig"; "nothing malicious-looking about him but not the kind of guy I would like to get into an argument with"; "one-track mind"; "laborer"; "slightly moronic"; "he's stupo"; "he's an ex-navy gob and hangs around a poolroom."

How valid were these judgments? The woman was a practicing nurse. The man was a schoolteacher. Neither one possessed the socially disapproved character traits ascribed to them. Yet the respondents in both instances not only judged personality but character traits as well. Moreover, on the basis of their impressions they speculated or drew conclusions about the activities or occupations in which the subjects engaged. (It is apparent that the facial deviations of the subjects set up a "halo" effect which greatly influenced the observers' judgments.)

This particular study does not invalidate the fact that expressive features and behavior provide important clues to personality but it demonstrates how misleading they can be, especially when they have symbolic significance for the observer. When they do, emotional responses are aroused and "a general attitude of approval or disapproval toward the subject colors every single judgment concerning his single vices and virtues."¹

From the foregoing discussion it should be obvious that the process of judgment can be adversely influenced in a number of ways. In addition to those already mentioned are superficial observation, selective inattention to clues, misinterpretation of clues, associated ideas, inferences, the influence of authority, and the like. All may lead to erroneous assumptions and quick and fallacious predictions.

¹ Allport, Gordon W., *Personality: A Psychological Interpretation*, p. 447.

IMPLICATIONS FOR NURSING

What implications does all this have for nurses and patient care? A major premise of this book is that the success of treatment and management is contingent upon understanding and fulfilling the subjective needs of patients as well as their physical needs. But success cannot be achieved if patients are misjudged by medical and nursing personnel, their behavior misinterpreted, or the reasons for it ignored or not understood. Incorrect assumptions lead to false expectations (even to blame and recriminations), and these in turn may lead to a course of action totally incompatible with the patient's actual needs. Total patient care then is not being provided.

Another insidious aspect is the contagious quality of the attitudes of staff members that are based upon false judgments and preconceptions. If these attitudes are held by those in positions of authority, they may be particularly virulent and an entire hospital unit becomes infected. This can produce an atmosphere that is not conducive to proper medical and nursing care.

Nursing students are exposed to, and contaminated by, the judgments loosely and erroneously made about patients—judgments, incidentally, that often tell us much about those who make them. Not only do students quickly acquire the habit of classifying patients as good or bad, or of referring to them according to rumor or their own superficial evaluations, but their whole approach to patients may be colored by the remarks of their superiors. Let us examine, for example, some typical judgments taken from a large collection of those heard in hospital and clinic settings:

A head nurse said, in referring to a nineteen-year-old man who was paralyzed from the waist down and was trying to get attention from a staff nurse, "Be careful, he's a wolf."

Because she was threatening to abort, a young woman was being given intravenous infusions. When she was denied food orally, she felt this was "cruel." Said the doctor, "She's a paranoid."

A woman with cirrhosis of the liver was placed on a high caloric diet. She hid the food that she could not eat and the staff dis-

covered it. One member of the staff remarked, "She's a deceitful woman."

A devout Catholic woman of thirty-six who had just married for the second time, was admitted for a possible hysterectomy (excision of the womb). She was worried over the effect of the operation on her personal life and because of her religious beliefs. A nurse commented, "Mrs. Kerwin is such a big baby; you'd think she was going to die."

A woman patient was extremely pleasant and amiable. She was cooperative and wanted to do everything for herself. After any procedure was performed for her by the staff she offered them candy or some other gift. One of the nurses declared, "Mrs. Davis is a honey."

When a woman was advised to undergo surgery for uterine tumors, she listened quietly while the doctor explained the necessity for the operation. She asked only a few questions and then agreed to the operation. The doctor said, "She's a very intelligent woman."

A twelve-year-old child underwent a prolonged cystoscopic examination (visual examination of the bladder by means of an instrument). Although she was sedated, she still protested; the examination was painful. The doctor who was making the examination said sharply, "That child is completely impossible. She won't cooperate at all."

A woman who underwent major surgery never complained about treatments or pain. She appeared well educated and was enjoyable to talk to. She helped herself as much as possible. A nurse remarked, "Isn't Mrs. Bailey just wonderful! She's really a peach. If all patients were like her this place would be heaven."

After a patient had consulted his physician several times about stomach difficulties that seemed indicative of cancer of the stomach, he was admitted to the hospital for a diagnostic workup. Said a nurse upon his arrival, "He just looks like a neurotic."

A man of thirty-seven in the last stages of cancer was so weak he could hardly lift a fork. He had lost 80 pounds in six months. A nursing aide declared, "He's so uncooperative he won't eat a thing or even take the medicine that he needs to get well."

The nurse had to explain instructions about diet several times to a middle-aged Italian woman. The latter was hard of hearing and spoke little English. The nurse concluded, "She's not very bright."

A young woman was brought to the hospital from a party at three in the morning. She was formally dressed and kept applying

cosmetics while waiting for admittance, despite the severity of her illness. A nurse commented, "She's a slick chick."

A woman who had been admitted for an abdominal operation, subsequently had a stroke and could not speak. She could understand but could make only incomprehensible sounds. "Mrs. Warren is a poor patient, constantly complaining by making noises, and is never satisfied," was the nurse's statement. "She must have been an extremely demanding person when well."

Some of these statements are made facetiously, some with affection, some in despair, some with irritation or contempt or resentment. Yet each makes a reference to only one aspect of the person, which by its very saliency masks all other attributes. These symbols Allport has called "labels of primary potency" that act like "shrieking sirens."¹ As such they are conveyed to others and, irrespective of their nature, tend to set up preconceptions that can greatly influence the quality of interaction between nurse and patient.

LEARNING AIDS FOR NURSING STUDENTS

To help students develop a more objective approach to the appraisal of patients, time is devoted to discussions and exercises in listening, observing, and interpreting. Consideration is given to misunderstandings traceable to semantic difficulties, the difference between intensional and extensional meanings of words, the implications of emotionally charged words, and to language and cultural differences in word symbols and meanings. Students learn to listen for what is not said as well as to what is said and for what is implied. They learn to watch for and "hear" the nonverbal communications—expressions, gestures, postures, and kinesthetic behavior which often convey more than the spoken word. In these exercises in observing, the multitude of factors which can invalidate hasty judgments are revealed to them.²

Particularly useful for demonstrating the pitfalls of subjective and undisciplined evaluation of patients were the written reports

¹ Allport, Gordon W., *The Nature of Prejudice*, p. 179.

² See: Allport, Gordon W., *Personality: A Psychological Interpretation*, chaps. 7, 8, 9; Berrien, F. K., *Comments and Cases on Human Relations*, Harper and Bros., New York, 1951, pp. 20-62; Ruesch, Jurgen, and Weldon Kees, *Nonverbal Communication*, University of California Press, Berkeley, Calif., 1956.

of the students about their own problems in interpersonal relations with patients. These reports had been turned in at the very beginning of the course, at which time some of the methods for handling the problems encountered were discussed. Subsequently these same reports were examined from another point of view: objectivity in personality assessment and reporting. For example, one nursing student had written:

Mrs. Moss, aged forty-eight, was assigned to my care. She was diagnosed as having cholecystitis (inflammation of the bladder) and her gall-bladder was removed. I was immediately struck by Mrs. Moss's superior, supercilious, and cold attitude toward me. I thought that it would gradually subside, but contrary to my expectations, it has only increased. She complains about the hospital routine and refuses to eat the "poor" food. Mrs. Moss is extremely upset by the Negro nursing aides who bring her food and contribute to a small degree in giving her bedside care, and by the fact that she is not in a private room. She calls for this and that and expects me to follow out her every wish regardless of my limited time, hospital policies, and the like. Mrs. Moss is very demanding, "authoritative," and dogmatic. She is also a pseudo-intellectual. Mrs. Moss treats as a maid everyone who participates in her care. I feel very subservient toward her, and my first reaction was to talk back to her or retaliate with similar hostile feelings. I find it hard to smile at Mrs. Moss and answer her demanding questions.

Upon reading Mrs. Moss's chart, I discovered that she was born in England, and that she lived in Kentucky for five years. Therefore, I think her environment has influenced her to regard the hospital personnel as her private servants. Because Mrs. Moss is on a semi-private floor and has Blue Cross insurance, and because she speaks of her former Kentucky plantation, I wonder if she was possibly once "well off" financially and has recently suffered financial reverses. I think her upbringing, which might have included many personal maids, could partly account for her present attitude. She is a widow. Possibly she not only lost a husband whom she might have been able to dominate, but her financial security as well.

Not only does Mrs. Moss expect the nursing staff to do everything for her, but she also expects us to make her well. It has been ten days since her operation and she still is not well enough to go home. She has little motivation to regain her health.

Is Mrs. Moss gaining a sense of security by asserting aggressiveness and power over others? How is the nurse to react and respond to this patient? Can the nurse help her in any way so that she can be more pleasant to be with and possibly have more friends?

Upon having such reports as this read back to them, now that they had reached a relatively higher level of sophistication, students were usually appalled by their former flagrantcies. They were quick to pick up such highly subjective and value-laden terms as superior, supercilious, cold, demanding, authoritative, dogmatic, pseudo-intellectual, and so forth. They saw speculation and assumptions in operation without supporting evidence: "I think her environment and culture have influenced her." "I think that her upbringing, which might have included many personal maids," and so forth. They noted the way in which judgments and interpretations are influenced by past experience and preconceptions, and how these in turn affect the observer's reactions: The nursing student has reacted to Mrs. Moss's "superior" and "authoritative" manner by feeling "subservient," as though she were a maid, and she wants to retaliate. Students were more alert to statements of fact which lack documentation, such as, "She has little motivation to regain her health"; and to the use of inference: Having lost her husband, she also "might have lost her financial security at the same time."

Other important points informally discussed were the student's own conception of her role and function as a nurse; why she reacted as she did; her self-image; and her apparent need to alter the patient's behavior according to her own standards. During the first half of the course these aspects were purposely left unexplored. However, by the end of the second half the students had acquired sufficient knowledge and a more clinical approach; discussions could therefore be fruitful.

Armed with some new insights and analytical tools, students were given an opportunity to see how these might be directly applied to nursing. They were requested to be alert to any value judgments, either positive or negative, that they might hear in the course of their daily work. If feasible, they were to obtain from the person who made the judgment his or her reasons for doing

so. This was to be followed by visiting and interviewing the patient involved in order to determine not only the validity of the judgment, but, if possible, the reasons for the patient's behavior which gave rise to it. This experiment proved to have considerable impact on the students. It emphatically demonstrated some of the dangers inherent in the nonscientific assessment of personality and behavior as their reports indicate.

They learned how the briefest visual perception may arouse a complex mental process that leads to prejudgment of an individual's personality which may prove erroneous on further acquaintance:

The situation took place on the day that I was assigned to care for a twenty-nine-year-old resident surgeon from another hospital who was suffering from ulcerative colitis. I walked into his room and immediately formed a judgment of his character from his appearance. He had a handsome face, long sleek black hair, penetrating eyes, heavy dark eyebrows, and was dressed in a satin robe. I classed him as the "romantic continental" type and put myself on the defensive. I introduced myself and to my surprise, instead of being flirtatious, he was really quite aloof. He mumbled something in answer, then left the room. I had the feeling of being snubbed and felt like asking him "who do you think you are?" Just because he was a doctor was no reason to think he was better than anyone else. I then decided he had an air of superiority about him and probably felt that I, a student, was beneath him.

Well, after analyzing the doctor to my satisfaction, I suddenly woke up to the fact that I was doing exactly what I had been taught not to do. I had come to all these "bright" conclusions without having any basis whatsoever. At that moment I decided I would reform and try to be objective in my relations with him. I was going to find out why he acted the way he did. Was he really being snobbish or was he worried about something? To solve that question I went delving into his case history.

Apparently the young doctor is dissatisfied with his profession; doesn't know why he went into it, and the only reason he is finishing training is that he feels he needs to fulfill his obligation to society. He would prefer getting out of medicine and trying his hand at art, history, or writing. He seems to be in a situation which is intolerable to him, yet one from which he is unable to separate himself.

After reading this, I made a special effort to get to know him. I approached his bedside and started a conversation. To my surprise, he responded, and many of the reasons for his dislike of medicine were brought out into the open. For example, in questioning me about how I liked nursing and why, he made the following remark, "I can't see how you can like it. You spend years dedicating yourself to others and then suddenly you look at yourself and what have you got—nothing." At the end of our conversation I felt that I had gained in my knowledge of human relations plus discovering that the doctor wasn't such a bad guy after all.

They discovered the hazards of jumping to conclusions:

Before this year, whether I was completely aware of it or not, I made snap judgments about people only to find out later I was wrong in the conclusions I had drawn. Another thing, I accepted what people said about others without thinking through a situation, or better yet, finding out for myself just what they were like. Now, instead of accepting the statements people make about others I try to find out the facts for myself.

The other day a new patient was admitted. The woman was in the hospital for the second time and the diagnosis was the same as on her previous admission, a particular perineal infection (involving the area around the genitalia and anus). As the admission papers came in, the head nurse said, "I have no sympathy for such people. They are cured and then they go right out and have affairs with just any old man." My first reaction was one of questioning whether the comment was too harsh to make without evidence. Before I accepted the "prostitute" theory I read the patient's chart and found that she was married, that there was no accusing evidence against her. The head nurse did say afterward that she "might have jumped to a conclusion." It is hard to know just what my reaction would have been previously, but probably I would not have been so aware that generalizations and false assumptions were being made. It takes me much longer than it used to, before I draw conclusions about anyone or accept another's conclusions.

They saw the influence of associated ideas in forming expectations and how pursuing facts can change their approach from a negative to a positive one:

In the Outpatient Department several weeks ago a nurse asked me to take charge of a male patient, aged thirty-seven, whom she "wouldn't have time for this morning." She said that he was evi-

dently "not too bright," and that he had great difficulty controlling his movements, "probably cerebral palsy which had affected him mentally." I was very apprehensive about approaching this patient. I recalled a girl in my hometown whom I had often seen walking up the street with great difficulty and an odd smile on her face. I read his chart carefully and was surprised to find that he was a college graduate and was at present working for the state tax department. This was completely incongruous with the picture the nurse had presented to me.

I ushered the patient into a cubicle to wait for the doctor and sat down with him. He seemed to fulfill the picture I had formed from his appearance, his ludicrous grin, spasmodic movements, and difficulty in speech. However, I approached him as I would any educated person because of the information I had found on his chart. Although his conversation was not scintillating, I could tell that because of his great difficulty in speech it was next to impossible for him to express his personality to anyone in a brief conversation, however hard he might try. Our conversation ran from college to nursing, to hospitals, and it was evident that he had considerable knowledge. I could tell from his eyes that he appreciated the level of the conversation. It required great concentration to understand his speech and I could see why many people, failing to listen carefully to him, might have misunderstood it for meaningless jabber.

The nurse had described him as "uncooperative and moronic," but I found that after an explanation of the procedures he was to undergo, he was cooperative and quite interested in the mechanics of them.

I talked to the nurse after his departure, deliberately mentioning the level of his education. She was amazed. It was easy to understand how often he must have been stereotyped by others just as she had done, until he reached the point where he acted the part unless he was approached differently.

They saw how false assumptions transmitted by irresponsible people can be misleading and actually damaging:

Mr. Sampson's private nurse referred to her patient during the morning coffee break as "the worst patient I've ever cared for." She continued to say that he was very uncooperative and difficult to restrain. As the nurses talked over their coffee, mention was made of a woman visitor, Mr. Sampson's "housekeeper," who was with him during each afternoon and evening. The private nurse stated, "I understand he lives in a swank apartment building.

She was the maid but she quit and became his housekeeper. She's straight from Ireland . . . a pretty gal . . . I've always thought Irish were Roman Catholics but when the priest came she turned her back on him. Maybe she's got a guilty conscience." At this comment the other two graduate nurses responded with laughter. "It seems like she's something more than his housekeeper." The private nurse continued, "Maybe she's after him for his money." The others nodded affirmatively. "He once said, 'I've left everything to you because I don't want my nephews to get any.'"

Later in the day at the nurses' station, Mr. Sampson's nurse told me, "You know, the aide came in to take Mr. Sampson's temperature and as she walked around the bed he yelled, 'Keep away from me you dirty nigger!' He hates colored people."

On the basis of what I had heard from Mr. Sampson's private nurse, I would expect him to be hard to care for, uncooperative and intolerant. It would be easy to assume that he was wealthy and that his housekeeper was something more—perhaps a mistress.

Upon reading his chart I found the following facts: Mr. Sampson, sixty-nine years old, has an apartment on X Street. He is a Protestant, born in Rhode Island and is retired. His "maid" was to be notified in case of emergency, and her address was the same as his own. The intern's note mentioned that the patient's wife died of heart disease six months ago at sixty. It also said, "About two years ago patient began to show signs of mental deterioration with episodic disorientation, visual and auditory hallucinations. He has required almost constant attention from housekeepers and nurses during this time but recently appeared to be doing better, and for the first time was venturing out alone." The intern mentioned that Mr. Sampson's present housekeeper had known him for five months. The diagnosis noted, "Mental deterioration probably secondary to cerebral arteriosclerosis" (hardening of the arterial walls of the brain).

They learned that the question of validity or the defensibility of a judgment about a patient's behavior is not so important as the recognition that there are reasons for it:

Upon admission to the hospital, Mrs. Sullivan was diagnosed as having Laennec's cirrhosis with esophageal varices, bleeding, splenomegaly, ascites and right pleural effusion, and early coma. Secondarily, she has chronic heart failure, external and internal hemorrhoids, and osteoarthritis.¹

¹ These medical terms indicate that this patient had liver, lung, heart, bone, digestive tract, and splenic disorders.

I have noted several remarks made by various staff members regarding Mrs. Sullivan's behavior. The medical social worker's note read as follows: "Mrs. Sullivan's looking older than her fifty-five years, has been made querulous and irritable by her illness." Nurses have stated, "She appears quite upset and distressed; moans occasionally for no apparent reason, 'Oh, Mary, help me,' talking in paranoid-like manner; seems quite depressed; straining and grunting without apparent need." The clinical clerk stated she was an "emotionally tense person." Again, the medical social worker said, "She seeks a more protected environment than the hospital or home, and I sense some escapism and withdrawal." The head nurse has stated several times that Mrs. Sullivan is seeking all the tender, loving care she can get—she acts like a child in her demands for attention.

From reading Mrs. Sullivan's chart, I have obtained the following facts about her personal history. Her husband describes her as an active person who always got along well with people. He is a bookkeeper for a Wall Street firm and receives a net income of \$88 a week.

Through my own personal contact with the patient, I have heard her make these statements: "I don't want to be sick; my husband is impatient because I am sick; I am sick and tired of this hospital, the way they treat you here, and the food I get here. I just want to go home and lie down in my own bed again."

After talking to the patient several times and from my own observations, I am inclined to agree with some of the statements the staff has made about her. I have found her continually criticizing the conditions here in the hospital. She cries, hides under the sheets, refuses treatments and medications, and is thoroughly disgusted with her present state of illness.

There are reasons why Mrs. Sullivan acts this way. Besides, the conditions found in a hospital are unlike those found in a person's own home and anyone would become depressed. I have also discovered that just spending a little time with Mrs. Sullivan cheers her up considerably and she has a right to expect a little attention.

In conclusion, I would consider it much more beneficial to give Mrs. Sullivan some of that tender, loving care which she desires instead of wasting time complaining about her.

They saw how their own value judgments could influence patterns of interaction and impair working relationships:

This is a report of an actual incident which happened when I started working on a new floor. Part I gives my first impressions

and value judgments about a certain graduate staff nurse. It includes my conclusions of what she was like on the basis of the way she looked and acted. Part II gives the facts about the staff nurse and how my attitude toward her changed with my knowledge of the facts. Before taking this course there could have been only one part to this report. I would have gotten no further in my thinking than the value judgments. However, because of what I have learned, I was *aware* that I was making value judgments and set out to compare these judgments with the truth. The results of this comparison taught me a lesson in personal relations.

Impressions of Miss Marder: Sloppy in appearance; dyed hair, heavy blue eye shadow and mascara; Brooklyn accent; ignorant; chewing gum; probably Jewish; cheap; brisk and rough with the patients, not careful about sterile technique; graduate of another school; makes negative statements about patients like "She's impossible to get along with"; "He doesn't really have pain, he's just being difficult"; "I was sick of the sight of her." No interest in the patients' feelings; probably biding her time until she finds a man; works quickly to finish what has to be done so she can leave early.

The facts about Miss Marder as obtained from objective observation and from her own statements: Actually neat in appearance but wears heavier makeup than *I* consider in good taste for work; Roman Catholic; has interest in patients but conveys it in a different way from what I would. Her nursing technique is not necessarily careless but just slightly different from the way we're taught at NYH. Patients have confidence in her efficient manner and like her "gruff" sense of humor. She admits that nursing is not a life's work with her but is a good way to earn a living. Says Miss Marder, "I can't complain. Nursing has put me through music school." Is hard working, intelligent, and talented. After many hard years of study and work, she has earned a music scholarship and is now able to leave nursing for something more important to her.

I made my judgments of Miss Marder on the basis of *my value* of nursing as a profession for which one has a definite calling and in which one has many responsibilities. But Miss Marder's idea of nursing was entirely different. To her, nursing meant a steady income and it was a good means to an end. At first I was set to dislike her and my work relationships with her suffered as a consequence. After I knew more of her story, I looked for her good points and found a person I could like, get along with, and even admire.

In the comments they heard they learned to "listen" for clues that might indicate the needs of patients:

One afternoon I walked into the linen and tray room on the surgical pavilion just in time to hear two nurses discussing a patient who had been recently admitted. "What a sourpuss—he doesn't have one good word to offer! I don't even like to talk to him; he only snaps back when he bothers to answer at all." The other replied, "I've noticed that. He doesn't seem to be that sick, but he's certainly uncooperative."

From the chart I learned that the patient was a white man of twenty-seven whose case had not as yet been positively diagnosed, but who was undergoing a series of tests to determine the possibility of a marginal ulcer. His job was that of inspector for one of the big airlines. Symptoms of an ulcer (occasional gastric bleeding, gastric discomfort upon eating) were indicated; otherwise his health was good. He complained of no severe pain.

I walked into the four-bed ward (where Mr. Fowler was a patient) with a smile and a general hello for everyone. Starting at the opposite end of the room I took pulses and respirations, pausing briefly to talk with each patient. I approached Mr. Fowler in the same manner, asking how he felt. "Not so hot," he replied sharply, "Whaddaya have to do to get something to eat around here? The doctor said I should try some milk and custard when I got back from the x-ray."

When I returned with the food, we began to chat as he ate. Gradually he told me that he came from a large family (ten other siblings) which was in some financial difficulty, and he was worried about missing his work. He had been admitted to this hospital last fall for removal of a gastric ulcer. His recovery from the operation had been slow (eight weeks) but satisfactory, and he had felt it was worthwhile until a couple of weeks ago when the symptoms began to appear again. One of his brothers had been in the hospital at the same time for surgery on a sunken chest which had recently fallen again. As a result of these two apparent "failures," he had lost faith in the hospital and the staff in general. "And do you realize I've been in x-ray since eight o'clock this morning?" he concluded. (Time then was 1:30 p.m.) "It's one test after another around here."

He fell silent for a few minutes, then suddenly thanked me for listening, apologized for his behavior, and said he realized everyone was doing everything possible and that he certainly wasn't helping

any by his negative attitude. "You know, I feel much better now. Tell the others I won't bite their heads off anymore, will you? And thanks."

By airing his problems, Mr. Fowler was able to get a new perspective or "sort things out" as he put it later. He "cured" himself; but had I not had some orientation in the social sciences, I probably would have passed up the clue the nurses gave me to provide him the opportunity to help himself.

They learned how investigation of the reasons underlying a patient's behavior can have therapeutic results:

A staff nurse in the pavilion complained about one of the patients. She said, "He is a sissy; everytime he has a little pain he cries and moans as if he were dying. I've taken care of patients in terminal stages and they weren't half as bad as Mr. Pezzuti. He really is a pain in the neck. I think a man should be brave and strong when he has pain instead of being such a coward."

After hearing her comments, I decided to meet Mr. Pezzuti. I first checked his chart, which supplied the following facts: Italian, aged fifty-six, cabinet-maker, single, both parents dead. He consulted the doctor two weeks ago about the present complaint; was admitted to the hospital three days ago with a gastrointestinal upset. No definite diagnosis had been made. In the nurses' notes it was stated that he was quiet, moody, depressed, and frequently cried.

During a lull in the afternoon I stopped in and got acquainted with Mr. Pezzuti. My first impressions were that he was a large-framed, grey-haired Italian man; he spoke broken English; had a meek and timid-appearing facial expression; did not volunteer information unless asked direct questions. He was very reserved and quiet during the first visit.

The next day he seemed pleased to see a familiar face and showed more enthusiasm toward me. Since I gave him care, I was able to talk with him for a longer period of time. At one point he appeared to be in much pain, and he moaned, writhed, and cried. After he was made comfortable, he confessed to me that he was afraid that he had cancer of the stomach. When he was only twelve years old his father died of it. Since then he had been very frightened by this haunting childhood thought.

Upon talking to his doctor, I learned that he knew nothing of this fear. The doctor immediately reassured Mr. Pezzuti by telling him that he had absolutely no symptoms of cancer. This was of

therapeutic value, for Mr. Pezzuti began to show enthusiasm toward the staff and his crying and moaning were reduced.

I related my findings to the nurse who made the original statement concerning Mr. Pezzuti. She said that if she had known the cause of his disturbance she would not have complained about him.

CONCLUSION

The nonjudgmental point of view that characterizes the social science disciplines is not easily acquired by all nursing students, and some actually resist it in the beginning. But in our opinion, this experience illustrated more effectively than textbooks the importance of a scientific approach to the evaluation of personality. It enabled the students to see at first hand how misunderstanding occurs because of insufficient data and misinterpretation. It pointed up sharply how a mental set may be produced by unqualified acceptance of authority. As one student said: "Listening to morning reports used to set up my expectations of the kind of day I was going to have." It helped the students sharpen their powers of perception, and to see the superiority of verifiable facts over dogmatic and authoritarian statements. They noticed the rapidity with which a careless judgment is circulated; the remark "slid from doctor, to nurse, to aide." The experience showed them that when feelings rather than facts are the criteria for assumptions, they have little utility for communication.

Because docile conformance by some patients to medical and nursing regimes may be misleading in terms of their unexpressed needs, nursing students discovered that the label "good patient" might be a signal for greater attention. In seeking out patients described as "difficult," "impossible," and so forth, with the initial objective of fulfilling a class assignment, students discovered the excitement of seeing "problems" as "challenges," and the satisfaction in many instances of solving them. And finally, they learned that an objective approach and an empathic one are not mutually exclusive.

In connection with this particular assignment, an interesting thing occurred. It was given to three different classes within a

period of fifteen months.¹ The first class experienced no difficulty whatsoever in collecting an assortment of value judgments: "We hear them everywhere." In following through on this assignment, however, the nursing students often explained, to the intense interest of staff members, what they were doing and why. When the second class began its assignment, the students reported that some clinical services offered less material than others. Students in the third class became anxious about fulfilling their assignment because the value judgments they were waiting to collect were heard so infrequently. "The doctors and nurses seldom make judgments—they are very objective in reporting and referring to patients, and we just don't hear any." Mentioning this to a nonmedical colleague, we received the comment, "The staff probably got wise and clammed up in front of the students." One would hope, however, that the decreasing use of judgmental terms was due more to the developing kind of awareness of which a number of staff members spoke. As one instructor said: "I used to make value judgments all the time until this assignment of the students made me realize what I was really doing."

¹ The assignment was first given in the second half of the course. The next two times it was given in the first half.

Chapter 9

Course Changes, Teaching Tools, and Methods

IN THE PRECEDING CHAPTERS we have described a major part of what went into a thirty-hour social science course designed especially for students of one collegiate nursing school. We wish to stress the fact, however, that the content of any social science course that is introduced into the curriculum must be flexible. In the initial stages of an experiment of this kind, those parts of the course that are observed to be least effective should be discarded. Even though the instructor has been fortunate enough to have found all her materials suitable for her purposes and objectives, she must continually make alterations. For as the educational process proceeds and the level of sophistication of nursing staff and students rises, she will need to be always ready to supply new or more advanced material.

We found that as instructors in other subjects began to integrate and utilize some of the materials and concepts stemming from the social science course, it became necessary for us to make substitutions in order to avoid duplication. If those teaching public health adopted, as they did, certain portions of material on the cultural aspects of behavior of particular ethnic groups for their courses, or a clinical instructor discussed cultural components in response to pain in her classes, we could use some of the time formerly spent on these subjects for the introduction of new content. Similarly, when instructors incorporated in their classes material on the psychological implications of dermatological conditions, or on the psychosocial aspects of blindness or tuberculosis—provided both the substance and depth of treatment were sufficient—we switched from these considerations to other types

of physical handicaps that are either treated superficially elsewhere or ignored altogether. Alterations like these are to be welcomed, since they serve to widen both the students' and instructor's horizons.

Not all alterations were necessarily made in the social science course. Some were made in other parts of the curriculum. Both preclinical and clinical instructors in such courses as professional problems, community and the nurse, obstetrical nursing, operating room nursing, and long-term illness, found that as a result of what was taught in the social science course they could modify or even eliminate whole units of content that had formerly required their time and attention. This was not necessarily because of duplication of subject matter but, in some instances, because of differences in approach to a particular subject. For example, one course known as professional problems centered around helping the nursing student to see herself as a professional person. According to the instructor, conflicts between the beliefs of students and "the rights of patients" were generally handled on a philosophical rather than a scientific basis. But after auditing some of the social science classes, she decided that she could eliminate this part of her course entirely.

The social science course must also be flexible enough for adding to, or building upon, the content of other courses in an ever-changing and dynamic curriculum. For example, when a new course in the growth and development of the child from birth to six years of age was added to the curriculum for preclinical students, we dropped material that was no longer so essential and replaced it with a lecture and film on Balinese children. This was done in order that students might examine the way another culture mutes or reinforces certain growth processes and molds character formation in a way quite different from our own. Simultaneously, clinical instructors in charge of the course in growth and development were advised of this and of other cross-cultural material on child development that we were using,¹

¹ Mead, Margaret, and Martha Wolfenstein, editors, *Childhood in Contemporary Cultures*, University of Chicago Press, Chicago, 1955; Soddy, Kenneth, *Mental Health and Infant Development*, Basic Books, New York, vol. 1, 1956; Mead, Margaret, and Frances Cooke Macgregor, *Growth and Culture: A Study of Balinese Childhood*, G. P. Putnam's Sons, New York, 1951.

should they eventually wish to weave some of it into their own teaching programs.

As each service or clinical area adopted certain portions of the social science course content, we were able to advance or shift to other as yet untouched areas. This is as it should be, and is ideally the objective of the total integration process. Not once in the three times our course was given, was it the same. The fundamental and basic objectives remained constant but the illustrative materials were altered from year to year. This is why, in one respect, course outlines and bibliographies for a social science course in schools of nursing (frequently requested by interested nursing educators and social scientists) cannot and should not be used as anything more than a guide. As the integration process moves ahead and instructors and students become more knowledgeable, so does the level of the social science course rise and the content shift. An ever-widening circle of knowledge is the measure of success of such an undertaking. If it is necessary to use the same materials year after year, one is not making much headway.

AUDIO-VISUAL AIDS IN TEACHING SOCIAL SCIENCE

Whenever it is feasible, the use of tangible teaching devices for students is advisable. Many who select nursing as a career are likely to find more congenial those subjects that demand physical skill and action or that deal with concrete data. For some of them understanding the nature of abstract phenomena, or what seems to them abstract, is more difficult. Moreover, from their exposure to college courses in the social sciences, particularly sociology, not a few are inclined to view the subject matter of social science as somewhat vague and elusive.

We have found that a judicious use of films not only helps to augment and reinforce the materials presented in the lectures and readings but to make clear some of the concepts and principles with which we deal. Quite early in the course we showed the film *High Wall*,¹ a case study of prejudice and how it is developed

¹ McGraw-Hill Text Films, 1952. Available through Psychological Cinema Register, Pennsylvania State University, University Park, Pa.

and perpetuated. This provides an excellent basis for class discussion of several concepts that operate in human misunderstanding.

As we have already said, we adopted for use the film, *A Balinese Family*.¹ Sensitized by previous courses concerned with the effects of parental behavior on young children, students are surprised to discover that methods of child rearing which could be expected to result in psychological misfits in our own society, do not ipso facto produce delinquents and neurotics on the Island of Bali. Why this is so can be understood when Balinese patterns of child rearing are seen in relation to the culture as a whole, and how the culture itself provides certain systematic checks and balances for handling the instabilities it creates. Since the film deals with a people who are relatively remote, it can be viewed with a certain degree of detachment. Furthermore, it is of considerable value in helping to dissipate such loosely used concepts as "normal" and "instinctive."

When we moved into the consideration of folk medicine and different concepts of illness and health, we used the documentary film, *Forgotten Village*² by John Steinbeck. This is a particularly dramatic and excellently photographed film that highlights the problems of a public health team in coping with the folk beliefs and practices of people in a Mexican village in the midst of an epidemic.

We mentioned elsewhere that it appeared to be less threatening for students to begin the course with cultural determinants of human behavior. By the time they have also examined some of the social and psychological determinants of behavior which are related to patient care, they have gained in self-insight. They are now far better prepared for objective discussion of intrapsychic factors. Two films, *Feeling of Hostility*³ and *Over-Dependency*,⁴ dealing with attitudes developed in early childhood, served to stimulate self-examination. Discussions following these showings were

¹ Bateson, Gregory, and Margaret Mead, American Museum of Natural History, Seventy-Ninth St., Central Park West, New York.

² New York University Film Library, 26 Washington Place, New York, 1956.

³ McGraw-Hill Text Films, National Film Board of Canada, 1948. Available through Psychological Cinema Register, Pennsylvania State University, University Park, Pa.

⁴ McGraw-Hill Text Films, National Film Board of Canada, 1949.

more often indirect than direct, but they revealed an effort on the part of the students to understand their own feelings and responses. Not a few found their way to our office to request reading matter that would help them understand and handle more adequately their personal or interpersonal problems.

The theater and motion pictures are excellent media for the study of human behavior, and students are encouraged to see and to analyze certain productions from this point of view. To add to their knowledge of other cultures, we have recommended for example, *Plain and Fancy*, a play about the Amish of Pennsylvania, and *Gate of Hell*, an outstanding Japanese film. For illustrations of such concepts as prejudice, ethnocentrism, and social distance, we suggested the Broadway musical, *West Side Story*, and *Giant*, the movie starring Rock Hudson and Elizabeth Taylor. On the other hand, *Storm Center* starring Bette Davis afforded an excellent opportunity to study the psychology of group behavior and the dynamics of mass hysteria that began, in this instance, with the fear of communism. Both American and foreign films are especially useful for making comparative studies of behavior and role expectations.¹

Learning the art of interviewing is of such importance for nurses that it deserves to be the focus of a full course in itself. But since the time that we could devote to it was limited, we were forced to be highly selective in our choice of materials. We found particularly useful the combination of the book and sound records on *The Initial Interview in Psychiatric Practice*.² This material was released for professional use during the first year of our course, and we decided, not without some trepidation, to experiment with it. The recordings and text are verbatim reports of actual psychiatric interviews with patients and were published for use in the field of psychiatry. We were not interested in becoming involved

¹ For example, see: Wolfenstein, Martha, and Nathan Leites, *Movies: A Psychological Study*, The Free Press, Glencoe, Ill., 1950; Wolfenstein, Martha, "The Image of the Child in Contemporary Films" in *Childhood in Contemporary Cultures*, edited by Margaret Mead and Martha Wolfenstein, University of Chicago Press, Chicago, Ill., 1955; and Bateson, Gregory, "Cultural and Thematic Analysis of Fictional Films" in *Personal Character and Cultural Milieu*, compiled and edited by Douglas G. Haring, Syracuse University Press, Syracuse, N. Y., 1956, pp. 137-142.

² Prepared by Merton Gill and others; published by International Universities Press, New York, 1954.

or involving students in the psychiatric implications and interpretations of the content of these interviews—a danger of which we were well aware. What we attempted to do, however, was to use the material as an instrument for sharpening the students' powers of perception.

Two recordings of interviews with neurotic patients were selected and students were instructed to listen for, and to note, the following: examples of good and poor interviewing techniques; signs from either interviewer or interviewee of threat, nervousness, feelings of guilt, anxiety, anger, warmth, and the like, as manifested by use and choice of words, tonal changes, silences, interruptions; loaded questions, emotionally charged words, permissive or blocking techniques, and so forth.

So intent were the students in their concentration on these aspects of the interviews that, fascinated as they were with the substance, they had little time to become too involved in the psychodynamics of the therapeutic sessions. The experiment was most successful in terms of student learning and interest, and we have continued using these devices ever since. In addition to the other reading assignments on interviewing,¹ students are encouraged to further their study of the art of interviewing by giving their attention to current radio and television programs which occasionally afford excellent examples of both good and poor techniques. At this writing such programs as "Meet the Press" and those conducted by Mike Wallace and John Wingate offer opportunities for critical analysis.

USE OF GUEST LECTURERS

The discriminating use of guest lecturers, we found, was another way of enriching the social science course. By utilizing representatives from the fields of anthropology, sociology, and

¹ Young, Kimball, *Personality and Problems of Adjustment*, Appleton, Century, Croft, New York, 1952, pp. 306-311; Greenhill, Maurice H., "Interviewing with a Purpose," *American Journal of Nursing*, vol. 56, October, 1956, pp. 1259-1262.

Suggested reading: Merton, Robert K., and Patricia L. Kendall, "The Focused Interview," *American Journal of Sociology*, vol. 51, May, 1946, pp. 541-557; Paul, Benjamin D., "Interview Techniques and Field Relationships" in *Anthropology Today*, edited by A. L. Kroeber, University of Chicago Press, Chicago, 1953, pp. 430-451; Allport, Gordon W., *Personality: A Psychological Interpretation*, Henry Holt and Co., New York, 1937, chaps. 18 and 19.

social psychology, one can demonstrate to students that flexibility of the behavioral sciences which makes it possible for members of these disciplines to focus on such disparate subjects of human activity as engineering, industry, or nursing. This helps the students see, too, that while the lecturers might talk to a group of academicians or their professional colleagues in one way, to those concerned with labor relations, mental health, or government administration in another way, it is also possible for them to gear their material for application to nursing. In order to ensure more direct application and specificity, however, and to fit the content of the lectures into the conceptual framework and maintain continuity, it is most important for the instructor in charge to provide each lecturer beforehand with a clear picture of the aims and objectives of the course and the particular purpose for which his talk was solicited at the time.

Another important experience for students was to hear interim reports from social scientists about research projects in which they were currently engaged.¹ This enabled students to learn at first hand some of the problems of scientific research, how persons undertaking such problems attempt to solve them, what methods are used, and how obstacles are overcome. Discussions of this kind are stimulating to students and give them a sense of being participant observers of work in process. Not only are they encouraged to ask questions, but exchanges between the instructor and the guest lecturer can serve to bring out other points the instructor feels are in need of emphasis or clarification.

With respect to the use of guest lecturers, it is quite true that in large metropolitan and educational centers the opportunity for obtaining social scientists and others who have special contributions to make to such a course is much greater than in smaller communities. But this should not deter those who are teaching social science in collegiate schools of nursing in nonmetropolitan localities. In all probability there is a medical or university center close by where social scientists, physicians, or psychiatrists can be

¹ Over the three years those who gave interim reports about ongoing projects were: Renée Fox, August B. Hollingshead, Jean Huntington, Bernard Kutner, Rhoda Metraux, Mark Zborowski.

found who are engaged in research or teaching that would be useful as background for a lecture to students. In our opinion, such lectures, particularly the kind we have reproduced in this book, enrich the content of a course. Over and beyond this, contact with specialists in fields other than nursing and medicine, particularly in schools that do not have an integrated program, helps to prevent or forestall that ever-dangerous potential in nursing education—the intellectual insularity which turns the profession inward instead of outward.

Chapter 10

Application of Social Science Content by Nursing Students

THE TIME HAS NOW COME for the question that is all-important: Given a course like the one described, what application do students make of the material? Certainly the utilitarian attitude that is characteristic of both nursing and medicine requires that any new subject pertaining to practice that is introduced into a crowded curriculum must have specific clinical applicability. While the social scientist may be aware of the utility the knowledge in his field has for nursing and patient care, the seemingly abstract and general nature of the concepts with which he works makes this less apparent to nurses, doctors, and students.

In presenting our course for the first time, we were admittedly uncertain as to how long it would be before results could be demonstrated, and how they could be identified as stemming directly from the social science content. We had focused our attention on helping nursing students to recognize some of the key social science concepts and tools that would “promote depth of understanding and flexibility of use,” but in what specific ways this would bring about changes in patient care or interpersonal relations remained to be seen. The ways in which nursing students were applying their knowledge to their clinical experience were noted, however, much sooner than we had anticipated.

In Chapter 8 we saw how a knowledge of some of the factors that influence personality and behavior assessment of others was put to immediate and practical use. By the end of both the first and second parts of the course, further evidence of the way

students were applying social science material came from several directions. Clinical instructors, head nurses, supervisors, heads of nursing departments, and several doctors provided us with many concrete examples in unsolicited verbal and written reports. In addition to those instances observed at first hand by the social scientist, there were countless examples cited by the nursing students themselves in written reports and course evaluations.

These data were examined from the point of view of relevance to the kinds of situations listed at the beginning of this book (see page 19), which are encountered daily by nurses. As we pointed out earlier, it is situations such as these that provided the frame of reference for the course, as well as the *raison d'être* for the whole experimental project. The data could be classified in several different ways, depending upon one's particular objective. But for our purposes, we have hewed to the pragmatic line and classified them according to the kinds of questions we wanted answered and that have been asked us by nurses, doctors, and social scientists. From hundreds of reports accumulated over a three-year period, we have selected a few excerpts for inclusion here. Unless otherwise specified, those that follow are taken from reports by the students, with minor editorial revisions.

1. Does social science knowledge help students understand and accept patients whose customs, beliefs, or behavior are different from their own?

Beliefs of patients which differ from mine seem less and less strange to me the more I realize that they are real to them. If their beliefs do not seriously interfere with their treatment, I am not bothered by them. A few months ago an Irish woman wanted me to fix her flowers because she was menstruating and thought they would wilt if she touched them. At the time I thought, "How misinformed this woman is!" But after reading "Cultural Backgrounds of Female Puberty" I realized that this is a common belief among Irish people.¹

* * * *

How many of us have run across patients who object to daily baths! Do we write them off as "dirty" or do we realize that in

¹ Abel, Theodora M., and Natalie F. Joffe, "Cultural Backgrounds of Female Puberty," *American Journal of Psychotherapy*, vol. 4, January, 1950, pp. 90-113.

some cultures cleanliness is not the holy virtue we hold it to be? Can we understand an Orthodox Jewish patient without knowing something of the reasons for his being a "picky eater," as he is so often accused of being? What are our feelings as we behold the tearful family surrounding an Italian patient, while in the next room a dry-eyed English woman watches her husband die? To understand people we must be conscious of the cultural differences each possesses and learn not to judge them by our own standards.

* * * *

Anthropology has enabled me to understand and accept patients' beliefs instead of criticizing them. For example, while I was on the labor and delivery service, a Puerto Rican patient who had just given birth to a baby boy asked that her son's first voiding be placed on her face to clear up the acne that was present. If I had had no training in anthropology I would have frowned on this.¹

* * * *

Understanding the psychological implications of amputation helped me realize why Mrs. Maisel, a postoperative mastectomy patient, became very depressed a week after her operation; refused morning care and refused to see her husband at visiting hours. This understanding enabled me to help her through this phase, for I could talk to her, listen to her, and reassure her, instead of rejecting her as a problem patient.

* * * *

I was able to understand why an Italian patient who was recovering from a coronary occlusion cried when the doctor told him his period of bed rest was to be prolonged to twice the usual time. Not only did I recognize that this crying was probably the expression of an Italian cultural trait—that is, the tendency to show emotions freely and unashamedly—but I realized that any initial disapproval on my part was merely an expression of my cultural background, the American ideal of "stoicism and independence." Understanding how cultural factors influence patient behavior often helps to explain the differing reactions to and expressions of pain. When the nurse can understand the patient's behavior on these terms, she is better able to plan the use of narcotics, and to know, for example, how far she can push a patient in exercising the stump after amputation or deep breathing after chest surgery.

* * * *

¹ That a baby's urine mixed with alcohol is effective in the curing of chicken pox is a belief held by many Puerto Ricans. See Padilla, Elena, *Up From Puerto Rico*, Columbia University Press, New York, 1958, p. 284.

Before I entered college and nursing school, I am sure I considered only the surface reasons for people's actions. It would never have occurred to me that the reason Mrs. Stein would not permit an autopsy to be performed on her husband was due to her cultural background. I probably would have thought she was a stubborn old lady who would not accept modern medicine. If Mr. Mahler refused to give a stool specimen, I would have thought that he was just shy rather than that he had been taught that elimination was a nasty subject and something one never, never discussed with others. And when Mrs. Edelman wanted her amputated leg buried in a certain spot, I very likely would have attributed this to superstition rather than to the fact that her religion specified such action.

* * * *

To understand the patient's reactions to his disease, it is necessary to know his goals, his drives, and his attitudes. To know the manner in which they cause him to react, enables you to give better and more complete patient care without rejection of the patient "because he acts so funny." To accomplish these things requires a thorough grounding in the social sciences.

This is important throughout nursing; but one of the very vital areas it affects is chronic illness, whether contagious (tuberculosis) or deforming (poliomyelitis). The nurse and the patient are together for extended periods during the time involved in cure and treatment. They must be well acquainted; the nurse in her position of authority has the responsibility to understand her patient rather than vice versa. The nurse must also have insight into her own reactions and attitudes.

The how and why of behavior is based on more than quirks of the personality. It stems from one's culture. One's religion, nationality, and family influence certain response mechanisms when given specific stimuli. The competent nurse is able to say, "Mr. Xavier is not being bad or difficult; he has learned to react in this manner. How do I react to the same thing, and how can I help him knowing this fact?"

* * * *

An Italian-American mother of twenty-two became very upset when her Italian husband refused to allow their son to be circumcised. I asked her if he gave any reason for his refusal, and she said, "No; he wouldn't even talk about it. He just repeated that he didn't believe in it." The next question I asked was why she thought the baby should be circumcised. She said she had

attended the pediatrician's conference where it had been discussed and recommended; and besides, *all* the other mothers in the ward were having their male babies circumcised. She felt that her husband was the only one who didn't agree and that he was just stubborn and old-fashioned. I suggested that she ask her husband if he would like to talk it over with the pediatrician.

The next day the patient was even more upset because her husband had said that he didn't need to talk it over with any doctor. That night at visiting hour she told him that the baby had been circumcised, "just to see what he would do," she told me later. He jumped up and angrily removed the baby's diaper to see what had been done. He was very sullen for the rest of the visiting hour and left early.

I looked up the backgrounds of these two parents and found that the wife was born of Italian parents in New York City. The husband was born in Italy and came to this country with his parents when he was sixteen years old. There was some inequality in their educational background, too. The young woman had had two years of college but her husband had not gone beyond high school, with the major part of his education received in Italy.

I had heard that the old Italian families did not want their babies circumcised. I interviewed two members of the medical staff who were Italian to see if there was any cultural basis for this attitude toward circumcision. They said that it was a common attitude among Italians but no more so than among other Southern Europeans, especially Spanish and Greek. Another factor is the belief that what is good enough for the father is good enough for the son. Then, almost as an afterthought, they mentioned that it was believed to decrease the potency of the male. This belief, I think, was perhaps the most important factor in the father's opposition. Since this is a matter which is highly charged with emotion, it could account for the father's apparent irrational and violent reaction against circumcision and his complete refusal to discuss it. How much his reaction was the result of his own personality pattern and how much the result of the influence of his culture cannot be determined from the limited information at hand.

When it became apparent there was no practical way to reach the father, it was necessary to try to help the mother (whose resentment was so strong that continual friction was likely) understand that the problem was not so difficult as she seemed to feel. I explained that not all mothers whose babies were born at our hospital had them circumcised; that some doctors feel it unnecessary unless the baby's foreskin is unusually tight (this baby's was not). The baby

could easily be kept clean by gently retracting the foreskin and washing the area every time she bathed him, so his health would in no way be endangered. I tried to help her understand that the few advantages to be gained by circumcision were not so important as family harmony and the good will resulting from acceptance of her husband's wishes.

The nursing care of this family, besides the usual teaching and physical care, involved giving the mother a chance to express her feelings and then providing her with the information, support, and reassurance she needed so that she might begin to make a realistic and satisfactory adjustment to this situation.

2. What evidence do we have that social science concepts enable students to recognize and analyze *in retrospect* factors in interpersonal relationships that limited or interfered with total care of patients?

One evening, when I was off duty, the Emergency Service notified the hospital floor that a woman was to be admitted with a throat stricture. However, the patient's arrival on the floor was preceded by that of her personal doctor. He informed the staff that his patient would be transferred to a private floor as soon as possible but in the interval he anticipated the nurses' "complete cooperation in doing everything to make this patient comfortable." His dictatorial manner antagonized the nursing staff, and after he left, the outraged nurses voiced the general opinion that a "strange doctor had no right to barge in and order everyone around." Other remarks were: "If he thinks his patient is going to get any more attention just because she's a private patient he's very much mistaken"; "if she wants special attention she should hire a special nurse." Already the staff had developed a "chip-on-the-shoulder" attitude toward a patient they had not yet seen. Everyone anticipated that she would be affluent, complaining, demanding.

The following morning she became my nursing responsibility. Unaware of what had happened the night before, I established contact with her and found her to be cultured, demanding, domineering, yet agreeable. Her care on this particular day included preparation for a bronchoscopy. In following the routine pre-operative procedures I asked the patient to remove her nail polish. She refused to do so, saying she was going away immediately after her release and had no time to get a manicure. She was adamant, and my explanations and pleas were most ineffective. With a

meager four weeks' experience as a clinical nursing student I went to the head nurse.

She was very angry and advised me not to take "any guff from her." She said to tell the patient that "we are not running a beauty parlor and hospital rules must be obeyed." No tact or courtesy was to be shown in order that I might put this woman "in her place." By now the staff had told me of their impressions about the patient, and of the incident that had occurred the preceding evening. All timidity left me and I returned to my patient thoroughly convinced that I would make my point clear. Repeating my request, I firmly indicated that she must comply. She refused to discuss it any further with me. (She constantly referred to me as a nurses's aide, despite my correcting her and showing great annoyance. Before I had seen the head nurse, however, this had not bothered me.)

Again I called upon the head nurse. She sympathized completely with me and went to "tell the patient off." A terrific argument ensued. By now things were disastrous: the hour scheduled for the test was close; the patient was in a high state of excitement; and the nail polish had not yet been removed. After much bickering, a compromise was reached. The patient removed the polish and we made arrangements for the hospital beauty service to give her a manicure before discharge. Much to the relief of everyone, the patient did not return to our floor following treatment. She had been transferred to a private pavilion.

Here was a shameful example of how stereotyping and prejudice can impair social interaction. The staff, guided by preconceived notions, decided to reject the patient without taking an objective view of the situation. The patient likewise had certain ideas about "clinic or charity" wards, and had insisted upon asserting her independence.

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I was working in medicine when the floor received a call from the Emergency Service saying that a patient was coming up. After the nurse had put down the phone, she let out a yell and began to get excited. Of course, a few other nurses had to join in, too. There was much laughing and groaning, and everyone was very upset. They told me the patient was a woman who had been on the floor for about seven months and had left only two months ago; that she was "just impossible, always wanting something and making a fuss"; and so the story went on and on.

Right away I built up my plan of attack. I was so flooded with these stories that I had let myself believe them and was therefore

not able to be objective about her or her situation. I was determined to meet her every move with some wisecrack or remark. I wasn't going to let her push me around, and I wasn't going to give in to her an inch. I knew not one actual fact about this woman, yet I felt that I knew all about her. This, of course, interfered greatly with the nursing care. The first time that I saw her I went in with an already-formed opinion about her and I expected that she would or should act in a certain way. Consequently, my nursing care was not sympathetic, and instead of making her feel comfortable and secure in the hospital environment, I was sharp and did not even give her a chance to express herself. I rushed through the procedures not even daring to stop for fear that she would start this terrible routine of hers. I let only a part of myself and my personality become involved in caring for this woman. On the other hand, because of my attitude I think the woman gave only a small part of herself also.

All of this greatly hampered my nursing care and my relationship with her. In a few mornings I realized how wrong I had been. She was very charming and was a lot of fun to work with. She did have some traits that were unpleasant, such as a very whiny voice and complaining a great deal; but I think these were just her ways of letting out some of the feelings she had inside.

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One of my patients was a man with a myocardial infarct (blockage of one of the arteries supplying the heart muscle) who was in imminent danger of death. He required constant nursing care. I enjoyed taking care of him, and hearing him tell of his wife and two children, whom he praised constantly. During the second week of his hospitalization, a floor clerk disclosed to me that he had a mistress who corresponded with him and called him daily. I was horrified and shocked. He had violated one of my mores. This man was enjoying extramarital sex relations. His thoughts on marriage and mine did not coincide. I was, of course, making value judgments. I performed every chore (and chores they became) with reluctance. Simple tasks repulsed me; I no longer derived pleasure in my ability to serve. I did not stop in to see him before leaving the floor as I had been accustomed to, but purposely avoided his room. My nursing done, I considered my duty finished.

My knowledge of this man's private life was very detrimental to his receiving good nursing care and adequate emotional support in his illness. Thus, value judgments, using my own mores as standard, prevented me from treating him as an individual who had his own mores and beliefs. However, even though I realize

I am in no position to judge, I still want to make it known that this type of behavior in my opinion is wrong, according to my religious and moral upbringing. But I should not have reacted as I did and think I would not today.

* * * *

Recently I was assigned to the care of a patient who was admitted to our pavilion with the diagnosis of subarachnoid hemorrhage (bleeding beneath one of the coverings of the brain). Having cared for several patients previously who had had this disease, all its nursing implications became clear to me immediately. This patient would need complete bed rest, baths, exercises, positioning, attention to elimination problems that invariably arise with a regime of bed rest, and explanation of various tests performed. Emotional support and reassurance would be needed, for progress is slow and for the average patient prolonged bed rest is "hard to take." However, because this patient was a physician, somehow I expected him to react differently to his disease from housewives or garage mechanics. I was under the impression that emotional support would be unnecessary—after all, he was a doctor, knew all the implications of his disease and treatment, and certainly would need no explanation of tests, and so on. How it surprised me to learn that he was afraid of having a lumbar puncture and arteriogram done; that he was more than slightly concerned with his prognosis; and that he disobeyed the doctor's orders outright when he stood up to void instead of remaining flat in bed as he had been told! In other words, it surprised me that a physician reacts to illness as a patient, as a person, in terms of his own personality and cultural traits. To be sure, I gave him good physical nursing care; but it wasn't until I realized the fact that I had anticipated certain emotional responses from him because of preconceived ideas of mine and had been wrong in these anticipations, that I developed any kind of rapport with him. From then on nursing care was definitely more complete. For example, it included many interactions between us as nurse and patient, which served to encourage and reassure him. In this particular instance social expectancy was interfering with good nursing care until it was recognized as such and something was done about it.

3. In what way do the concepts provided by the social sciences help students to analyze difficult or unusual situations?

Mr. Aaronson has a diagnosis of cancer of the prostate (a gland associated with the male reproductive tract). He is in a great deal

of pain, is up *ad lib* (at pleasure) as tolerated; has had numerous extensive examinations; resents being hospitalized for what he considers an undue length of time, and feels he is not progressing or being cured. Socially the patient gets along with the other patients but is not outgoing. He seems to like the staff when they are paying attention to him but is generally distrustful of their "real reason" for talking to him. He tolerates the staff doctors only because of their knowledge, without exhibiting any pronounced confidence in them and their examinations.

Over a period of two to three weeks the patient gradually became resentful about "the whole situation" and was unable to lash out either at his disease or the staff without violating his respect for people or himself. Meals became an outlet for his aggression. It is socially acceptable to discuss food, its quality, or its lack of quality. He was able to complain to the dietitian as well as to whoever brought his tray that "the meals are poor." He invariably greeted his meals with "What have they thought up for this meal?" "Don't these people know how to cook?" "Meat loaf, meat loaf, and more meat loaf, what is this, anyway, meat loaf week?" Once he had his tray he asked for more, for extras, for exchanges. Criticism of meals entered into every conversation and phase of patient care. "I feel all right, but that meal upset my stomach." It was hard to establish any degree of rapport with him. Two methods were used: to avoid any mention of food, which worked only in "off-guard" moments, and to discuss meals to get them off his mind and go on to other topics. This succeeded, for it enabled the patient to express his aggression and resentment verbally without criticizing the people around him.

For example, one day I had to prepare Mr. Aaronson for a proctoscopy. He had had one three weeks before and was familiar with the procedure. However, his comments were in the following vein: "Oh dear, that examination is so uncomfortable. I just know I'll not be able to eat any lunch. Now why do I have to have a second one? I'll be so upset afterward. I suppose the doctors know best." Afterward the patient could not eat anything, refusing his tray as "messy" and "unappetizing." He was overheard to comment to visitors that afternoon that it was a shame the "meals here are so unpleasant because everything else is just fine."

This is an excellent example of scapegoating. The meals are not so terrible as the patient would have the listener believe. (He was on a general selected diet.) He was upset at his illness and what it brought to him in the way of pain and treatment. He could not lash out at people, for "it is so nice to have someone nearby

to console me." To do so would estrange the staff from him, so he thought. The food served as a focal point for his feelings against others without hurting "another human being." Patient care was not directly interfered with but small talk which opens the way to deeper understanding of a patient and his trouble was hard to come by. It required a great deal of patience and tact to get below his "I don't like the food here."

* * * *

One of my most enjoyable experiences has been evening duty for a week on surgery; but it was a week of hard work and greatly increased pressure as compared to day duty. During this time one incident occurred in which the social distance between a patient and me, the nurse, was traversed in a few seconds because of a stress situation. I found myself a bit shaken by this experience, but I think it actually resulted in better patient care.

I felt that the atmosphere while working evenings was one of "hurry, hurry, hurry—get everything done," and there was a good deal more responsibility placed on the student than during the day. There was only one graduate and one student nurse (compared to a staff of six or seven in the daytime). The graduate nurse was responsible for medications, posting orders, and generally running the floor while the student was responsible for the treatments on all twenty-nine patients during the evening. The size of this assignment and responsibility seemed especially great to me, because surgery was my first clinical service and I had not had much practice in organizing my work and in judging which are the most important patient needs. Among the patients on the floor was one middle-aged woman, Mrs. Johnson, who had a large wound infection on her abdomen which would not heal in spite of repeated skin grafts. It was being treated with periodic exposure to heat lamp for two hours followed by a wet saline dressing. Aside from the annoyance of this wound, however, Mrs. Johnson was in no distress. She was up *ad lib*, seemed generally comfortable, and was usually quite cheerful except for occasional despondency because "I've been here so long—will I ever get healed?"

I think there is and should be social distance between a nurse and her patients. The nurse does not allow the whole of her personality to become involved with each patient as she would with a personal friend. But this social distance is really "situational"—that is, it is not necessarily so because of the incompatibility of the two personalities but rather because of the situation in which they

find themselves. If the same two persons were to meet in another social situation, they might become very close friends with psychological and sociological convergence.

Thus, my relationship with Mrs. Johnson was one of friendly interest and sympathy, but one in which some social distance was maintained between us in our present roles. With one incident, however, this distance was traversed and we "interacted socially" as would many a young girl and a kind older woman in a social situation outside the hospital. When a patient is as nice and as seemingly well as Mrs. Johnson, her needs are not considered so pressing by the nurses as those of other patients, and her treatments are likely to be put off until more urgent ones are completed. This was the case one evening when I was especially rushed. I felt very tense because I was so hurried and every little thing seemed to upset me. Mrs. Johnson's dressing was overdue; she had been under the heat lamp for more than her two hours. When I finally got to her bedside about half an hour late, I found her very irritated and in tears. I tried to apologize and explain how busy I'd been, but she said she was so uncomfortable under the heat lamp and no one ever cared about her or thought it important to take care of her on time. I think this outburst was the result of feelings which had been building up within her, partly due to her own discouragement, since she was not a particularly self-centered or demanding person. Her remark about being considered unimportant was perfectly understandable, and because there was some truth in it, it made me feel even worse. Much to my horror, all of a sudden I burst into tears, too. And then, before I knew it, Mrs. Johnson had her arms around *me*, comforting *me* with, "There, dear—I didn't mean to make you cry!"

Not only was the social distance between us gone but we had also completely reversed roles. One minute previously I was in the role of authority (the "good authority," I hope—the so-called mother figure) and Mrs. Johnson was the patient whose psychological and emotional feelings had regressed subconsciously at least to those of a child—someone dependent and perhaps insecure—even if her behavior was not childish. Now Mrs. Johnson was definitely the mother figure and I was the insecure child. I was distressed and terribly embarrassed. I said, "Oh dear, I'm sorry; this isn't very professional of me." Whereupon she handed me a Kleenex and replied, "That's all right; just have a good cry. I know you have a great deal to do, and I know you're just going on nervous energy tonight. I didn't mean to complain." Then I assured her it was my fault and she had a perfect right to be upset.

I felt very guilty for abandoning my professional role but her comforting me there behind the drawn curtains where no one could see us was certainly welcome at that moment. So I took a deep breath and felt much better. I finished her dressing and gave her a quick hug before I pulled back the curtains. We then resumed our former roles; but I felt especially warm toward Mrs. Johnson after that.

This was something that happened spontaneously and I would certainly not recommend playing on a patient's sympathy as a method of giving good patient care. Nevertheless, I think this incident was good for the patient and no credit to me. First of all, it certainly provided a diversion to occupy her attention, which is a cardinal principle in helping a patient endure the depression of a long hospital stay. Secondly, most people receive a great deal of satisfaction from helping someone else, and this may have diminished her own troubles for the time being at least. Last of all, I suspect many adults resent being placed in a dependent position, in which they are insecure because they have no control over it. It may have given Mrs. Johnson's self-dignity quite a boost to be able to assume a position of authority or control, even momentarily. She was again the mother not the child. I believe I was better able to resume my former role, however, with a minimum of embarrassment because I thought I understood the concepts involved in what had taken place and could understand Mrs. Johnson's feelings and the possible value of the incident to her.

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An expectant mother sat huddled in the small dressing room adjoining the examining cubicle in the Obstetric Clinic. It was a busy morning. She had been waiting alone for approximately an hour, undressed and wrapped in a drawsheet. When I told her the doctor was ready to see her, she very slowly rose and entered the uncurtained examining room. She was a slim girl in her early twenties, her mouth set in a firm line. While I carried out routine procedures (weighing and measuring, height, etc.), I explained why the clinic was busy and tried to soothe her seeming irritation. She acknowledged me with glances only and "yes" and "no" answers. As I helped her onto the table and draped her, I noted that her hands were cold and perspiring. Slowly, I explained what was routinely done on a first visit to this clinic (this was to be her first child). I explained how and why she would be measured externally and internally. She had no questions. Her hands, with short-bitten nails, fidgeted with the sheet. She seemed more frightened than annoyed.

When the doctor came in, I introduced him to Mrs. Markham and he conversed with her for a while. Then the physical examination which he made without haste went well. When the time came to put the woman in lithotomy position for her pelvic examination however, she could not relax. She kept her knees tightly clamped together, her hands firmly pressed the sheet against the lower part of her body, and she kept sliding her hips back from position on the edge of the table. Each time the doctor touched her, she withdrew. Throughout I had been at Mrs. Markham's side, attempting to help her relax and repeating the reasons for the examination in terms of her and her baby. All for nought, however, for the doctor finally gave up and said that if she didn't want to continue, he wouldn't. With that, as she gathered the sheet about her to return to the dressing room, the doctor said, "Frankly, Mrs. Markham, what did you expect when you came here?" She replied, "Just what I got!" and slammed the door behind her. The doctor glanced at me and said, "A schizo of some sort!"

Shortly afterward I knocked on the door of the dressing room to see how Mrs. Markham was managing. She was fully dressed and more voluble than she had been in expressing her feelings: "Even though this is routine to those doctors it certainly isn't to me, especially with all those other people (nurses and doctors) walking past in the hallway."

In considering the dynamics of this incident, I think that several concepts were involved—mainly attitude, role, and rationalistic bias. Mrs. Markham, I believe, exhibited an attitude which functioned negatively in this situation by interfering with the doctor's goals. She engendered in me the feeling that inherent in her reaction was a resistance which she did not truly wish to overcome. Had she succeeded in doing so, it would have been with great difficulty. I think her words, "Just what I got!" indicated that her response, though probably not consciously premeditated, was in accordance with an attitude toward examination.

Regarding role, I felt aware of mine, as a nurse, to "reassure the patient and assist the doctor." Ideally, by success in the former, the latter should have followed. Although I tried to individualize my approach in line with the patient's cues, the hoped-for result was not obtained. The specified role fulfillment was modified in this situation, leaving me with the unsatisfactory feeling that I had not helped the patient help herself, and that this type of reaction on her part may prevail through or overshadow her entire pregnancy. The doctor's comment of dismissal, "A schizo of some sort," I think represents a rationalistic bias. Although said without strong

feeling and possibly only as an incidental remark, it might be an attempt to explain the less than satisfactory results.

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A man named Henry was admitted because of bleeding into his knee joint. He was a hemophiliac (one who has an abnormal tendency to bleed) and had injured his knee by hitting it against a car door. Besides his unfortunate physical illness, he had a rather sad social background. His father and brother were alcoholics and one of his sisters was mentally ill. Henry was outwardly all smiles but underneath his gaiety he seemed to be lonely and depressed. He would often express his desire to go home and then would quickly add, "Well, not home but away from here!" It was obvious that he needed and would have appreciated someone with whom to talk. However, he was for the most part avoided by the nursing staff. We usually had enough time to visit with the patients during the afternoon, particularly those who had no visitors. Though Henry never had visitors, few of the staff went to see him. I, too, was guilty of this and it bothered me.

As I thought about the situation, I came to understand why it existed. Henry was very handsome, intelligent, twenty-eight years old and a bachelor. The nurses on our floor are also attractive, young and single. As one of the nurses said, "I'd like to call him Henry and talk to him all afternoon but I don't think it would be too professional."

A nurse is taught that she has a certain role to play. She is expected to maintain a certain amount of social distance. Once she is in uniform she is no longer "Mary" but "Nurse." Her own personality should not become too involved. She is to be "professional." In this situation the concept of herself as a nurse was in danger. There was too great a possibility that her own personal feelings would prevail and she would be "Mary" instead of "Nurse." Her fellow workers would expect her to maintain her professional attitude. If she failed to do this there would be disapproval by the other nurses. It was safer to remain out of Henry's room altogether.

On Henry's last day in the hospital, he said, "I've been here for twelve days and have had only three back rubs." He said it with a smile but added, "No one cares about me." It was too late then to improve this situation. I think that if he had been older, married, or not so good-looking, things would have been different since the nurse's concept of her role would not have been endangered.

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4. What evidence is there that the study of human behavior makes any difference in the way nursing students feel about what they are doing?

I was assigned to take care of a patient whom I had heard the nurses discussing. "He's always whining, that's nothing unusual"; or, "It's the same old pain," were some of the comments I had heard. Of course, from these remarks I had built up certain opinions of the man myself so when the time came for me to go in and start his care, I was set for a pretty miserable morning. Little did I realize that I had fallen into the trap of social expectancy and how difficult it would be to escape. I checked his chart for information that I had always considered important, and found that he had undergone a portocaval shunt (a surgical joining of two blood vessels in the abdomen for the purpose of shunting the blood flow away from the liver or its own blood vessel) two days before and that he was able to sit up in a chair. After checking the Kardex, I went into his room and introduced myself. "Good morning Mr. Jacobs, how are you this morning?" This was just the wrong question at the time, for in his high whiny voice he started off on a long dissertation about a persistent abdominal pain. He spoke very broken English and it was difficult to follow his conversation. "I sit, it hurts, oh-oh-oh; I stand, it hurts; ohhhhhh, it hurts!" I was pleasant and urged him to tell me about it; but all the time I was under the influence of the attitudes expressed by the other nurses and found myself "listening but not hearing." I didn't probe as deeply as I might have or try to find any of the reasons for this type of behavior. I figured it must be "natural" for him and so I went about my work and finished everything as quickly as possible. I then left him sitting in his chair sputtering and whining about his pain, and went on to another patient in the bed across from him. As I was working about in the room, Mr. Jacobs would interrupt me every few minutes with "Nurse roll up my bed" or, "Get me a drink." Each little thing seemed to be more annoying to me as the day went on.

During the early part of the afternoon while I was giving him a back rub, a visitor arrived and introduced herself as his daughter. I thought that she might help to cheer him up a bit, so I quickly finished his back rub and left them to visit. When I came back to straighten up the unit, she was still there and Mr. Jacobs was still complaining—only this time it had shifted to his diet. His daughter sympathized wholeheartedly with him and asked me if something might be done. I listened to her and told her that I

would tell the nurse, who would probably consult with the doctor. When I did report it to the nurse she shrugged, took it all in and answered, "Thank you; that's one of his usual complaints." The afternoon dragged by as I listened to him complain. But whenever I did anything for him he appeared pleased. When four-thirty came, I was rather glad to be able to leave his whining behind, yet I couldn't help feeling that there must be something that could be done to make him happier.

Ironically, this patient was readmitted to G7 two months later and I again was assigned to care for him. How different my attitude this time! In fact, I found myself actually looking forward to this as more or less of a challenge. First of all, I looked for more information than just the patient's diagnosis and activity recorded on his chart. I paid special attention to his personal history on the back of the chart. I found he was fifty-seven years old, born in Czechoslovakia, and now living in New Jersey. Since he was unemployed and had no savings, he was being supported by his daughter, one of four children. He was of Jewish faith. This last point might account for some of his outward expression of pain.

Equipped with facts I went in to start his morning care. I approached with the same question but a different attitude, and what a difference it made. He answered in much the same way, "Oh, ohhh, it hurts!" but that didn't phase me, for this time I wasn't concerned with what the other nurses had thought of him. I was going to try and treat him as an individual with individual problems, and try to find out what might be causing him to act this way. The morning went quite smoothly. Mr. Jacobs still complained but I tried to comfort him about the future. As far as the language barrier went, I tried to understand as much as I possibly could by really listening to what he said. Concerning the complaints about the food, I stopped to find out what he was used to eating and what might be added to his diet here in the hospital that might make meals more enjoyable for him. In addition to my speaking to the nurse who seemed so biased, we made out a list as a reminder for Mr. Jacobs himself to speak to the doctor when he came the next time. Throughout my care for him I tried to picture him in terms of his background and family situation; consequently, the day became more pleasant for both of us. When four-thirty came, I was rather sorry to have to leave, for it had been an enjoyable day. It is true that the complaining and the whining were still present, but when properly understood this patient was no trouble at all.

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A few weeks ago I had the opportunity to care for a man who was known on the floor to be "a difficult and impossible patient." With our advantage of psychosocial training, this kind of introduction to a patient is something we seem to take as a real challenge, almost as if we resent the idea that any patient is "impossible."

My early contacts with this sixty-year-old man of Armenian origin were certainly not smooth-going. He insulted me and he was uncooperative about his care. As I worked and talked with him, I realized that a great part of his negative attitude stemmed from his fear of the hospital and the personnel. He was afraid of these "mysterious" surroundings; the doctors who came on their rounds and talked *about* him but only occasionally *to* him; and the nurses who came in with an injection and told him that it would not hurt, but it did. From these experiences Mr. Zovickian grew not only to fear his dependent situation but also to distrust the people who forced him to depend upon them. He feared and distrusted the authority. As I began to understand him, he began to trust me and no longer was "difficult" for me.

The attitude of the other people on the floor toward him stayed the same. One day the doctor told him he would have an intravenous puncture to find out how he was "passing his water." Not five minutes later a nurse went in and asked him to sign a permit for the test. He flatly refused, although she, too, had explained why the test was necessary. Both the medical and nursing staffs were furious at him for his attitude in this situation. The next morning as I talked to him he told me why he had refused. Then I realized that he was not being unreasonable. His objections were valid. Mr. Zovickian, who already distrusted and feared the hospital, had been presented with a permit to sign—pointblank. He said, "I did not like the approach. I'm a good business man and I know that's no way to get anything." He went on to say that he knew that if he had to sign for the test, there must be some risk involved. He wanted to know what this risk was. Certainly that is not an irrational request, and it could have been fulfilled if someone had taken the time to find out why he did not want to sign. Instead, they interpreted his refusal as an example of his ignorance and irrationality and continued to brand him as "impossible."

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My patient that day was Miss Ledell. She was a small, pale woman with three congenital heart defects. Her fingernails showed signs of cyanosis (inadequate oxygenation of the blood which gives the skin a bluish color). She had bulging eyes, a long face, wide mouth, and long unkempt black hair. She was thin almost to the

point of emaciation. Miss Ledell had been admitted to M4 because of self-induced abortion. When my head nurse "assigned her" to me, she told me that this pregnancy was conceived "out of wedlock." At that moment I felt all of the indignation and resentment that my family and society had taught me to feel when a person breaks the mores of our society. I also thought of members of my own family who wanted children and could not have them; and yet this woman who didn't want a child became pregnant and then destroyed the life within her. I felt that it was unfair; that she must be cruel to do a thing like this. I already jumped to the conclusion that she probably was selfish and hard.

Then I remembered the assignment for this course and decided to think this problem out clearly. I decided to try to forget about my own biases and meet Miss Ledell as I would any other patient. I decided to "live and let live" and accept people as they were. I walked into her room and found a woman so small that you could hardly see her in the bed. She was partially deaf but could read lips very well. She could not speak distinctly because of her deafness. She would not let me do much for her and she just kept smiling at me. From such external signs as wrinkling the brows, perspiring a good deal, and a twitching of the mouth she appeared to be very tense and nervous. Her eyes seemed always to rest on a little bottle on the bedtable and the gastric lavage set right near it.

I thought to myself that I wasn't trying hard enough. I must talk to her and try to find out how I could ease her anxiety. So I kept talking. We talked about the hospital, other people on the floor, and she seemed to open up a bit more now. She told me, "I think your uniforms are so cute." She asked me about her being on bedrest and what it meant. I tried slowly and carefully to explain it to her, and felt her confidence in me building up. Then I very carefully asked her about the gastric lavage. She asked me what it was like. Then she broke down. She said, "I'm scared to death of one of those things—please, please, I wish I didn't have to have one of those things." I tried to reassure her but nothing seemed to help. This patient had now become a challenge to me and I wanted to help her as much as I could. I asked the doctor about the lavage and described to him the anxiety Miss Ledell felt about having this done. He said she had not been coughing up sputum and that was why the lavage was being done. "If you can get her to cough, she doesn't have to have the lavage." I went back to the patient and explained this to her. She said she had not understood this before and she would cough as much as she could. As I left the room, the rasping sound of a cough could be heard.

I thought back on this experience. If the nurse recognizes her own biases and prejudices she can start to overcome them. There was a lecture about them in the course, too. But you do not actually believe something until you try it out. I'm sure if I had continued to feel about this patient as I did before I took care of her, I would have done the routine things expected of me and would not have helped or even bothered to notice her anxiety about the gastric lavage.

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During my first associations with plastic surgery patients, I noted that there seemed to be a very definite social distance between us. I was not relaxed, warm, or even interested in them. Our conversations were limited, because I felt no desire to understand their emotional or social needs.

I began to investigate my own attitude when I observed what a negative feeling I had when assigned to one of them. For example, a young man walked into the pavilion to be admitted. I saw him standing at the desk and immediately assumed he was a visitor. I considered him healthy, strong, and good-looking. After I inquired whom he wished to visit, he told me that he was to be a patient. My surprise and perhaps my disgust must have been reflected in my expression because he forced a laugh and pointed to his nose, saying, "You women shouldn't begrudge a man some vanity." That word "vanity" gave me some insight. It was the sum of my impression of these patients and the key to my negative attitude. Later that day I recalled how my mother had been vehemently opposed to the idea of one of my high school friends having a rhinoplastic operation (plastic surgery of the nose). It was "vain and a waste of money." Associated with these feelings, I remembered a discussion of the religious belief that operations not related to physiological functioning are opposed to "God's plan." From these experiences I had formed my attitude that by caring for patients whose elective surgery concerned only ameliorative cosmetics I was wasting my time.

Although that young man had been released before I returned to the pavilion the following week, I have had the opportunity to care for other plastic surgery patients. My previous attitude must have been very strong because it required conscious effort to eliminate feelings of social distance with these patients. Last Thursday marked a gain in my effort. I was admitting a young woman and by not underestimating her emotional need for plastic surgery, I was able to phrase my questions better and discuss her inquiries

about the operation. Our conversation could be considered one of mutual aid, for both her needs and mine were satisfied.

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One of the most important things a nurse must realize about almost every patient is that he is scared to death of the hospital. With a woman in labor this fear is doubled. Not only is she placed in a new situation but she is afraid and in pain. Once she enters the hospital she is stripped of her identity; strange people give her enemas, shave her, and make rectal and pelvic examinations. At this point a sustaining force is necessary—someone to talk to, someone sympathetic to her problem, just someone to be with her.

This was graphically demonstrated to me recently when I was working on the labor and delivery service. A young woman was admitted in early labor to have her second baby. I went in and began talking with her, having been told she was extremely tense. As we talked she seemed to relax until I got up to do some charting. She was terrified that I was going to leave her alone. I explained that I wasn't leaving and would be with her until the baby was born. After this explanation all her fears poured out. She had had her first baby in another hospital and all through her labor had been left in a big dark room with other women in labor. The doctor came only to examine her and the nurse only to tell her to be quiet when she cried out. No one explained what was happening to her; nor did anyone pay any attention when the baby was at last ready to be born. Finally, after a great deal of screaming, a doctor came and gruffly told her to cross her legs and breathe rapidly through her mouth so the baby wouldn't be born in bed. She recalled this as one of the most painful and terrifying experiences of her life. "No one cared." Because of this experience she dreaded becoming pregnant again. And when she did become pregnant she told no one of her fears because everyone was "so busy."

With this in mind, I began slowly to explain what labor is all about. She seemed extremely interested so I got out the birth atlas and showed her in pictures what was happening to her and to the baby. As her labor progressed she relaxed and dozed between contractions, apparently content that everything was all right. When the time came, we moved her to the delivery room and her baby was born easily and with a minimum of pain.

What I'm trying to show is the importance of taking a patient's emotions into account. I had always thought I did this but I had not realized how afraid many people are of the hospital and what emotions may be manifested in a given situation. In other words,

it is all well and good to act through instinct but if one knows why he is doing something, the results are likely to be more beneficial to all involved.

5. How do insights gained from the social sciences help students meet pressures resulting from staff tensions?

Miss James was new to our department and when I arrived on the floor I was assigned to work with her as a member of Team B. After the team conference I set out on my morning assignments. I had taken care of two of my three patients when Miss James walked into the room and asked me if she could give me a hand in making my second bed. Since I only had the pillow case left to put on I thanked her and told her I was almost finished. At this Miss James asked me if I had changed all the linen on the bed. I told her no; that team instructions called only for certain pieces of linen to be changed unless the bed linens were soiled. You can imagine my surprise when she proceeded to tear the bed apart and remake it after securing fresh linen from the shelves! After making the bed she went to the first one I had made and also put all new linen on it.

Had this happened a few weeks ago I would have felt as though I was being made a fool of in front of the patients. However, remembering what had been said in class, I figured that she probably had reasons of her own for doing as she did. Therefore, instead of feeling hurt and moved to tears as I might have at one time, I smiled and even helped her remake one of the beds. Later during the day while she was helping me to take a patient out of the bed, Miss James reprimanded me in front of the patient when our methods of lifting seemed to clash. She told me I was doing everything wrong and made me stand on one side while she lifted the patient from the bed. I watched her intently, trying to see if and what I had done wrong. There's no need saying I wasn't hurt but I didn't allow myself to form an opinion against her.

To my amazement Miss James used profanity in front of the patients, the doctors, and the nurses in the nurses' station. Also, without realizing it, she alarmed one of my patients so greatly that the patient burst into tears after she left the room. She had told the patient that unless she drank plenty of fluids the doctor was going to perform a cut-down for an intravenous infusion (a minor surgical procedure consisting of placing a needle securely in a vein for the purpose of administering fluids). She ended this statement by saying to the patient, "And that's a direct threat."

After this incident I felt as though I'd like to talk to her at length about nursing, patients, and other things that had to do with our profession. One thing she said that day, "I don't see why I do this for a living," indicated she was unhappy in the work she was doing. I was very proud of myself because my behavior in this situation was a direct achievement for me. It was nice to feel I had made a step in the right direction in trying to understand the behavior of others.

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On my floor the assistant head-nurse was Miss Lane, a recent graduate with an outgoing personality. She was very friendly to the members of the staff. At first she was nice to the nursing students but as the weeks went by we noticed a change. Some days she seemed moody; in answer to a simple question she would snap an answer. When I approached her with a question about a procedure she would glare at me (or so I thought) and retort, "I'm sure you know how to do it," and offer no advice. Since everyone else on the staff was most helpful I concluded she was "a crab." To further substantiate my conclusion, I cared for a patient one afternoon who was in tears. I learned that the patient had told Miss Lane she was constipated and had been told that if she thought about something besides her bowels occasionally she would be better off. I was by then completely disgusted with Miss Lane.

Then in class we talked about feelings of hostility and displaced aggression and the need for "reading between the lines." I began to think about this situation. Miss Lane might have had a dogmatic supervisor when she was a student or she may have been tired or rushed that day. There were a multitude of reasons that might explain her behavior when she reprimanded the patient. I couldn't judge what they were, but concluding that such reasons might well exist, I changed my outlook. I no longer feel that Miss Lane has it "in" for me; and I no longer dread having to ask her a question or to work with her.

6. Do students communicate their knowledge to their superiors or peers, and with what results?

Italian-born and sixty-five years old, Mr. Marino was admitted to the hospital for extensive abdominal surgery. He was subjected to numerous preoperative studies, some of which were undoubtedly painful and all of which were at least uncomfortable. Mr. Marino reacted violently and volubly to all this and many members of the staff felt he was overdoing it and proceeded to voice their objections

to his complaints. Mr. Marino's volubility regarding his pain continued postoperatively. The situation was further aggravated by his objections to his preoperative diet which was a very bland one, and his postoperative diet which was a slowly progressive one from "nothing by mouth" to a regular "American" diet. In addition to these problems, Mr. Marino had a large, attentive, and concerned family which included his wife, several married children, and a number of young adult grandchildren. Since Mr. Marino was a pavilion patient and the visiting hours preoperatively were limited to the usual four times a week, the family made numerous telephone inquiries about his condition and progress. Needless to say, he was labeled "a pest" by a number of staff members and auxiliary workers.

As a result of what I had learned in this course, I was better able to understand and adjust to this patient, his family, and their culture than I would have been formerly. This new knowledge alleviated my own feelings in the situation and I tried to increase the awareness of other personnel in order to make this particular patient's hospital stay more pleasant. In the Italian culture, unashamed emotional display and verbal expression of pain are perfectly acceptable and even considered necessary to mobilize help. The Italian patient typifies the individual who is concerned with immediate relief of pain. When this relief is forthcoming he is restored to peace of mind. I suggested that an attempt be made to keep this patient as comfortable as possible by the use of medication. He was therefore given more narcotics (within the limitations of the doctor's orders, of course) than many patients with a similar ailment, and a special effort was made to schedule its administration prior to any treatment or circumstance which might be uncomfortable.

The patient was accustomed to a highly spiced and rich diet, and it was difficult for him to adjust to hospital fare. As his condition improved, small additions were made to his menu which were more to his liking and he was occasionally permitted to eat food that was cooked for him by his wife.

Although Mr. Marino seemed to be overly dependent and demanding, I thought he was expressing the feelings of any patient to whom the hospital situation is new and terrifying. He looked to the staff for support, which was difficult to supply since the pavilion was a busy one. Postoperatively, the patient was on the serious list for a number of days and consequently visitors were unlimited. The family took advantage of this leniency and one or several of them were always on hand, much to the annoyance of those who were involved in his rather complicated care. However,

the mere presence of family members at his bedside was reassuring to Mr. Marino as well as to his family. Since we were so busy, it was possible for us to utilize their help. They were happy to be doing something for him and relieved us by feeding him and helping in small ways with bedchanging and minor treatments. The presence of the family provided us with the opportunity to give them as well as the patient necessary instructions for his care at home.

Thus, Mr. Marino's hospital stay was a much more tolerable experience than it would have been had not some of us been able to understand his needs and his reaction to his illness in the context of his cultural background.

* * * *

A thirty-year old woman from Colombia, South America, came to Women's Clinic with a complaint of vaginal discharge. She would not submit to a pelvic examination because she was a virgin and didn't want her hymen ruptured. Her anxiety was not alleviated by the doctor stating the conditions under which the rupture occurred, if such should happen. On investigation it was found that the patient was hoping to get married soon and was required by cultural expectation to be a virgin at the time of marriage. In her social and cultural milieu even statements signed by a doctor are not accepted as valid. A woman whose hymen is ruptured, no matter what the cause, is considered a social outcast and unfit for marriage. By understanding her reasoning, it was possible for me to interpret to the doctor the significance of her concern and the necessity for extreme care.

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Reported by a graduate nurse: In the clinic for planned parenthood a Spanish woman was to be fitted for a diaphragm. A visiting male physician from Europe had been brought along by the clinic doctor to observe the procedure. The patient became exceedingly upset and refused to allow the doctor to proceed while the visitor remained in the room, in spite of the doctor's exasperated arguments. A student nurse, "aware of the concept of modesty which Spanish-speaking people have," took the doctor aside and explained the situation to him. The visitor was requested to wait outside and the patient's composure was restored.

* * * *

Reported by nursing instructor: At a staff conference the doctors and nurses were discussing the condition of Mr. Pokolsky, who had

undergone radical surgery three days before. It was noted that though he had hardly slept during this time, he had never once requested a sedative nor complained about the pain that inevitably results from the kind of operation he had had. They considered Mr. Pokolsky "very courageous" and a "good fellow." A nursing student, her curiosity aroused by these approbations, went to talk with Mr. Pokolsky. She returned to the doctor with the information that Mr. Pokolsky was Polish-born and a Catholic; that a cultural trait common to Polish men is the tendency to equate stoicism with masculinity. To request a sedative for pain, therefore, would be an admission of weakness. The student suggested that in order for the patient to "save face" he be requested to take a sedative. The doctor responded with interest and instructed the student to carry out her suggestion. "When I handed Mr. Pokolsky the medication," the student reported, "he took my hand and kissed it and tears came to his eyes, he was so grateful. Later he had his first good sleep."

* * * *

Angered by the tears and remonstrances of a pregnant Italian woman about to have a pelvic examination, a young gynecologist threw his gloves down in disgust and stamped out of the room. "She must be crazy," he said. "She's had six children and she puts up a fuss over a simple examination."

A student nurse remaining with the patient tried to uncover the reasons for her behavior and gently questioned her as to why she felt as she did. She learned that the patient had come from a small village in Sicily where all of her children had been delivered by a midwife. She had expected to be examined in the clinic by a woman doctor and was horrified when a male physician walked into the room. The student relayed this information to the doctor and a woman physician was asked to take his place.

* * * *

At a clinic conference a student presented a report on a sixty-nine-year-old Czechoslovakian man who had terminal cancer. He had had a colostomy and a cystostomy (the former procedure is the opening of the large bowel through the anterior abdominal wall; the latter is opening of the bladder through the abdominal wall). He was left postoperatively with a large open wound running down the mid-center of his abdomen. The student had observed that in spite of the constant draining and the irrigations, the patient did not complain about his discomfort, nor of the odors and humili-

ation that accompanied this condition. But she had noticed that holding the patient's hand or soothing his forehead brought expressions of gratitude. She recommended that such personalized attentions be incorporated in the nursing care plan. "Furthermore," she suggested, "the patient's innate dignity and his apparent need to maintain it should also be valued and respected." She described how the physician in attendance would gather with other doctors around the patient, examine the open wound and exclaim, "Did you ever see anything like this? We seldom have had a patient that had this kind of condition." Then speaking of the seepage around the skin, "What a filthy mess this is." Afterward, the student noted that the patient seemed "devastated" by such conversations. She determined to track down the physician in the hall, and on the pretext of another matter, engage him in conversation. Getting around to her patient, she told the doctor how upset he was because of the comments made in front of him. The doctor replied that, indeed, he had not considered the effect these remarks had on the patient and he would be more careful in the future.

7. What conclusions can be drawn as to the value of providing time in a tightly scheduled educational program for courses in the social sciences?

In answer to this question we could summarize the various points made in the illustrations above and in Chapter 8, Value Judgments, such as the use of appropriate concepts in making decisions about courses of action, meeting status-role conflicts, reduction of frustration and feelings of futility, gains in self-insight, improved communication and interstaff relations, and changes in patient care. But these are so obvious that to repeat them would be redundant. More telling, we think, are the answers that have come from the anonymous evaluations of the course by the students themselves:

The course has shown me where my biases were and how I was rationalizing them. It made me see the worth of bringing these biases out into the open and examining them.

I never realized how little I knew, how much I need to know, and how complex human behavior is.

It has led to an increased understanding of my co-workers. I attempt to see them in the situation as they themselves might feel,

or at least attempt to understand and realize that actions should not necessarily be taken at face value.

It has taught me to think before I make value judgments, not only about the patients but about my friends and associates.

Produces greater tolerance of the unfamiliar.

Makes it easier to judge the actions of others in terms of individual needs and cultural background.

Gives one a point of view in regard to illness other than that of the medical sciences.

Helps one to consider what people *aren't* saying instead of just listening to what they are saying.

Provides fuller understanding of the role of the nurse and the doctor.

It has sharpened my powers of observation, deepened my understanding, and lengthened the limits of my patience.

Teaches one to re-evaluate the terms "good" and "bad" patients.

One becomes aware of just how fragile people are psychologically.

One learns to ask, "Where have I failed?"

CONCLUSION

From the evidence we have—and this has been further substantiated by the results of two successive years of teaching—we are convinced of the effectiveness of social science courses for nurses. Though the results are gratifying, we would stress the fact that we did not then, nor do we now, delude ourselves that because of their exposure to one or two courses, nursing students become models of understanding, objectivity, and seekers after the truth. What we find are the early stages of a developing awareness and sensitivity to the complexity of human behavior. Adeptness in handling conceptual tools is still to be achieved, as is that delicate balance between the acquisition of new knowledge and its skillful application. But in spite of obvious inaptitudes and gropings in what is still none too familiar territory, students show both an eagerness and a potential for continuing growth. This potential should be encouraged and nurtured.

Without continuous study in the behavioral sciences and reinforcement of learning by clinical instructors who are also oriented

in these disciplines, there will be many students whose learning is only on a cognitive level, and who will lapse into old habit patterns and ways of thinking. There will be those, too, who, lacking the confidence that comes with sureness of knowledge, will not quite trust what they do know when questioned by an authority figure¹

What we are saying here is that we are far from satisfied with a thirty-hour course in a program of almost three years. We are of the opinion that in order to forestall inevitable lapses and to broaden and deepen students' insights into human behavior, the social sciences should be made an integral part of the entire educational program of the professional nurse. This is an opinion, however, that is not unreservedly and unanimously shared by all those who have given thought to the education of nurses. Concern has been voiced by both nurses and doctors that by expanding the curriculum to include the social sciences means, perforce, taking time away from the basic sciences and technical courses; that nurses will be consequently less well-equipped and skilled in nursing techniques and the physical care of patients. We are in full accord with those who hold that sacrificing any part of the curriculum designed to produce technical proficiency would be highly undesirable and we shall continue to emphasize, as we have elsewhere, that social science courses should not be *in place of* but *in addition to* those necessary for developing competence in the traditional skills and procedures.²

We do know, however, that a careful scrutiny of many nursing school curricula will reveal several areas of repetition in both theory and practice, as well as courses drawn out far beyond their usefulness—a fact that is cited by the proponents of two-year programs. Our concern is not with the temporal aspects of nurs-

¹ During her public health training experience a student had a supervisor who insisted that a patient's anxiety and depression were caused by "guilt feelings." The patient, a Greek woman, had come to the United States only two years before and had manifested considerable conflict over the contrasting ways of life in the two countries. The student appropriately suggested that the woman's Greek background might be a contributing factor in her present problem. This was summarily dismissed by the supervisor who said, "I think if you look at this from a cultural point of view you are stereotyping."

² Macgregor, Frances Cooke, "Social Sciences and Nursing Education," *American Journal of Nursing*, vol. 57, July, 1957, pp. 889-902.

ing school education but with its quality. In this respect we believe that education for nurses should not be terminal but that education and proficiency should continue to grow. And further, we believe that nursing schools should provide students with a body of social science knowledge to which they can add, and which prepares them for flexibility and continued mental activity.

The advisability of presenting social science courses to nursing students has been questioned from another quarter. Some social scientists have suggested that "a course here or there is worse than none at all; a little knowledge may be more dangerous." It is certainly true that the thirty hours, or even more, devoted to the study of human behavior, will not be sufficient to enable students to master very much of the relevant knowledge that exists. That is why we strongly recommend that the social sciences should be extended throughout the entire program either by way of formal courses, seminars, or reading courses. On the other hand, our experience has by no means convinced us that all instruction in social science should be eschewed on the assumption that a little knowledge is dangerous. It is our contention that in lieu of the ideal amount of time that should be spent on the study of human behavior, even one course, provided it is directly applied to nursing, is justifiable.

At the present time it certainly seems probable that nursing schools will give increasing attention to the inclusion of social science courses in their programs. But in so doing both nursing educators and administrators must be prepared for certain difficulties within their institutions. When any innovation is made in a curriculum, some resistance is to be expected. There are those who want to see no changes made in the status quo. Others with vested interests in their own subjects are fearful of having their allotted time cut down. Though it is still popular in some places to complain of "all this foolishness about degree nurses and higher education," the latest addition to the curriculum—in this case the social sciences—is likely to become the object of attack. Complaints such as "Nursing students want to spend more time talking to patients than making their beds" and "They are giving

more emphasis to the emotional aspects but neglecting the physical care of patients” may be anticipated. Moreover, the cultural know-how of student and graduate nurses and their special awareness of the psychological needs of patients—aspects that some medical and nursing practitioners still neglect—will not only be threatening to the latter but they may even be devalued and ridiculed. Fortunately, however, for nursing education (and patients), the climate of opinion regarding the urgency for study in the behavioral sciences is rapidly overriding the kinds of objections cited above.

Chapter 11

Integrating Social Science Into the Clinical Services

A SPECIFIC COURSE in the application of social science to nursing should be regarded as only one important aspect of the total integration program. Educational responsibility requires that relevant social science material must also be integrated directly into the clinical services. How this may be achieved, and how rapidly, depends upon a number of variables: the character and size of the clinical facilities; the receptiveness and level of sophistication of students and faculty; the degree of cooperation not only from teaching staff, but from heads of departments of nursing and administrators of the school; and finally, the individual social scientist himself, his goals, foci of attention and approach. No two situations will be identical and probably no two methods for accomplishing integration will be the same.

Just how does one go about the task of trying to introduce and integrate social science in the clinical services? How does knowledge of human behavior penetrate and become part of the daily nursing care program of the sick? And how can one observe and measure results? Neither the process nor the results, unlike an experiment conducted in a laboratory, are easily observed or describable. Much of what takes place is so subtle in nature that results sometimes appear to be, and often are, diffuse. Nevertheless, proper utilization and application of social science knowledge can produce results that are discernible: changes in attitudes toward patients; in the amount and quality of care they receive; shifts in teaching emphasis from procedure-centeredness (emphasis on such things as mouth care and body mechanics) to

patient-centeredness; greater concern for, and understanding of, patients' reactions rather than nurses' reactions.

According to the plan of our project, we did not focus attention on the clinical services until the first half of the social science course for students was completed. Before this, however, we had spent a considerable part of the three-month orientation period in the clinical services. As a kind of "free-floating agent," we not only had the privilege of observing the educational experience students undergo in the process of becoming graduate nurses, but, through the courteous cooperation of the staff, we were able to participate in the daily activities in the seven different departments of the hospital: Medicine, Surgery, Obstetrics, Pediatrics, Psychiatry, Outpatient, Private Patients.

From observations of clinical teaching and practice, patient care and staff-patient relationships, and from participation in health-team conferences, careful note was made of those areas where social science concepts and methods might be most applicable. Useful clues came from many directions. Particularly fruitful, from our point of view, were the clinic conferences devoted to student presentations of case studies of patients. Students and staff discussed in detail the specific needs, problems, and difficulties of individual patients in order to formulate present and future nursing care plans. These sessions were, for the social scientist, special vantage points from which to ascertain: (1) the level of sophistication in the social sciences on the part of students and staff; (2) the particular social science disciplines in which knowledge and application were strongest or weakest; and (3) the social science concepts and methods that should be most stressed in our course and in the overall integration program.

At these presentations which were usually made by second- or third-year students, we noted that the introduction to a typical case study followed the form used in the average medical presentation: "Mr. F. is a forty-two-year-old white male who had a diagnosis of Buerger's disease," or, "Mrs. K. is a sixty-two-year-old female who has a cancer of the breast." Such statements provide no information about the many facets of a patient's life or personality. A rather detailed medical history would then fol-

low. The patient's health and illness record would be described, going back perhaps to the age of six when he had a tonsillectomy or to the time he had rheumatic fever at thirteen, and then double lobar pneumonia at the age of twenty-one, coupled with descriptions of the types of medical treatment the patient received during these various illnesses. Further consideration would then be given to the present condition which had brought the patient to the hospital, his prognosis, type of treatment or surgery which had been, or would be, undertaken, kind of anesthesia employed, amounts and kinds of medication, number and kinds of tests made, x-rays and EXG (electrocardiogram) reports, diet record, nursing care involved, and plans for future nursing care. Somewhere, sandwiched in among all these items, might be a reference to the fact that the patient had a family or a life outside the hospital. Where "social histories" were given, they were more or less on the order of the one below. This report, thirty-five minutes long, concerned "Mrs. C., a thirty-year-old female" who had had a mitral valvulotomy (operation on a valve of the heart):

Before discussing Mrs. C.'s hospitalization, let me go over a little of her family and home life.

She was born in New York City, the second of two girls. They have always gotten along well with each other, and in all, it was a very happy home situation. She married when she was twenty-four, and her husband has been very concerned about her condition and been very helpful. She went through the twelve grades in twelve years, despite the many times she had to stay out of school for one reason or another. She is very well adjusted to illness and wants to help herself as much as possible. But she is still a bit apprehensive about doing too much.

During her childhood she had measles three or four times. She has no history of malaria or typhoid, no history of diabetes, kidney disease, heart disease, mental illness, suicidal tendencies, hypertension, cancer, goiter, bleeding tendency, or tuberculosis. She has allergies to cigarette smoke, perfume, and questionably, to sulfa. She has no children because she was advised against it by her local medical doctor. Her home situation is quite ideal for her, as she lives on the ground floor of a remodeled tenement house where there is room for eight families. Her mother and a good friend of her mother live in this house also, and the rest of the rooms are taken by young couples about her age.

[After further medical and nursing details the student concluded:]

In taking care of Mrs. C., I found it quite a challenge to meet all her needs. Every morning she could have nothing by mouth until blood had been taken. When they finally came to draw it, they would have great difficulty getting into the veins. This would fatigue her no end. By that time, her alevaire (a drug) was to be given but she'd want her breakfast first. Then she would say she couldn't take the alevaire so soon after eating because it made her nauseated. She would spend hours taking just one cup of tea because she would only sip it. Fortunately, she liked cold tea rather than hot. By this time her other 10 o'clock medications would be due and finally by about 10:15 I might be lucky enough to start her bath so that by 11 she would be fully ready for me to get her weight. This was another heartache for her. In between all this, observations every half hour needed to be taken. In caring for her a great deal of patience and gentleness was required.

In the group discussions that followed reports like this, attention was primarily focused on technical nursing procedures. In those instances where a patient was considered a "problem" because he was resistant to the prescribed diet or exercises, or was "demanding too much attention," the nurses discussed possible methods for circumventing his resistance and persuading him to be more cooperative. A behavioral problem was more often approached from the nurse's rather than the patient's point of view as something that interfered with the plan of treatment. The nurse's feelings about the problem rather than the patient's were explored and discussed.

With the exception of an occasional reference to emotional or psychological aspects, the opportunity for students to enrich the case histories of patients with sociocultural data was usually bypassed. Seldom did anyone suggest that the systematic collection and examination of information about the patient's education, ethno-religious and social status, or personal involvements might be pertinent or provide important insights. In the case just cited, it is apparent that the nursing student was sensitive to her patient's needs and difficulties, and was making an effort to help her. And she had gone as far as she could within the limitations of the training she had received.

There were, at this time, very few clinical instructors who might be described as oriented in the sciences of human behavior. The general lack of sophistication about these disciplines and the absence of social science data incorporated in the clinical teaching, however, in no way implies a lack of concern with, or lack of, sensitivity to patients as people, their fears and their problems. On the contrary, throughout the whole teaching program ran the underlying themes: "total patient care," "patients are people," "patients have families," "patients are unique individuals." Yet too often these phrases were little more than clichés representing clusters of underlying assumptions. That importance was attached to the psychological and social aspects was indicated by the frequency with which these terms appeared in course and lecture outlines. Indeed, they were referred to so frequently that they were drained of substance and caused students to complain of being bored by the frequent repetitions. Their complaints were valid for the most part because treatment of these aspects was primarily characterized either by lack of depth or specificity, or both.¹ The tendency to give lip service rather than substance to these concepts not only indicated the lack of a scientific body of knowledge of human behavior on which staff and instructors could draw for teaching purposes, but, on a broader level, seemed to be a reflection of the peripheral role that human behavior topics occupy in the core of nursing education at the present time.

REACTIONS OF INSTRUCTORS

What happens when students are provided in their professional training with a special body of knowledge that has not been

¹ In a two-hour lecture on nursing care of patients who had had or would undergo a mastectomy (removal of the breast), the topics for consideration included "emotional aspects." Yet, by the clock, less than three minutes were devoted to this important subject and were confined to the need for the nurse to know what information the patient has concerning her condition and the coming operation, in case she should ask questions; the policy of not telling patients in the recovery room if they had had a mastectomy "because it would be an emotional shock"; and the stage at which, according to nursing instructors, emotional reactions of patients to a mastectomy are usually first noticeable—that is, "the first time the dressing is removed."

In a lecture by a physician entitled "Anesthesia: Some Emotional Problems and Technical Procedures," the consideration given to emotional aspects of surgery was expressed in two sentences: "An operation is a serious thing to a patient. We must show them that we take it seriously, too, even if it's a hernia—and not tell them 'it's nothing'."

made accessible to their clinical instructors and nursing staff? When the first group of students, fresh from their course in the social sciences, moved into the clinical services and began both to apply and verbalize their newly acquired knowledge, few instructors were prepared to provide continuity. Because of the limitations of their own traditional programs that had not included study in the behavioral sciences, they found themselves ill-equipped to reinforce or add to students' knowledge in these areas.¹

As might be anticipated, members of the teaching staff reacted in various ways. Those few who had some orientation and interest in the social sciences provided students with the opportunity for discussion; others, though they had had no previous training in the social sciences, were nevertheless both intrigued and challenged by the students' new approach to patients and encouraged discussion and elaboration; still others, uninformed and less curious, ignored such material or let it pass; a few, whose insecurity was deep-seated, appeared threatened by subject matter with which they were wholly unfamiliar and either covertly or overtly discounted its utility. It was noted that students who found themselves working under instructors in the last two categories, made less frequent attempts to gather pertinent background data about patients or to utilize social science material for gaining further insight into patients' behavior. Instead, they more often followed the line of least resistance and conformed to the instructor's predilections by centering their attention solely on clinical nursing procedures and techniques.

This can be a critical period in such an experiment, for if enough instructors are threatened by the introduction and incorporation of a new discipline or resist it, the process of integration can be exceedingly difficult and the whole undertaking jeopard-

¹ The three-year hospital school of the past was mainly service-centered. In those university programs where nurses later completed work for the B.S. and M.A. degrees, the education was largely geared to public health nursing, supervision, and instruction. Nurses have frequently been heard to complain that in these programs they were steered into more nursing courses or courses designed primarily to prepare students in methods of teaching and curriculum construction. Even today many express the wish for instruction in the social sciences and other subjects that would give them a broader background.

ized. Moreover, should they so wish, instructors may use the exigencies and pressures of their clinical teaching and duties as an excuse for their inability to cooperate in the experiment. Without either their encouragement or assistance, the knowledge students have acquired may be temporarily, if not permanently, shelved. Fortunately for our project, this did not happen. The impact upon instructors of having students whose knowledge in the behavioral sciences was greater than their own had, for the most part, a positive effect—a commentary on their professional maturity. As one instructor remarked, “I never learned so much about Puerto Ricans as I did today from the students at our clinic conference!” Another said, “If these students know more than I do and are going to discuss these things and ask me questions, I had better start learning!”

At the risk of being repetitious, it is necessary to point out that at this time we had been in the School just six months, a period devoted mainly to orientation and the teaching of students. Although faculty members had been invited to a few selected lectures, the course had, for necessary experimental purposes, been restricted to students. For the most part, the clinical faculty and nursing staff were comparatively unfamiliar with the nature of our project and its purpose, nor were they clear about the role and function of the social scientist in their midst. In an institution of such scope and size, research projects, special surveys, and all manner of activities may be going on without affecting the duties or routines of nurses or eliciting their curiosity. Hence, our presence had represented for most of them “just another study.”

METHODS OF DISSEMINATING SOCIAL SCIENCE CONTENT

It was at this point that the social scientist shifted attention to the clinical services with the aim of disseminating social science content among instructors and staff. To accomplish this purpose, a number of methods were employed. We participated in the clinical classes and health-team conferences attended by students who had had the course and elicited from them relevant socio-psychological data upon which we elaborated. This served to

expose the supervisor-instructors, staff nurses, and even nursing aides to the scientific approach for understanding human behavior.

Another type of situation that offered excellent teaching opportunities was that requiring psychiatric consultation. When, as occasionally happens, the nursing staff feel unable to cope with a behavioral problem, they may ask the psychiatric division of the medical center to send a nursing consultant who can give them guidance and counseling. For example, a surgical supervisor requested a psychiatric nurse to meet with her and her staff nurses, who were "up in arms" over what had become an acute situation on the floor. Since the patient happened to be foreign-born, the social scientist was also invited to the conference.¹

A seriously ill thirty-year-old man not only had accused the nurses of neglect, but was threatening to sue the hospital. He was described as "depressed," and he had, said the nurses, been a constant problem. He had undergone a partial gastrectomy (removal of part of the stomach) for cancer. A week later two more operations were performed on his esophagus. The need for these last operations had come as a great blow to him, because he was entirely unprepared for them and did not know why they were necessary. He required a great deal of nursing care, and although the nurses had been "knocking themselves out for him," he never thanked them; he only stared at the wall, did not answer their questions, and volunteered no information except that he was very ill and was being neglected. He had been difficult from the beginning, they said, and although they had given him "good care," they had avoided him whenever possible. Now they were both angry and alarmed by his accusations and threats, and nobody wanted to be assigned to his care. Accordingly, the psychiatric nurse had been called upon in the hope that she could "calm them down." She first discussed the patient's behavior in terms of such psychiatric concepts as "depression" and "regression." She then endeavored to help the staff analyze their own reactions in order that they might better understand how the

¹ Our function as seen by the nurses at this time was mainly to supply useful facts about people from foreign cultures.

patient's apparent rejection of the nurses had aroused their feelings of hostility.

Finally, the social scientist asked where the patient was from. No one knew for certain, but he had an accent which they thought sounded Polish. "Was his nationality on his chart?" It was not. The chart indicated only that the patient had come from Europe at the age of twelve. The nurses knew he was a Catholic because they had seen the rosary he kept beside his bed. They had no further information about him. The patient's name suggested he was of Czech origin. With these two possible backgrounds as clues, the social scientist described cultural patterns of behavior that might account for some of the misunderstanding. We discussed the Polish patient's image of the nurse as a woman of compassion, and his expectations of her. On the assumption that the patient was Czech, we discussed the resistance of Czechs to authority, the dominant role of the mother in Czech culture, and the possible failure of the nurses to have fulfilled this role for the patient as he defined it. The perfunctory and mechanical carrying out of duties and the lack of real personal interest, if this were the case, could conceivably irritate the patient because he would see no love behind what they were doing for him, and, consequently, no need for him to express gratitude.

It was suggested that one of the nurses ask the patient where he came from. This suggestion was met with some consternation. How, they asked, could they do this? "Do we just come out and ask him where he is from? It might embarrass him or make him angry." We explained that it is sometimes forgotten that people from other countries are as proud of where they are born as are Americans. The nurses acknowledged that they had not thought of it in this light before. It was further suggested that after a few remarks showing genuine interest in the patient, the nurse could refer to his name, saying, "This is an interesting name. Where do you come from, Poland or Czechoslovakia?"

Immediately following the conference, a nurse visited the patient and came back some time later looking very pleased because "it had worked." When she had asked the patient where he was from, his response had been immediate; he had "beamed"

when he told her that he was Czech. When she asked him what he did during the day, he said, "Nothing." She asked him why he didn't play the radio, but he replied that no one had placed it near enough for him to reach. She corrected this oversight, and the patient thanked her and appeared to be pleased with her visit.

The social scientist suggested to the staff that they see the patient at least every half hour, in addition to the visits made for specific nursing or medical purposes; that they try to show some warmth toward him, pat his hand now and then, and give him the kind of psychological support that patients should be able to expect and that should be available to them. The staff were interested in this suggestion and accepted it as an experiment. Some few days later they reported that his attitude had changed considerably and that he was far easier to manage. The nurses were pleased with themselves because of his response and no longer tried to avoid him.

Participation by the social scientist in such conferences can be of considerable value in helping nurses to see the importance of cross-disciplinary approaches to problems in human behavior. Too often it is considered sufficient to have a "psychiatric consultation," or to call in an instructor in mental health whose orientation is also primarily a psychiatric one. As we have said elsewhere, interpreting and evaluating behavior only from a psychiatric point of view, or only from an anthropological or sociological perspective, can be misleading if not actually dangerous. If there is to be a holistic approach to problem-solving of this order, representatives of both the psychiatric and social science disciplines should participate.

In the situation described above, the psychiatric nurse and social scientist freely discussed the reasons for their particular interpretations and suggestions, and the staff nurses learned the utility of each approach. Not only were they given insight into their own reactions when frustrated by a patient's behavior that did not conform to their own expectations, but also they were enabled to see the necessity for taking into consideration the fact that a patient may come from a culture in which different patterns of expected behavior apply. Such insights helped to mitigate

their resentment and frustration—reactions that can be a two-edged sword.

Several instructors in the various services asked us to participate in their small group discussions with students who would present problems they were having with certain patients. An example was given earlier of the type of case presentation we were accustomed to hear from students, which provided no clue as to *who* the person was, about whom they were talking. Few presentations in these group discussions differed from the example given. To stimulate students to gather background material about their patients, to include it in their presentations, to report accurately, and to search for significant facts, we frequently engaged in an exchange something like this:

- STUDENT: The patient is a fifty-five-year-old male.
SOCIAL SCIENTIST: Male what?
STUDENT: The patient is a fifty-five-year-old man who is diabetic.
SOCIAL SCIENTIST: What's his name? Who is he? Where does he come from?
STUDENT: Mr. Hoffman is a ballistics technician. He came to this country from Berlin, Germany.
SOCIAL SCIENTIST: When?
STUDENT: Two years ago. [continuing] Mr. Hoffman seems to be happily married.
SOCIAL SCIENTIST: What evidence do you have for making this statement?
[The student may or may not have any.]
STUDENT: Mr. Hoffman is difficult to care for because he finds fault with everything we do for him.
SOCIAL SCIENTIST: In what way?
STUDENT: He gets mad if his injections aren't given on time. He gets mad if they make the slightest mistake in his menu. He got terribly upset this morning just because the nursing aide rearranged the books and things on his bedside table. The doctor says, "Mr. Hoffman's reactions to such little things are abnormal."
SOCIAL SCIENTIST: Are these the only reactions the patient exhibits that seem abnormal to the doctor?

- STUDENT: Yes.
- SOCIAL SCIENTIST: What do you think about them?
- STUDENT: Well, it seems to me he's terribly exacting.
- SOCIAL SCIENTIST: Could Mr. Hoffman's insistence on precision and orderliness have anything to do with the fact that such traits are not only requirements of his profession, but are also characteristic of his culture?
- STUDENT: I hadn't thought of that.

In our role as consultant to the faculty, we received numerous calls for assistance in situations where patients or their families resisted professional advice or posed special problems. These requests provided us with opportunities to increase understanding of people and teach the social science approach to problems of behavior. Typical of the requests received are the two examples given below. One came from a nursing supervisor in the medical department, who was meeting with her staff and the resident physician. They were puzzled about a particular situation which they had encountered not a few times before. They wanted to know why it was that the adult children or relatives of an elderly Jewish patient who was ready for discharge, were reluctant to take him into their homes to live. The relatives argued that it was the responsibility of the hospital or some other agency to take care of the patient; yet in this instance, as in others, they were both physically and financially able to do so. In the staff's judgment this indicated a lack of concern for the aged, which they contrasted with the attitude of Italians, for example, "who take their aged relatives into their homes without question."

The patient and his children were from Eastern Europe. Among Eastern European Jews there are certain traditional attitudes and expectations toward caring for the aged that are different from those cultures where children are expected to take care of their aged parents and about whom they feel guilty if they do not. While such attitudes, it is important to stress, are not necessarily predictable for any given Jew, they might explain those of the relatives in this particular case. According to Natalie F. Joffe's study, "The Dynamics of Benefice Among East European

Jews," a minimum of reciprocal behavior is exhibited in Jewish families.¹ It is most obvious within the family circle that age should give and youth should receive. That parents should give to the children is taken for granted; they owe them support, education, and training for future life, a training both practical and spiritual. In return, the child owes his parents deference, respect, and obedience; but it is by no means taken for granted that children should repay their parents for this care.

On the contrary, it is a matter of pain and shame for parents to ask or even to have to accept economic assistance from their children. "One father supports ten children, but ten children can't support one father," is a common saying.

The community makes provision for the aged, and to accept impersonally from the group represents merely acceptance of one's due as a group member—far better than to be dependent on the charity of one's own children. The pattern is evident even in the United States, where those who are familiar with it wonder at the willingness of prosperous sons and daughters to have their parents live in a home for the aged; or at the insistence of parents on doing so, despite the pleas of the children who come to visit them in shining limousines. An informant in New York told of an old man who begged his livelihood and lived in want but was frequently visited by a daughter who arrived in a resplendent automobile and tearfully pleaded with him to come and live in her home. Both her affection and her acceptance of American ways made his situation painful to her. But to the father, the beggar's role represented virtue and honor. This is not an isolated example.²

In another instance, a supervisor in neurosurgery consulted us about a man of fifty-two who was scheduled for an operation but refused to have his head and beard shaved with the long-blade razor which the hospital ordinarily uses. No amount of persuasion by doctors or nurses was of any avail. He insisted upon an electric razor which seemed to them either a "ridiculous whim or a psychological quirk."

We were asked what we thought might be done "to get the patient to cooperate." It so happened that this patient was also

¹ *Social Forces*, vol. 27, March, 1949, p. 239.

² *Ibid.*, pp. 241-242.

Jewish and of strong orthodox faith. He strictly adhered to Jewish laws, one of which specifically deals with the matter of shaving. According to Mosaic law, shaving the corners of the head or the beard is prohibited (Leviticus XIV:27). Originally intended to counteract the influence on the Israelites of the "heathen rites" or the ways of the Amorites, the prohibition of shaving applies only to the operation with a razor, but not to the removal of hair with scissors, chemical depilatories,¹ or, more recently, electric razors. Upon receiving this explanation the staff relaxed. An electric razor was procured and the necessary procedure carried out.

Obviously, the social scientist cannot provide solutions or explanations for all problems of this kind that arise within the hospital. He is neither a walking encyclopedia nor an expert on the customs, beliefs, and attitudes of all peoples of the world. Moreover, there are still many gaps in the available body of knowledge about other cultures. These facts are important to point out to nurses who are quick to see the usefulness of such knowledge, but are just as quick to add, "How can we be expected to know all these things?"

The teaching value of such situations as these, then, lies less in demonstrating the advantages to nursing of specific kinds of information than in providing us with an opportunity to make two important points. The first is that when a question arises for which one has no answer, he can try to find it. And the same avenues that are open to the social scientist are open to the educated nurse who is willing to extend herself. She may consult the literature; she may consult specialists in related areas; and most important, if she has sufficient knowledge and has been trained in the techniques of interviewing, she can talk to the patient and his family, who, though other sources fail, may provide clues to the answer. The second point is that the value of social science is not in supplying specific pieces of information or a catalogue of unrelated facts, but in providing concepts, methods, and tools that can be applied to diverse and unrelated situations.

¹ *Jewish Encyclopedia*. Funk and Wagnalls Co., New York, 1916, p. 234.

As in the cases cited above, it is less important—though certainly useful—to know about the dynamics of beneficence among Eastern European Jews or the precepts of Mosaic law, than to have a method of approach to problems of human behavior which are seldom, if ever, wholly identical. What is more important than a collection of random information, then, is tailoring the therapeutic goal to the value system of the patient rather than that of the doctor or nurse. To do this, the nurse must have the ability to assume the patient's cultural perspective—to see the world through his eyes. And she must be alert to the significance or symbolic meaning which a recommended or necessary procedure may have *for the patient*.

The process of integration was accelerated in other ways also. Pertinent social science literature and reports from research findings were widely circulated among heads of departments and staff. In doing this, however, one must make allowance for the rather overwhelming number of reports, notices, and communications received. Many are tossed aside for future perusal or get lost in the shuffle. Furthermore, nurses generally feel pressed for time and anything that suggests more work on their part, but which is not mandatory, is likely to be postponed or ignored. Far more profitable were the informal and personal contacts we made with nurses during coffee breaks, luncheons, or conferences, when there was an opportunity to stimulate interest and suggest materials. To reinforce and consolidate the educational process further, tape recordings of lectures having particular relevance for such clinical fields as pediatrics, psychiatry, or rehabilitation were played for members of these services. Special showings of films for faculty and in-service staff were also held.

Since we were preparing an additional fifteen-hour course for the students, we asked several nursing instructors to preview some of the material we thought of using and with which they were unfamiliar. We did this not only to obtain their reactions and often valuable suggestions, but to involve them in the learning process and to make them aware of the content to which students would be exposed. Thus, we hoped both to stimulate interest in the social sciences and to develop some common body

of knowledge, as well as to facilitate communication and further the integration process.

As we became increasingly involved in committee activities, we attempted a wider dissemination of social science concepts and methods. Though too numerous to list here, the committees ranged in subject from curriculum changes, planning or altering courses, and student evaluations, to special projects or studies requiring the formulation of objectives and methodological tools. The involvement and interest of the faculty in the social science project, which at first was gradual, rapidly gained momentum and began to show definite results. Many faculty members requested reading lists or information on specific problems. A number enrolled in social science courses in nearby universities or sought consultation on projects in which they were engaged, either in the hospital or while working for advanced degrees. The growth of interest was such that by the time the second half of the course began, six months later, it was necessary to open the course to the faculty and staff.

USES MADE OF SOCIAL SCIENCE KNOWLEDGE

By the beginning of the second year of the project, there was considerable evidence that a synchronization of knowledge and interest on the part of both faculty and students was taking place. Many instructors widened the scope of their own lectures by incorporating social science content and reference materials. One of them reported:

A year ago three clinical instructors and I gave a class on "The Care of Patients with Pain." We discussed, among other things, the criteria which a nurse might use in order to determine if a patient is in pain. We were, we said, trying to help students differentiate between the person with "real" [physical] pain and the person having a pain response due to other factors, such as need for attention or sympathy. We stated that posture, facial expression, frequent distractibility while talking, skin moisture, and other manifestations of autonomic activity were guides which the nurse might use in assessing whether a patient had pain or not. After hearing a lecture in the course, "Psychosocial and Cultural Aspects of Nursing," on the cultural components that influence pain, I realized that these criteria could be unreliable guides. Our statement,

"Facial expression can provide a clue to the nurse as to whether a person has pain or not," sounded somewhat offbeat to us this year. We also wondered if we had been giving students the idea that a patient having a pain response caused by cultural factors rather than "real" pain meant, "He's not having pain—it's just his imagination." At any rate, we changed our class this year to include, rather than the above, a discussion of how cultural components can affect an individual's response to pain, and how the physical manifestations of pain might therefore be different.

As clinical instructors became more familiar with the content of the Social Science Course, they grew more confident in helping the students apply their learning to patients. This was an invaluable aid in providing continuity. One instructor reported:

Before, I wouldn't have dared, but this week I attempted to help students apply their knowledge of cultural aspects of nursing at a formal class in diagnostic examinations of the urinary tract. It was the first time I have attempted discussion of cultural patterns as they affect the patient's reactions to examinations and treatment. I have often considered how such material might be utilized, but felt that it was too important to be treated lightly. To make a single statement about the effect of cultural background upon an individual's behavior can be quite misleading unless qualified by additional explanation. Worse, in the minds of an unskilled person, it can become involved and even confusing to students. However, since I was convinced of the value of applying such scientific knowledge in the practice of nursing, I decided to ask students to use any cultural information they felt would help them anticipate and understand patients' possible reactions to the procedures being discussed [those used in an examination of the urinary tract].

Students had no advance notice to prepare for the discussion by reviewing notes. It was an "on the spot" recall. [Students had completed the first half of the social science course two months prior to this discussion.] One student mentioned that to be placed in a lithotomy position [with knees flexed and apart] for such an examination, is likely to be embarrassing for any patient but might be particularly so for patients from Spanish-speaking cultures. She felt that the nurse should anticipate embarrassment and try to reduce it with additional explanations and reassurance before and during the examination. Her comments indicated acceptance of this reaction and the need for handling it with understanding.

A second student said that diagnostic examinations of the urinary tract were likely to be physically painful, but that people from

different cultures often react differently to pain, mentioning that Jewish and Italian patients are likely to react noisily because in their cultures they are expected to express their emotions. When asked how this would affect nursing care, the student replied that the nurse should anticipate this behavior. She should plan to stay with the patient as needed, explain what was being done, and give any necessary assistance to ensure safety and optimum comfort. Again there seemed to be absence of a judgmental attitude regarding such behavior.

Meanwhile, at the request of the faculty of the Outpatient Department, a series of semi-monthly seminars were instituted. These were requested because the faculty believed that "a better understanding of emotional and cultural factors would aid in providing better patient care and be useful to nursing personnel in guiding student learning activities. In brief, we need to know more in order to help students use the material they get in the social science course."

By the end of the second year, the acceptance of social science content and methods was such that their inclusion in many parts of the curriculum was beginning to be routine procedure. In the clinical services the now second-year and third-year students selected, or were assigned, projects that involved utilizing or furthering their knowledge of human behavior. In obstetrics they did "research" on such subjects as cultural patterns of birth and maternal care, sociological aspects of planned parenthood, and cultural differences in attitudes toward illegitimacy. In pediatrics they broadened their studies of social class and cultural differences in child-rearing practices. In public health they made an attitudinal study of student nurses toward Puerto Ricans. In gynecology they developed questionnaires and interview techniques for investigating the psychological reactions of women who had undergone hysterectomies.

The results of their findings, in this last instance, were considered so significant by two doctors in the gynecological service that they recommended that the medical staff give more attention to the psychological preparation of patients for this type of surgery. In orthopedics and plastic surgery, students applied their knowledge of the social and psychological aspects of physical deformities. In nursing rounds, a semi-monthly event for nursing

faculty, staff, and students, there were also innovations. Normally given over to presentations by the different services of practical problems and technical procedures in nursing care, the rounds now included sessions on such topics as cultural factors that should be considered in public health nursing among the Navajo Indians and in Costa Rica.¹

The stages of advancement in the sophistication of both teachers and students were particularly noticeable in the differences in the case presentations at many clinic conferences, and in the seminars on chronic and long-term illness and rehabilitation. Two years previously, psychological or psychiatric variables might have been considered in attempting to explain "problem patients" or what were thought to be their personal shortcomings. But with the exception of possible influences of the patients' immediate home environments, other societal or cultural factors were seldom taken into account. Moreover, opinions based largely on past experiences or "common sense" were freely exchanged. And speculation, rather than demands for supporting data, was common practice. Seldom had references included relevant social science literature.

As instructors became more familiar with the concepts of culture and social class, they began to seek ways of applying it to patient care. At first, application was generally restricted to those patients with behavioral problems who happened to be from noticeably different racial or ethnic backgrounds. In such instances the social scientist might be consulted for possible interpretation. With respect to second-generation or third-generation Americans or "Old Americans," however, cultural and social class interpretations were rarely seen as offering possible explanations of behavior and attitudes.

By the end of the second year, however, case reports were almost automatically expected to include workups on factors in a patient's background that might be related to his needs and

¹ Interest in the Navajo was stimulated by the public health clinic that is currently being conducted on the Navajo Reservation by the Navajo-Cornell Field Health Project where several of the nursing instructors have had the opportunity to spend short periods of time. A report on nursing in Costa Rica was given by two third-year students who had been granted a leave of absence "to work among people in another country."

expectations. Consideration of these factors was no longer limited to patients who presented "problems" for the staff but for the purpose of adding to the general fund of knowledge. One student, for example, using her convalescing Greek patient as a point of departure, reported on patterns of Greek culture as they influence attitudes toward health and illness. She did so, she said, because "many of the staff nurses and nonnursing personnel tend to lump together such peoples as Italians, Spaniards, and Greeks when explaining their behavior or expecting them to act in certain ways."

"Because the staff doesn't attempt to talk much to Negro patients, seeming to feel Negroes will talk only to other Negroes," another student did extensive reading on the social class structure of this racial group. She wanted to demonstrate the fact that being a Negro may be less important in explaining his attitudes and behavior than his social class position and the geographical area in which he was reared.

If it appears to the reader, as it must, that the above is a recitation of accomplishment in integrating the social sciences in the clinical services, he should not be unduly misled.¹ The process was not so smooth or the results so widespread as they might seem. In an institution as large as that of the New York Hospital-Cornell Medical Center, total integration is far from being realized. At this writing, we are of the opinion that it is just beginning. While the entire student body of the School of Nursing has now been exposed to the social sciences through the experimental course, nursing staff education has been spotty, and there are still many segments of the clinical services that have had no contact with the social sciences.

On the other hand, there has developed a substantial core of faculty and some head and floor nurses who are exceptionally adept in implementing the social science program. But even here there are inevitable setbacks. An instructor who has shown unusual ability in learning and applying social science concepts and methods leaves to take a position elsewhere. Another is lost to teaching because she is promoted to an administrative job. One must begin anew with their replacements.

¹ For some of the difficulties see Chapter 13, Problems of Collaboration.

Chapter 12

Role of the Physician in Nursing Education

THROUGHOUT PART TWO of this book we have been concerned with reporting on an experiment in the application of three social science disciplines to nursing education and clinical practice. We have described a considerable portion of the content of a course in the Psychosocial and Cultural Aspects of Nursing, and discussed some of the procedures for integrating social science concepts and methods.

The success of any program of this nature, however, which has as its ultimate purpose the improvement of patient care, can be gauged only in terms of its weakest link. For example, even though the professional nurse receives expert training in the science of human behavior, her knowledge and skills will be of limited value if they are not recognized, understood, and reinforced by the physician with whom she works so closely. If he is unaware of the insights that such training provides her, the nurse may find it impossible to make full use of her skills and educational understanding. If, in addition, he lacks trained insight into human behavior because of the limitations of his own education, he may counteract or make futile all that she attempts to do. Conversely, the nurse who has technical skills but no understanding of human behavior may undo much that the doctor accomplished.

At the present time the average physician knows little about educational programs for professional nursing, nor, it must be admitted, has he much interest in them. It is the rare doctor who reads nursing journals and relatively few have any contact

with nursing schools. It is unrealistic, therefore, to expect physicians to be cognizant of the rising level of nursing education, of the transitional stage which it is going through, and of the growing trend to incorporate social science concepts and methods into the educational program. It is our belief that if integration of the social sciences is to become fully effective, efforts must not be confined to nursing students, members of the faculty, and nursing service personnel, but must also involve the medical personnel. Obviously, in large medical centers this is a formidable objective and it is no less so at the New York Hospital-Cornell Medical Center. Nevertheless, it is one of the centers where recognition of the contributions of the social sciences is continually growing and where active support is given both on an administrative level and within specific clinical fields, such as psychiatry, preventive medicine and public health, and the Comprehensive Care Clinic.

As part of our experiment, therefore, we invited to our class as guest lecturers certain members of the faculty of the Medical College whom we knew had either a social science orientation or were engaged in collaborative research with social scientists. These physicians were asked to lecture on topics relevant to the course content. Besides the formal instruction of the students, we had two purposes in mind. First, we wished to demonstrate to them the growing importance given to the psychosocial and cultural components of health and illness in certain areas of medicine. This we thought important, for as students move rapidly from service to service, they often gain the impression, except perhaps in pediatrics, psychiatry, or the Comprehensive Care Clinic, that these components are given little consideration. Second, we wanted to acquaint at least a few physicians with the kind of preparation in the behavioral sciences that nursing students were now receiving. Those we approached were not only enthusiastic but "amazed" that nursing students were "getting material that not even our medical students get."¹

In briefing the doctors about our course and the preparation students had had thus far—an essential procedure if their lec-

¹ At this writing there are no courses in the social sciences offered at the Cornell University Medical College.

tures were to maintain proper continuity—we found it necessary to stress the students' level of intellectual maturity so that the speaker would not "talk down" to the class. It is not unusual in collegiate as well as hospital schools of nursing for doctors to deliver medical lectures to students during their preclinical and clinical experience, but because the educational preparation and professional needs of these students are not the same as those of medical students, an attempt is seldom made to treat the subject matter with the same degree of breadth or depth. By tradition, therefore, the content of the lectures is often simplified or "watered down."

During the briefing sessions with the physicians, it was observed that their surprise at the kinds of social science material to which nursing students had been exposed was followed by a seemingly intellectual acceptance of the need to raise the level of their own presentations. Once in the classroom, however, it frequently happened that when the doctor in his white coat faced a large group of young students in uniform, he found it difficult to deviate from the traditional approach. Apparently, the situation was so charged with cues of a longstanding nature for him in his role and status position vis-à-vis nursing students, that he had trouble addressing the group at the level on which he had been requested, and, indeed, had come prepared to speak. (This was not true of the woman physician who was a lecturer, nor of men social scientists. And, it was no longer true of those physicians who returned to lecture in successive years.) Not until he noticed that the students' attention was drifting off in the inimitable way that students have of showing boredom, would he remember this was not the unsophisticated group which he was accustomed to face. His real awakening, however, would inevitably come during the discussion period, when he was challenged by the penetrating and incisive comments and questions. It was at this point that the second purpose, to familiarize the medical staff with the students' knowledge of human behavior, was unquestionably achieved.

It would be valid to ask whether these occasional lectures justify the time consumed if physicians tend to talk down to students or oversimplify content when every one of the few hours

allotted to the social science course is important. The answer is both yes and no; but considering the experimental nature of our particular project and the longterm goals, the time given to bringing nursing students and doctors together seemed to be justified. Even if, on occasion, the students' hour was partially sacrificed, the doctors gained a greater understanding and respect for the knowledge they possessed.

THE GAP BETWEEN THE PROFESSIONS

It is of singular interest that members of the two practicing professions most concerned with the health and sickness of human beings are, in many respects, so far apart. Though individual doctors and nurses work closely together, are often greatly dependent upon one another, and have a common denominator of interest—the patient—as representatives of different professional groups they remain largely apart and self-contained. Yet, if these two groups are to utilize their joint potentials to the fullest, a rapprochement and closer collaboration are requisite in situations besides those involving the physical care of patients. This is particularly true in the field of human relations where there should be the same kind of coordinated action and service—the same mutual confidence between doctor and nurse—that is recognized as essential at the patient's bedside or in the operating room.

If, for example, health personnel are to deal adequately with the socio-psychological and cultural aspects of illness, physicians and nurses must not only share a common body of knowledge but they must have the kind of relationship that derives from a deeper appreciation of, and respect for, each other as allies working toward the same goals. This type of relationship, however, requires the bridging of certain gaps that exist between a substantial number of members in these professions. They need to make concerted efforts to understand, to be objective, to get rid of biases, blind spots, and prejudices. These are requisites for the understanding of any other groups of people, who, because of age, sex, social class, or ethnic and religious backgrounds may have different attitudes and values from one's own.

We do not presume to have the answers for bridging the gaps between physicians and nurses, but we do suggest that there are certain critical areas in the educational program of nursing students where the foundation for better relationships might be established. Before discussing these, however, we should like first to bring into focus an aspect of the physician-nurse relationship that seems to us to deserve closer attention than it has hitherto received: the role and responsibility of the physician in the education of the professional nurse. This, it would seem, is a subject for fruitful investigation that should have relevance not only for those interested in the dynamics of interaction and the process of attitudinal learning, but important, if indirect, relevance for those concerned with the care of patients.

The Physician's View of the Physician-Nurse Relationship

The continuation of traditional attitudes and behavior of physicians toward nurses in general and nursing students in particular, may play a greater part than is perhaps realized in the development of nurses' attitudes toward themselves, toward doctors, and even toward patients. We would not hazard a guess as to how much the nursing shortage (or the quality of nursing) might be influenced by the low esteem in which some physicians hold nurses¹ or in which many nurses think they are held, nor how many young women eschew nursing or drop out of it for this reason. But we do suspect that it is a factor, along with poor salaries, cost of education, overwork, and long hours, for some of the general discontent and lack of interest in nursing as a career.²

The fact must be faced that today women are enjoying greater occupational choice, independence, and higher salaries than ever before. Traditional conceptions of differences between men's jobs and women's jobs, the peculiar suitability, or particular traits and characteristics of the two sexes which make them fit or unfit for

¹ See, for example, *Public Images of the Nurse*, Part II of *Study of the Registered Nurse in a Metropolitan Community*, published by Community Studies, Inc., Kansas City, August, 1955, and *The Evaluation of Nurses by Male Physicians*, Part I of the same study, published in March, 1955.

² "The low esteem in which nurses are held by doctors" was one of the most frequently mentioned difficulties encountered by our students during their first year of experience.

jobs, have, "under pressure of the need for manpower and as a result of technological, attitudinal, and other changes . . . broken down."¹ Few remaining occupations are the exclusive domain of men; women are found in practically all occupations listed by the Bureau of the Census and are represented in every professional field. To be sure, almost seventy per cent of all women employed in professional occupations in the United States are in teaching, nursing, library work, or occupations based on home economics.² But with the emergence of technological and scientific occupational opportunities, accompanied by higher levels of responsibility, young women will be less influenced by the weight of tradition. This situation is very different from that of thirty or forty years ago when the parents of many young women deemed teaching and nursing the only respectable professions that they would allow their daughters to pursue. Now there are countless fields from which women can choose to make careers for themselves, and where they can enjoy not only comparable salaries but the prestige and esteem of the men who are their co-workers.

Consequently, the medical profession and the public must rely on young women who are no longer forced to choose nursing as one of two or three career possibilities, but who select it in spite of the attractions of other occupational choices. Even an attitude of dedication or the desire to have a professional skill which is believed to offer a bulwark against job insecurity—two major motivations for entering nursing at present—cannot be depended upon as they could in the past to attract, hold, or return young women to nursing. This appears to be particularly true of the student in the collegiate school of nursing, for in addition to the satisfaction she seeks from caring for the sick or earning a living, she looks for greater understanding and professional recognition from the physicians with whom she works. As our students put it, she wants to be recognized "as a woman with intelligence and training, and worthy of the doctor's respect." She wants to have

¹ *Womanpower: A Statement by the National Manpower Council*. Columbia University Press, New York, 1957, p. 36.

² *Ibid.*, pp. 11, 203.

her capacities utilized effectively and she desires "a cooperative relationship that is aimed at, and will best achieve, the goal of total patient care."

There are still, however, a great many physicians who take a dim view of the development of the professional nurse and what they think this presages. Some see it as an attempt by nurses to usurp some of the doctor's functions or to become pseudo-physicians. Others see "the educated nurse" as a threat to the superior and sometimes god-like status they have enjoyed. The hospital is one of the few institutions in our society where the role and status of the sexes are sharply defined and where traditional attitudes toward male (dominance) and female (submission) are well perpetuated. It represents for many physicians the last stronghold of a patriarchal system that they are reluctant to see broken down. Greater professional freedom and status mobility for the nurse, they believe, can only deprive them of the authoritarian or paternalistic role they have found so congenial. As one physician said:

. . . There has been a big change in nurses in the last 25 years. They used to be courteous little girls who were willing to take orders from the doctor and carry them out to the best of their ability. In return for this the physician took an interest in nursing and in protecting nurses very much as if he was their father surrogate. Generally speaking, nurses are now much better educated and less dependent. All of the old courtesy is gone and often in its place is a certain degree of flippancy. They are more likely to want to give orders than to take them. The attitude of many physicians toward nurses has likewise changed. Instead of the close personal and protecting relationship, they now tend to consider the nurse in a cold businesslike manner as they would one of their competitors. If a nurse falls into trouble nowadays the physician is likely to feel she should sink or swim on her own merits. The hospital patient is much the same person now as he was 25 years ago. I personally think the patient received better care from the nurse 25 years ago than from her much better educated daughter of today.¹

In the eyes of such doctors, nurses have low professional status and require a modicum of intellectual deference. At the same

¹ *The Evaluation of Nurses by Male Physicians*, March, 1955, p. 23. (Part I of study cited in footnote 1 on p. 266.)

time these doctors disparage higher education for nurses on the grounds that it is not necessary in order to be a "good" nurse. As the family physician of one nursing student said, in advising her against attending a collegiate nursing school: "A nurse with a degree is no better than any other." She could, he said, "accomplish the same thing in much less time and be just as good a nurse and not understand everything."

The Nursing Student's View of the Physician-Nurse Relationship

If we can take the views of our students as an indication, nurses today see themselves neither as pseudo-doctors nor as non-thinking "automatons." Moreover, their ideas of what the doctor-nurse relationship should be are clearly defined. Said one student:

The nurse's role and function in the doctor-nurse relationship are determined by her acceptance of medical direction from the physician and her concern for, and responsibility to, the patient. The nurse's functions include giving the patient the physical care needed, carrying out specific orders given by the physician, and assisting the physician with treatments. The nurse also assists the physician by interpreting to the patient and his family the reasons for the treatment prescribed and by giving them the kind of information they need.

Because of her opportunity for observation of the patient's personality, cultural traits, attitudes, strengths and weaknesses, she is in a position to understand his response to illness, and the adaptive mechanisms which he employs in adjusting to the disease. The nurse can convey and interpret this information to the doctor so that he can plan effective medical care. The nurse is also able to report the patient's reaction to treatment and to changes related to progress or remission of illness.

Although the nurse works under the physician's supervision, she has well-defined areas of responsibility involving judgment and evaluation. She accepts the physician's leadership, but recognizes the value of her role in implementing his plan and in helping the patient to accept and benefit from treatment. Whenever necessary, however, the nurse must be flexible and adapt herself to the role which the physician assigns to her, regardless of whether or not it is compatible with her training and expectations, in order to function effectively in relation to her primary responsibility, the patient.

The role and function of the doctor in the doctor-nurse relationship center around his responsibility for planning the medical treatment program, which includes specific orders for treatment to be executed by the nurse, as well as any other area of nursing care indicated by the patient's condition. The physician's role as director or supervisor of the treatment program carries with it a responsibility to share information with the nurse so that she will be able to give good nursing care and interpret accurately the reasons for the treatments prescribed. He must also have confidence in the individual nurse, respect her judgment, accept the help she can give, not only in carrying out treatments but in assisting him to adapt or modify medical care so that it will be acceptable to the patient. And he must support the nurse in her work with the patient and the family by planning with her in regard to the information which they need.

Students look upon the doctor as the "recognized leader," "boss," "chief," "the authority," "the director of the team"; but they also expect the doctor to regard the nurse as a responsible member of the team (competent in her field as he is in his) rather than a subordinate or even "servant," as is so often the case. No longer willing to be considered "ancillary," nursing students want to be recognized and utilized as professionals in their own right. The relationship, according to them, should be one of interrelatedness and interdependence.

With total patient care as the main objective, I believe that the doctor and nurse are in the responsible position of helping each other to help the patient help himself and thus return to society as a useful being. Each must recognize and respect the other's training and capabilities; each must be willing to go more than halfway in trying to cooperate with and assist the other; each must remember that no one and nothing is perfect, that mistakes are made, and that these mistakes must be forgiven and profited by.

* * * *

The nurse must try to understand and carry out the doctor's orders to the best of her ability, and must constantly be on the alert for anything that might aid the doctor in his care of the patient. The doctor must recognize the fact that the nurse is with the patient more than he is, and that there is a possibility she might very well find something that would help him do a better job.

Neither should feel that his or her work is more necessary, as both careers are interrelated and interdependent, and neither could have advanced to its present status without the other as a support and guide.

The majority of students also recognize that they must prove their professional worth before laying claim to deference from physicians. "The doctor's respect depends on how effectively the nurse functions in her profession, and also upon her own observable attitudes toward herself and her work. It seems to me that doctors have little respect for nurses who regard their work as mere jobs, or for those who lack warmth and regard for patients."

Students usually enter nursing with some preconceptions of what physicians' professional attitudes and behavior toward nurses will be. Depending upon past experience or hearsay, these preconceptions may be definite or vague, positive or negative or neutral, but whatever they are, students' first contacts with physicians are seldom inconsequential. The impressions they receive may not only alter or reinforce their preconceptions but they may be lasting. Not only are students' contacts and experiences with physicians in a large hospital varied, but the reactions of students—even of those with similar preconceptions—also vary. One student reports:

Before I started training, I thought many doctors regarded nurses as glorified maids—someone to do the menial work and to carry out their orders. I thought they felt that some nurses were very capable and outstanding, but on the whole nurses were inferior. Since I started training, I have changed my mind because most doctors here [in our hospital] treat the nurses, and even the students, as competent, intelligent persons, and treat them with a respect due a profession. I have seen the respect the doctors on F7E give to my head nurse's opinion about patients and their care. I have never seen the doctors being discourteous to the nurses on my floor, and they seem to work with them as equals and not inferiors. I have seen that the doctors leave many important problems of judgment up to the nurses without any qualms.

A second student reports:

Before I began training I naturally assumed that the doctor gave the orders which the nurses carry out. I also had the idea

that there was not much contact between doctors and nurses. My ideas have not changed since then, for I feel that in my limited association with doctors they do not take time to discuss with the nurse the patient and his total care. Although there were no specific conclusions previous to my entering the School, my general impressions have been reinforced. Some doctors do not act as if they are so far above the nurses that it would be a waste of time for them to speak. But at the risk of generalizing and stereotyping, I think most doctors consider themselves far above nurses.

Physicians are important figures in the eyes of nursing students and graduates; and what they do and say in their professional capacity carries considerable weight. Moreover, a minority participate in the education of nurses. In addition to occasional formal class instruction and conferences, a sizable amount of informal participation by doctors in nursing education takes place daily on the floors of the hospital. In all of these situations the quality of interaction between doctors and nursing students, we believe, is of no little importance in determining the student's attitude toward herself as a nurse, toward doctors in general, and her future working relationships with them. Moreover, it has high potential for contributing toward the rewards and satisfactions, or the discontent and dissatisfactions of nursing as a career. As one student commented, "Another very satisfying part of nursing is the relationship with cooperative doctors who take a sincere interest in helping and teaching students. They will explain in great detail almost any treatment or disease, and they also can point out the best places to find out further information."

Considering the significance of nursing student-physician interaction, the responsibility of physicians in the education of nurses throughout the country has not received the attention it merits. Part of the difficulty stems from one of the very gaps it is hoped may be bridged: the social distance between the two professions. Though there have been exceptions, nurses in general have made little effort to take physicians into their confidence. Neither have they, by discussions, writings, or research, brought to the attention of physicians what they need and expect of them in educating

and encouraging more and better nurses. Either because of awe, pride, insecurity, resentment, professional "clannishness," or lethargy, or because they assume that physicians are not interested, nurses make little attempt to alter the situation. Obviously, the demands upon physicians and their responsibility in a hospital setting are heavy. Their primary concern must be the patient, and in any large teaching and research institution they carry additional responsibilities. To expect them to concern themselves with the education of nursing students may therefore appear to be asking too much.

IMPROVING THE RELATIONSHIP

Yet nurses might be surprised to find that there are physicians who have a keen interest in the problems of nursing and nursing education, and who, if approached, would be most willing to work with them. As an internist with whom we were discussing this matter said, "I wish that the nurses in charge of teaching *would* come to us. There are many aspects of medicine and prognosis that should be included in the content of nursing education, which would enable us to work more closely with nurses and which would benefit patients." There are many other physicians, too, who are not aware of the things nurses are concerned about but who would welcome the chance to help if such matters were brought to their attention. If, however, the profession of nursing is to gain the understanding and active assistance of greater numbers of the medical profession, many more nurses must relinquish their traditional hesitation. They must show more initiative in dealing with physicians. They must approach them with confidence and demonstrate their professional capabilities.

From the long-range point of view this is of the utmost importance if nursing is to attract and hold not only more young women, but women who can raise the quality of professional nursing. The need for doctors and nurses to work in unison and to understand each other is greater than ever before, both because of the growing concept of comprehensive medicine and total patient care, and because of the team approach to the

patient in the hospital, to public health practice, and to research. ✓
If archaic attitudes on both sides prevail, there can be no true collaboration. To be sure some progress is being made, notably in the fields of public health and psychiatry, where many relationships are optimal and consequently highly profitable. But these are the exceptions rather than the rule.

Improving Physicians' Lectures to Nursing Students

We mentioned earlier that there are certain areas where the foundations for better relationships might be laid. On the basis of our observations in several medical institutions and discussions with nursing educators, the following suggestions might be helpful. One is to improve the content of physicians' lectures to nursing students. Following the decision by a nursing instructor to include physicians' lectures on certain topics the request may be made directly to a particular physician. Not infrequently however, it is made to the chief of service. He in turn may assign a young resident or even a specialist in a particular field to "give" an hour or so to the nursing students. But in either case it is the unusual nursing instructor who makes an effort to meet with the doctor beforehand to explore carefully with him the approach and content of his coming lecture. More often the instructor is reluctant to do so on the assumption that the doctor is "too busy" or that it would be "presumptuous" of her to approach him about a lecture in his own field. Usually she sees nothing of him until he arrives at the classroom door. She introduces him to the students and then with much self-effacement retires to a classroom seat.

In physicians' lectures to nursing students, four approaches may be distinguished. The first, a straightforward, stimulating, and understandable lecture is delivered by a speaker who not only respects his work but the students whom he is addressing. In the second approach (referred to earlier), a physician with the traditional attitude toward nursing students, "talks down" to them. The third approach characterizes the physician who is obviously bored by his assignment and is indifferent to what the students learn; he is slightly patronizing or talks over their heads.

The fourth, fortunately infrequent but the *bête noire* of the serious student, is used by the young resident who is flippant and, as students say, "treats us like high school girls." He may begin by commenting on "how nice it is to be facing such a group of pretty girls," thereby reducing the professional tone of the session. He uses layman's jargon rather than the technical terms with which students are growing familiar. He is apt to make inappropriate jokes or employ dubious expressions. He may even take pleasure in shocking nursing students on subjects about which they may be particularly sensitive.¹

The last three approaches are unfortunate because they tend to produce or reinforce the sort of negative attitudes that perpetuate or widen the social distance between doctors and nurses. Equally unfortunate is the small educational gain for students. In some instances dissatisfaction has led nursing instructors to eliminate doctors' lectures from their courses altogether and to rely on nursing faculty who are not so well qualified to cover the particular subject, or who are being encouraged to take graduate work in order to replace physicians as teachers. Such measures, of course, only serve to increase the insularity of the two professions.

If participation by doctors in nursing students' learning is to be profitable, careful pre-planning and cooperation between members of the nursing and medical staff most concerned with nursing education is necessary. Those physicians genuinely interested in teaching young people should be selected to give the lectures. But much of the responsibility for successful cooperation lies with the nursing instructor herself. It not only behooves her to acquaint the doctor beforehand with the background of a particular class and its needs, but it is her responsibility to know what and where in other parts of the curriculum students may have already received instruction related to the particular subject. If, for ex-

¹ In this respect those responsible for the education of nursing students might well heed the warnings of educators concerning factors which interfere with the learning of new ideas: ". . . We see often well-organized scientifically valid material being taught with little realization that most individuals, children and adults cannot accept much of the medical, biological information offered because of their preconceptions and often strong feelings about their own body and its functions." (Frank, Lawrence K., "Storage, Coding and Receptivity, Noise and Learning," in *Education and Anthropology*, edited by George D. Spindler, Stanford University Press, Stanford, Calif., 1955, p. 215.)

ample, she has invited a surgeon to lecture on cancer to her class in gynecological nursing, she should know what has already been learned about cancer in pathology, in medicine, and in surgery. This information should be conveyed to the surgeon. He can then avoid the repetition of content, about which students frequently complain, and instead build upon the knowledge they have. If he is not fully briefed, he cannot be held responsible for a lecture that is atomistic, unrelated, or repetitious.

Improving the Clinic Conference

Better relationships might be established also at the weekly ward or clinic conferences that are scheduled on some hospital services. At these conferences the doctor, usually a resident physician, reviews the medical and physical status of patients on the floor. Theoretically, the conferences are held to enable the nursing staff to obtain information relevant to the management and nursing care plans of their patients. Attendance is normally made up of the supervisor (or the supervisor-instructor), head and staff nurses, social worker, occupational therapist, students, and nursing aides. Conferences such as these provide splendid opportunities for the interested and responsive physician to contribute to the learning experience. If he is, as some physicians are, adept in handling interpersonal relations, he can do much toward increasing staff interest, motivation, and job satisfaction. On the other hand, if he sees this hour as an unwelcome assignment that he must fulfill—and the sooner it is over the better—he will probably rely exclusively on his professional status and its symbols to carry him through.¹ When this happens results are far from satisfactory.

Below are notes that were taken by the writer during two consecutive but different clinic conferences:

The physician enters the room without speaking to anyone, slumps in his chair wearily, picks up the patient's chart, and flips through the pages. He is tall and young, probably in his early thirties. He speaks softly with a slight accent which is not always

¹ Brown, Esther Lucile, *Role Expectations and Deprivations: Their Implication for Patient Care and Health Service*. Paper read at the meeting of the Massachusetts Public Health Association, Boston, January 30, 1958.

easy to understand, but to make it more difficult, he keeps his forefinger over his mouth much of the time. In a monotone and with obvious lack of interest, he comments upon the present physical status of the different patients. Miss Murray, the supervisor, asks questions now and then about problems of care or future plans for patients, in an effort to get further information for herself and others. Sometimes students ask pertinent questions, but the doctor's replies are either so abrupt or phrased in such a way that they do not stimulate further questioning. In some instances his answers seem to indicate that the questioner should have known better than to ask. Neither by gesture nor facial expression does he evince any interest in those around him. A nurse enters a little late and courteously makes her excuses to the doctor. He does not acknowledge this or even glance in her direction as she sits down. Once he yawns openly. Throughout he manifests complete indifference to the nurses, if not covert contempt. A message is brought to him and for some minutes he peruses it, obviously preoccupied with thoughts other than about the conference. Before the end of the hour he leaves as though to attend to whatever the message had been about. He seems glad to have an excuse.

During the hour one could sense the group becoming progressively depressed. No one was stimulated and though Miss Murray had tried to keep the conference going, she had bogged down toward the end by the doctor's lack of responsiveness. The nurses and students filed out of the room in a dragging fashion. One beckoned to another, saying without enthusiasm, "Will you help me with Mrs. Bates (a patient) this afternoon?" The other sighed and said, "Oh, all right."

* * * *

Before the arrival of the physician the head nurse discusses some matters about the hospital floor with the group in a professional manner. Dr. Digby enters, sits down in his chair without acknowledging the presence of those around him. He picks up a chart and turns the pages. He rubs his eyes, his nose, his mouth, scratches his head. The same gestures continue, particularly the eye-rubbing, through the greater part of the conference. He speaks as though talking only to one person in the room—the head nurse who is sitting next to him. His attitude seems to be that this is a routine job he has to go through. The head nurse does some talking but she has altered her attitude and posture since his entrance. Her gestures have become more feminine and she smiles at him warmly. There is a suggestion of flirtation in her behavior. He seems to be aware of this, for there is a hint of a smile in the corner of his mouth when replying to her.

Except when he looks toward the social worker, an older woman whom he apparently relies upon for some information, he glances at no one, gazes over the heads of the others and out of the window. The supervisor endeavors to get additional information by questioning him, but his replies are abrupt and he neither elaborates nor encourages further questions. The interest of the group noticeably lags. The session over, the doctor rises, and without saying goodbye, walks out. The others slowly follow him in silence.

Three days later the supervisor, Miss Butler, comments to the writer that Dr. Digby "was better the other day than usual; but this is the kind of thing I have to go through each time with him." She says she cannot express the way he behaves—"his boredom and cynicism." She feels discouraged; she finds it difficult, if not impossible, to talk with the attending staff physicians. Neither she nor the graduate nurses, she states, ever see the chief doctor of the service. They have no way of meeting with staff doctors and discussing patient problems. This difficulty is in sharp contrast to her experience at her last hospital. She is not only dissatisfied but concerned about what she will be able to accomplish. She makes a point of talking with patients, yet must practically "lie in wait to catch a doctor." She wonders why this situation exists, whether the hospital is too large for good communication and contacts.

These reports are admittedly negative. Positive examples might have been used to match the ones presented, but the former are not atypical. Their inclusion here, therefore, is deliberate because of the forcefulness with which they demonstrate what is not conducive to good professional relationships. Even more important, such examples in many instances are the reflection of medical school and postgraduate programs that have given little attention to training students in behavioral science concepts and team relationships. Since this has been a universal problem, the individual physician is not always to blame. It is however, a problem with which medical education sooner or later must come to grips.¹

EFFECT OF THE PHYSICIAN-NURSE RELATIONSHIP ON THE PATIENT

Good relationships are essential when patients are directly involved. The therapeutic importance of mutual respect and

¹ As some medical schools have already recognized; for example, those at Stanford University, University of Kentucky, and Boston University.

interdependence between the doctor and nurse at the patient's bedside or in the clinic cannot be stressed enough. As we have pointed out elsewhere in this book, patients feel more secure in a hospital environment that is symbolically like a "family" and where there is harmony between doctor and nurse. When there are conflict, tension, and lack of respect between them (or between any other members of the health team for that matter), the patient reacts unfavorably; he may lose confidence and begin to worry. Students are quick to recognize the effect of doctor and nurse interaction on patients and on the quality of care they receive:

Several of the doctors I have worked with have expressed just what is wrong with the patient, how they know, and why certain treatment is desirable. However, one doctor in particular seemed to regard nurses as errand girls who, nevertheless, were supposed to be mind-readers. There was a lack of communication between him and the nurses, with a corresponding lack of good patient relationship.

* * * *

The physician should support the nurse by expressing his gratitude once in a while and by asking her for suggestions and discussing the patient with her. He can also reinforce the nurse's position with the patient by mentioning her in a positive way in front of the patient, thereby displaying his approval of her care. A friendly smile or look from a doctor can make the nurse realize he accepts her as an "equal" in the treatment of his patient and can contribute to much more efficient patient care.

Not only students but graduate nurses look for and appreciate the doctor who, when time allows, is willing to answer their questions, to support their efforts, and who regards them "as a part of the health team." This they view as necessary and important for what it can contribute to more effective patient care.

There are physicians, too, particularly among the more experienced and less status conscious, who not only wholeheartedly subscribe to the team concept but whose expectations of the doctor-nurse relationship are compatible with the concept of total patient care. Their attitude is not always conveyed directly to nurses but when it is, it can do much toward making them

glad they are members of the nursing profession. For example, one can readily imagine the response of nursing students to a lecture by a prominent surgeon who said to them:

The reason that I speak to you as if you were doctors is that you are a part of the doctoring mechanism. There are things that you can do that I can't do; and there are things that I can do that you can't do. But we are not hostile to each other, and we are not defensive toward each other; we are part of a single unit whose ultimate purpose is one thing.

Unless you and I recognize that our contributions must be large, we have not fulfilled our real obligation. That is why I'd like to tell you what you mean to me in the hospital—what you mean to me and what I want from you. When I leave orders, unless they are urgent, I don't really care if the penicillin is given at exactly two, five, eight, and eleven o'clock. I don't really care if the urine is taken at ten minutes after eight or ten minutes after ten. I don't really care if the chart is meticulously made so that there are no blottings. I don't really care if the corners of the bed are well-mitered. What matters first to me, and what I consider the prime requisite of nursing and its prime accomplishment, is the establishment of an interpersonal relationship between your patient and you. Patients who are in a hospital, in a strange world with strange smells, abandoned, they often think, by their families, transported into a world where they cannot function at their maximum, need an extra kind of support besides the aspirin and the demerol and the other medications. They need a special kind of support which can come from you by a word, gesture, thought, or holding of the hand.

I don't know how many of you have been in the hospital as patients. If you have, you will know there is a special thing that happens to everyone, no matter what his social, intellectual, cultural, or financial level, no matter whether he is a child, an adolescent, or an adult. You are in that strange semi-somnambulant state where you're not asleep and yet you're not necessarily in pain, but you're alone. You're alone and confused by thoughts of tomorrow that are terrifying. As student nurses you haven't any idea of the joy that is here in store for you, if you avail yourself of the knowledge of what your contribution can be at that moment—when you walk into the room of a patient, child, adolescent, or adult, and give him a word of encouragement, a word of feeling, a word that connotes to him that he is not really alone; that he does not always have to press the button and feel that he is imposing on the nursing staff. This is what you can give me, the physician!

SOCIAL SCIENCE COURSES FOR MEDICAL AND NURSING STUDENTS

There is yet another, and we believe a most important place and time, where the groundwork for coordinated action in the field of human relations might be established. It is in the medical school when the young student is learning to be a physician. As things are now, the hierarchical status position of nurse versus doctor is so well defined and of such long standing that entering students of medicine have already acquired images of the nurse that are much like those held by the average physician. She is a dedicated and kindly person, a necessary aid, a handmaiden for the doctor or an efficient technician. Her function vis-à-vis the physician is to assist him, carry out his orders, and defer to him. He may respect her highly for her worth and proficiency; he may acknowledge her value as a member of the health team; but it would be rare, indeed, for him to regard the nurse as a colleague in the medical care of patients. Even if her professional education has provided her with some special knowledge and skills not shared by the average nurse, he is in all probability unaware of the fact.

Medical and nursing schools must, in fact, prepare their own students for unique and specialized roles and functions. For this reason the utility of common courses for nursing and medical students is highly questionable. At the same time the distinct educational programs, even though both groups of students may share the same medical environment, tend to perpetuate the gap between the two professions. We are not proposing that nursing students and medical students receive the same training. Obviously, this would be an absurdity. We do suggest, however, that coeducation of medical and nursing students in one appropriate academic subject should have advantages for the future. Inclusion of the behavioral sciences in both medical and collegiate nursing school curricula might provide the opportunity and the place for such joint education.¹ Differences in background between the two groups as to traditional courses in sociology, social

¹ At schools of public health, such as those at Harvard and the University of California, courses embodying considerable amounts of social science are offered jointly to graduate students representing the several health professions.

psychology, and cultural anthropology previously taken in college would presumably be no greater and no less than those existing within the same group. Moreover, the content of a social science course designed specifically for application to the fields of medicine and health need not necessarily require a body of highly specialized knowledge that one or both groups may not have. Sharing the same educational experience in a subject devoted to the study of human behavior should lay the groundwork for better understanding and collaboration between the two groups. Equally important, joint training should result in more nearly approaching the realization of the ideal of total patient care. Given a common core of knowledge in the application of the behavioral sciences to medicine and health, both doctor and nurse would know what they might expect from each other in this field. More intelligent use of the professional nurse as a therapeutic agent could be made by the physician. Often too busy himself, he could delegate to the nurse with confidence the delicate and necessary tasks of utilizing what he knows she has been prepared to utilize—her knowledge of the psychosocial and cultural aspects of illness. Equally competent in these areas, he could provide her with much needed understanding and support, the absence of which leaves her to struggle alone.

PART THREE
CONCLUSION

Chapter 13

Problems of Collaboration

WITH THE STEADILY INCREASING RECOGNITION by the nursing profession of the contributions that the social sciences can make to nursing education and nursing problems, it is becoming fashionable, if not yet mandatory, for schools of nursing to appoint social scientists either as full-time or part-time faculty members, or as consultants on special research projects. Social scientists are also evincing more and more interest in nursing for purposes of teaching and research. This mutual attraction is gratifying and marks an important step forward in the efforts being made by the health professions to improve patient care. The relationship, it is hoped, will be both lasting and productive. But like similar relationships, if it is to succeed, expectations must not be unrealistic and knowledge of the strengths and limitations of each discipline is essential.

When members of two or more disciplines initiate cooperative projects, differences in perspective are likely to generate conflicts. In the process of discovering each other, problems are bound to emerge that are neither quickly nor easily resolved. Yet seldom in the published findings of joint undertakings is mention made of the fact that interdisciplinary problems did arise, let alone what they were, and from which others might profit.¹ Deprived of this knowledge, those beginning to work together for the first time tend to regard their difficulties as unique. But problems of collaboration per se are not unique to any particular combination of disciplines though they may differ in kind according to the

¹ For general discussion of interdisciplinary problems, see Caudill, William, and Bertram H. Roberts, "Pitfalls in the Organization of Interdisciplinary Research," *Human Organization*, vol. 10, Winter, 1951, pp. 12-15.

combination. They are frequently encountered wherever representatives of two or more disparate disciplines or professions begin to work together for the first time. Academicians and industrialists, social scientists and Department of State officials, social scientists and psychiatrists or social workers, and even, within the field of social science itself, anthropologists and sociologists, have all been at one time or another confronted with obstacles that impeded, and indeed sometimes precluded, effective collaboration.¹

In the relatively new collaborative ventures of the practicing profession of nursing and the academic one of social science, there are also potential difficulties that may be anticipated. As their members learn to work together, however, many of these difficulties will be overcome. Meanwhile, if the nature and causes of some of them are better understood at the start, many pitfalls can be circumvented and the process of collaboration accelerated. Furthermore, needless expenditure both of energies and funds—of which there is a lamentable waste in some well-intentioned but naive attempts to collaborate—can be avoided.

One of the barriers to effective collaboration is that at present many nursing educators and administrators are uncertain as to what exactly the social science disciplines are and what they can contribute to nursing. Consequently, they are unable to state specifically what they want or what they expect. As the director of education of a large midwestern university nursing school said, "We don't know what we want from the social sciences nor what they can give us. We realize, of course, that they can help us to understand human behavior and to solve problems, but we really don't know what to expect." The director then went on to say that although there was no social scientist on her faculty, the student nurses were receiving training in the social sciences: a social worker gave a course in interviewing and making "case

¹ For example, see: Kluckhohn, Clyde, "An Anthropologist Looks at Psychology," *American Psychologist*, vol. 3, 1948, pp. 439-442; *Russell Sage Foundation: Annual Report, 1958-1959*, New York, pp. 7-16; Gladwin, Thomas, "Anthropology and Administration in the Trust Territory of the Pacific Islands" in *Some Uses of Anthropology: Theoretical and Applied*, Anthropological Society of Washington, Washington, 1956, pp. 58-65; Kelly, William H., "Anthropology and the Administration of American Indian Affairs," *Ibid.*, pp. 66-72.

studies," a mental hygienist instructed the students in "mental health concepts," and a psychiatrist gave occasional lectures! "What," she asked, "would there be left for a social scientist to do?" Moreover, she saw no reason for keeping a social scientist on the staff for very long: "After the nurses learn this material they can take over."

Even where contact with social scientists has resulted in greater sophistication, there is likely to be some confusion about how to make use of one. "When you were first appointed to the school," the assistant dean told the writer some months later, "I said, 'Now that we've got a social scientist, what are we going to do with her?' " This inability to specify needs and expectations is understandable, however, since social scientists have not adequately interpreted for the nursing profession what their specialty has to offer. Moreover, the two disciplines have neither collaborated nor experimented sufficiently to indicate with certainty what parts of social science knowledge are most useful for nursing and how social scientists might best be utilized.

As for the social scientist who allies himself with nursing education, the situation is almost equally nebulous and ill-defined. He, too, is confronted with unexplored territory, lack of precedence, and a paucity of relevant and published material. In all likelihood he knows little about collegiate schools of nursing, their philosophy or the roles for which they are preparing students. He may know scarcely more about what is expected of nurses within the setting of the modern hospital, the industrial plant, or the public health agency. Consequently, the few social scientists who are currently participating in the application of social science knowledge to nursing education programs are doing so largely on an experimental basis.

There are reasons for the lack of standardization and unanimity among social scientists as to what portions and methods of the social sciences are most effective. The field of social science is vast, both in scope of data and techniques. As we pointed out in Chapter 2, the particular disciplines, each an elaborate and necessary specialization, which fall under the heading social science have different theoretical approaches and techniques in

teaching and in research. The method and emphasis of each social scientist will therefore vary according to his particular specialization and skills. Moreover, he will be influenced by whether he has specialized in one field or whether, by training and experience, allied disciplines are included in his armamentarium.

Other important factors influencing the way he approaches his task are the amount of orientation he has had in the medical and health fields before his alliance with nursing, and his knowledge and familiarity with problems of illness and problems of nursing. His background may range from no experience at all to a considerable degree of experience in research and application. Other variables include the type of nursing school—collegiate or hospital—the size of the institution, the number of students and faculty members, and the initial objective which brought him into the institution in the first place.

Still other factors are involved, but those mentioned above are sufficient to illustrate why probably no two social scientists who are working in nursing education today are doing so in the same manner, and why their objectives, course designs, methods of integration, and results, up to the present time lack uniformity.

DEFINING ROLE AND FUNCTION

A common problem confronting social scientists is that of defining their role, status, and function for those with whom they will be working. This is as true in the medical and health fields as it is in such fields as criminology, industry, or government administration.¹ Social scientists are ordinarily accustomed to the fallacies and misconceptions held by the average layman regarding the different social science disciplines. If one happens to be a cultural anthropologist he is used to the popular stereotype that associates him with a "bone digger," or a student of exotic and primitive peoples, but not of contemporary cultures. If he is a sociologist, he has had the not-infrequent experience of being

¹ For example, see Barnett, H. G., *Anthropology in Administration*, Row, Peterson and Co., Evanston, Ill., 1956.

confused with a social worker.¹ He may even have been suspected of having some sinister connection with socialism! As a social psychologist he has received facetious jibes about being a "crystal ball gazer"; or he has been regarded as a pseudo-psychiatrist, a counselor, or a technician who administers psychological tests.

In a professional milieu, however, he might expect to find an awareness of the distinctions between physical and cultural anthropology, between clinical psychology, social psychology, and sociology, and their different foci of interest. But this is not necessarily the case. Even when, for the sake of simplification, the social scientist refers to himself as such rather than identifying his particular field of specialization, he will discover that considerable confusion obtains among medical and other professional personnel as to what he is or what he does. Consequently, it is not unusual for behavioral scientists who enter the medical and health fields to find that their roles and functions are sometimes confused with those of psychiatrists, counselors, statisticians, and social workers.

Furthermore, because of the considerable ambiguity in assumptions regarding the specific areas in which social scientists are qualified or trained to function, they are often expected to perform tasks or to serve in capacities that vary widely from, or are ancillary to, those originally designated by the job. For example, an analysis of problems encountered by some dozen social scientists who were working in the medical and health fields revealed that in addition to their functions as initially defined by their positions, they had been expected to serve in such other capacities as diagnostician; liaison between doctor and nurse, doctor and patient, surgeon and psychiatrist; arbiter for members of the medical and nursing staffs; confidant, problem solver; fund-raiser; public relations person; coordinator of projects; assistant in writing reports or preparing questionnaires, and so forth.²

Ideally, the social scientist who joins a nursing school faculty should be able to teach or undertake research, and preferably

¹ See Goss, Mary E. W., and George G. Reader, "Collaboration Between Sociologist and Physician," *Social Problems*, vol. 4, July, 1956, pp. 82-89.

² Reported by Frances Cooke Macgregor at a meeting of medical social scientists at the New York Academy of Sciences, March 14, 1955.

both; interpret technical literature and methods of research so that they are understandable to nurses; advise on behavioral research projects and their budgets; direct conferences; participate on some committees; and prepare reports. He also needs the ability to become interested in problems that formerly were of no concern to him. Initially, he may find that because nurses do not comprehend what he is prepared to do, they will ask him to participate in all kinds of unrelated activities beyond the scope of his professional position or competence. He may be expected to serve as adviser in areas for which he is untrained; to develop research projects on subjects that are not researchable; to make assessments of complex situations without time to gather data.

Unwittingly, he is placed in an awkward position. He is not only reluctant to dampen the manifest interest of nurses, but his failure to comply with their requests may be misinterpreted as rejection or lack of interest. At the same time, the success of his work is greatly dependent upon two interrelated factors: cooperation from his new colleagues and acceptance by them. This in turn places a heavy responsibility upon him. He must be patient and flexible, and at the same time retain his own integrity and that of his profession. To attempt to comply with unreasonable and unrealistic requests would do a disservice to both professions. Instead, he must direct his efforts toward clarifying and interpreting for nurses the definition of his role and function. He must help them reshape their expectations. If he does this with care, their initial disappointment will be supplanted by understanding.

Requests Made of Social Scientists

As his co-workers become more conversant with him and his work, the social scientist will undoubtedly receive an increasing number of requests, not only for consultation, direction, and information, but for participation in the innumerable committees with which nursing schools and nursing organizations seem to be peculiarly and abundantly endowed. Up to a point, this may be viewed as gratifying, for it is both an indication of the interest and receptivity of the nurses, and to some extent a measure of his

progress. Many requests will be legitimate in that they are directly related to his job. These should be accepted. Others are either peripheral or entirely outside his professional sphere. Those of a peripheral nature may be necessary to accept, at least in the beginning, in order to establish or maintain good relationships. As for the demands that are beyond the scope of his ability or training, he can only try to demonstrate the ways in which his services can be of value rather than argue how they should be used. This is particularly important in establishing confidence in those who are likely to be skeptical of the usefulness of social scientists.

There will be times when he may resist certain requests, or feel frustrated because they seem to have no bearing on his true functions, or because they pull him away from the area in which he is attempting to concentrate. He may resent the time he feels is being absorbed. Yet participation in many of the routine activities will enable him not only to understand better the nurses' problems and points of view, but will present opportunities for him to make his own contributions, both direct and indirect. He can help provide objectivity, broaden perspectives on human behavior, and bring his knowledge of research methodology to bear on specific problems.

As he participates more widely in the clinical services, it is highly probable that he will also be approached by physicians, social workers, administrators of nursing, and others for assistance with questionnaires, research designs, special projects, seminars, or lectures. His major commitments must take first place, and he must guard against exploitation of his services; but if he sees his role as integrator of social science knowledge and as a catalytic agent, some requests should be viewed as opportunities and accepted on a highly selective basis.

A point is likely to be reached, however, when the law of diminishing returns sets in. The social scientist can literally be overwhelmed by the miscellaneous demands made upon him—a situation that becomes self-defeating. If he endeavors to meet them all, he will spread himself so thin that his work will be seriously impaired. Moreover, he may lose his identity. If he does

not redefine his limits, he becomes a handyman or jack-of-all-trades and does an injustice both to social science and to other social scientists who may follow him. Progress at this point should no longer be judged by the volume of the requests he receives but by their quality and pertinence. They will indicate far more accurately how successful he is in his educational efforts.

But there is also another danger: the innumerable activities of a large nursing school. If the social scientist is a member of the faculty, he is expected to participate in the school activities. In no time at all he may become enveloped in nursing problems and nursing affairs. Neither he nor those for whom he is working must allow this to happen. Time should be willingly provided for him to take part in activities outside nursing that are important for his professional growth and that, in turn, enhance his value to the school.¹

COMMUNICATION

Effective cooperation depends to a great extent upon communication. All too frequently it is taken for granted that professional people share common interests and problems, and therefore can communicate with each other. If this assumption is made, it often results in greater misunderstanding than if members of different professions realize and acknowledge from the start that they do not understand each other.

The social scientist, with his special training, must recognize that nursing is a professional subculture, the collective membership of which has certain needs, values, and behavior patterns not wholly shared by other groups. Yet it is of singular interest that while social scientists presumably recognize the importance of subcultural differences in their relations with other ethnic, social, or age groups, they seem to attach less importance to differences between themselves and those of the professions with whom they may be working. But unless these differences are

¹ Social scientists have specified the danger of losing touch with their parent discipline as one of the disadvantages of working in the medical and health fields. See Anderson, Odin W., and Milvov Seacat, *The Behavioral Scientists and Research in the Health Field*, Health Information Foundation, Research Series, New York, May, 1957, p. 6.

recognized, the social scientist may react to difficulties and failures in cooperation by frustration, a sense of futility, and discouragement.¹ In working with nurses, then, the social scientist must immediately put to use his knowledge of human behavior. He must analyze his own role in relation to nurses as well as the nature of the group with which he is working.

Not only is nursing, like medicine or engineering, a professional subculture, but as a growing profession its members are not yet professionally secure. Like those in other groups who are reaching for full professional status but have not yet achieved it, nurses are, as one administrative nurse has said, "loath to admit their insecurities to others, and are hypersensitive to anything which seems to them to be a reflection on their status or competence." Certainly the reactions of nurses are not unique; but the fact that they are not, does not indicate that they should be dismissed from consideration.

It has been suggested that for a great many nurses "the profession is an idealized image—something vaguely equivalent to a personal identity. It represents a symbol . . . which stands more for a way of life than a codified body of knowledge."² Professional sensitivity has, perhaps, been compounded and intensified because of the present state of transition in which nursing finds itself and by the need to redefine its functions, needs and aims. All of this has involved a considerable amount of critical self-examination which many other professions have undergone and continue to undergo in seeking greater maturity. Like any other form of self-evaluation or self-analysis, it can be a painful process, and at times one avoids, denies, or resents it. Anxiety, aggression, and hostility are manifested by oversensitivity and defensiveness.

To assist it in the process of examination, the nursing profession has called upon social scientists. Studies over the past five years, conducted jointly by social scientists and nurses, or separately by the former, have begun to produce a plethora of published find-

¹ Young, Donald, "Sociology and the Practicing Professions," *American Sociological Review*, vol. 20, December, 1955, p. 647.

² Bennis, Warren G., and others, *Reference Groups and Loyalties in the Outpatient Department*. Boston University Human Relations Center, Research Reports and Technical Notes, No. 20, p. 17. Undated.

ings on the numerous aspects of nursing and nurses.¹ "Images" of the nurses as seen by the public, by doctors, by nurses themselves; typologies of different kinds of nurses; the role and function of the hospital nurse, the public health nurse, the industrial nurse; motivations for entering or leaving nursing; and many other facets have all been subjects of research or investigation. Nurses have filled out innumerable questionnaires. They have been observed, interviewed, classified, analyzed, and evaluated, mainly by psychologists and sociologists. But like the patient who seeks help from the analyst, there are times when what nurses learn does not please them. Defenses are put up and suspicion of the "outsider" or expert develops. Nurses themselves are often the first to admit these occupational idiosyncrasies. "We are like the Indians," said a nursing administrator; "it takes us a long time to make friends with outsiders."

Traditionally conditioned to individual evaluation by teachers, supervisors, and doctors, and more recently to collective evaluation by researchers, nurses tend to be wary of the social scientist who first enters their midst. Even though his task is specifically to teach students and to assist faculty and staff in the application of the sciences of human behavior, it may take time before they are fully convinced that they are not being critically studied. "What are you here for?" "Are you going to study us?" "Have you got your microphone with you?" were some of the questions asked of this writer within the first two weeks of her appointment. Such questions must be frankly and fully answered; but verbal reassurance is not always sufficient. The social scientist will be carefully and widely observed, and what he does and says will be noted. Sometimes he will be questioned about his working in the field of nursing. Questions are not always aimed at learning whether or not he is trying to ascertain the truth but rather whether he is for or against nurses. He will be sounded out on his opinion of recent published studies on nursing, which, unless

¹ See, for example, studies listed in *Nurses Invest in Patient Care: A Preliminary Report on a Five-Year Program of Studies of Nursing Functions*, conducted by the American Nurses' Association, New York, May, 1956; and *Twenty Thousand Nurses Tell Their Story*, by Everett C. Hughes, Helen MacGill Hughes, and Irwin Deutscher, J. B. Lippincott Co., Philadelphia, 1958.

favorable, will be viewed by some as critical and therefore "unscientific." Questions are phrased not always to elicit his objective opinion, but rather to "tell us what we want to hear."

PERCEPTIONS OF TIME AND WORK

Another barrier to communication and collaboration between social scientists and practitioners lies in their differences in perceptions of time and work. Traditionally, nurses go on and off "duty." Work begins and ends promptly and at specified times. While "on duty," nurses must stay at their posts, and reasons for not doing so must be accounted for. Consciousness of time and of staying on the job are so ingrained in most nurses that it permeates the whole profession. Even among those who have risen to administrative positions or professorial rank there are many who continue to feel impelled to explain in detail any tardiness or absence. If an hour or so has been taken off for personal reasons, it is usually made crystal clear to anyone who happens to be near that this time has been or will be made up.

Nursing has meant physical activity for so much of its history that even today there is a considerable amount of guilt-feeling about what might seem to look like inactivity. A nurse who had become an assistant professor still felt uneasy when sitting at her desk studying "because," she explained, "we are conditioned to equating physical activity with work. When I was a staff nurse I would rearrange the linen closet several times over on an unusually slow day instead of using that time to talk with patients, just so others wouldn't think I was loafing." "Fatigue" usually implies, for nurses, body fatigue; and rest is equated with physical relaxation. "Go put your feet up" is the customary advice of nurses to anyone who is tired, even though the fatigue may be the result of prolonged mental exertion.

The discrepancies in attitudes between the service-oriented profession and the research-oriented social scientist pose certain problems for the latter in adjusting to his new environment. For the most part he views his work in the field of human behavior as a permanent commitment. Often he is accused of both "eating and sleeping" his work because he does not see his job as begin-

ning and ending at a specific time. Since his progress and achievements greatly depend upon his professional competence, he alone must assume the responsibility for maintaining and improving it. And he is accustomed to the deference accorded him as a professional to do what he knows is important to do. He is used to measuring work in terms of accomplishment and work to be done, rather than in hours put in. He knows this demands continuous study, preparation, and careful thinking. Though he may fully understand the reasons for the nurses' attitudes, he will occasionally find them discomforting and constraining. One social scientist complained that after a few months spent among nurses he began to feel guilty every time he was found in his office reading a book. Another suddenly realized that he, too, was beginning to explain how many hours he had worked at home—something he normally did anyway—after being away from his office for professional purposes.

METHODS OF WORK

Differences in training, foci of interest, ways of looking at things, and methods of work may also be serious road blocks to smooth interdisciplinary relationships. Between nurses and social scientists these differences are particularly marked. The very nature of nursing demands that the nurse be action-oriented. It is also an occupation that is characterized by fragmentation of work and shifts of attention. Within a single day the hospital nurse may move from patient to patient, perform a variety of functions, and employ different skills; similarly, a public health nurse may visit many patients during a day, all in different environments and with different types of disability and needs. Most nurses agree that the demands upon them, coupled with the lack of time, continual interruptions, and shortage of staff, make it impossible to accomplish all they wish to do. Frustration is further heightened by the atomistic nature of patient care, as it is practiced today, which denies them the emotional satisfaction derived from continuity of patient care. Nurses no longer feel that they have the opportunity or the privilege of getting to know their patients and of giving them the kind of patient care

they would like to give. For example, a nurse may prepare a patient for surgery and never lay eyes on him again. Seldom do nurses have the satisfaction of seeing the end results of their care and teaching. An obstetrical nurse bemoaned the fact that after spending weeks instructing pregnant women in preparation for labor, "I don't even have time to go up to the labor room with them and follow through." Nor was it often that she could take time to go to another floor to see the babies of these mothers while they were there for three or four days. This nurse considered herself "part of an assembly line in a factory!"

The constant and varied pressures under which nurses ordinarily work are expected characteristics of the practicing profession, and for the most part they are, if reluctantly, accepted. Frustration is taken so for granted that resilience to it is a *sine qua non*. Indeed, it is one of the first precepts to which nursing students are directly or indirectly exposed.

The working habits, needs, and expectations of the social scientist are by tradition and training in direct contrast to those of the practitioner. Time for reflection and study, and freedom from undue constraints or pressures that fragment his work are as essential for his performance as are the instruments of the surgeon. Lack of these, on the other hand, can be exceedingly threatening to his professional obligations and goals.

Since action and quick decision-making are imperative for the nurse, and since careful deliberation and weighing of all available data are requisites of the social scientist, difficulties in communication are bound to arise. Accustomed to being pressed to take action or to "do something," nurses often look to the social scientist for quick solutions to problems. Not infrequently they are under the impression that because he is a student of human behavior he has a fund of knowledge and some magical techniques by which he can produce answers to problems in human relations. Moreover, it is erroneously believed that solving problems is his primary function. "What," they may ask, "do you think we ought to do about the problem between the head nurse and the supervisor on the fifth floor?" Or, "What should we do about the two patients in Room 10 who don't get along with each other?"

Questions like these ask for an opinion which the honest social scientist cannot give. If, however, the question is phrased differently, that is, "Can you help us understand *why* there is this problem?" the social scientist is being asked to function in an appropriate way.

Another order of problems arises when the social scientist is consulted about a study that has been under way for some time. Uncertain in the formative stage of what to ask him or of the ways in which he might be useful, nurses begin a study, and months later when they are suddenly faced with a problem, they decide to consult him. At this point he will find it difficult to be as effective as he might have been earlier. He must try to learn in a hurry what has been going on. If he suggests changing a method or instruments that have already been in use, he may create more problems. Yet if he is unable to pull the chestnuts out of the fire or to overcome the impasse that has been reached, his ability is questioned. In any study, then, that may possibly need the social scientist's consultation later on, it is to the advantage of all if he is brought in at the beginning, preferably in the planning stage, and is also kept *au courant* as the study proceeds.

Another pitfall of which the average social scientist is wary is the expectation that he can forecast or predict the outcome of certain contemplated innovations. The methods of his professional training require that he assemble all relevant data in order to foresee possible consequences, but this is not taken into account. Most social scientists are reluctant to assume the role of forecaster, and for good reasons as H. G. Barnett has pointed out:

By comparison with the physicist or the engineer, social scientists are amateurs. They are much more in the category of meteorologists who must take daily and hourly readings and even then refuse to forecast the weather for point X at time Y except within wide limits and when subject to stipulated conditions.

The course of human affairs runs no more smoothly than does the weather, but social scientists know more about its turbulencies and their causes than most people are willing to grant. Their predictions are neither more nor less reliable than are those of the physical scientist dealing with natural as distinct from laboratory phenomena. In all science, including that of things social, it is the

prediction of causes, not effects, that is risky. Under natural conditions—that is, conditions which are not externally manipulated—the conjunction of events that is necessary and sufficient to produce another event has itself such a complex set of antecedents that it is rarely possible to do more than to say that it is likely to occur. For this reason, in sociology as in physics, a regularity, hence a prediction, is properly phrased in the conditional tense: *if A happens, then B will follow.*¹

Actually, the value of the social scientist to nurses does not reside in his supplying specific answers to problems but in developing an attitude. Social science, like other sciences, is more a method of approach than it is a body of knowledge. The scientist, trained to observe, formulate hypotheses, and test them against facts, knows how tentative his conclusions are; and he knows, too, that they are always subject to change in the light of new and better information. Some of the disappointments experienced by nurses when the social scientist fails to meet their immediate and practical needs could be forestalled if nurses were more cognizant of a major concern of social science: “demonstrating what is true—why it is true and to what extent.”²

LANGUAGE

So far we have tried to point out how effective collaboration and communication between nurses and social scientists depends on their familiarity with the subcultural values and orientations of each other's profession; their goals and methods of work. Another potential obstacle to mutual understanding is terminology. If the social scientist is to introduce concepts and methods that are relevant to nursing, he must not only be familiar with the nurses' point of view, but he must be able to communicate with them freely in their language. If he does not sufficiently understand medical and nursing vocabulary, he may lose time and make costly mistakes. This is, among other reasons, why the inexperienced social scientist should serve an apprenticeship in

¹ Barnett, H. G., *Anthropology in Administration*. Row, Peterson and Co., Evanston, Ill., 1956, p. 130.

² Stein, Herman D., “Social Science in Social Work Practice and Education,” *Social Casework*, vol. 36, April, 1955, p. 1.

the medical and health fields before attempting to relate his specialty to these occupations.

Equally important, the social scientist must take pains to translate his own technical concepts into language that is understandable to nurses and doctors. Perhaps in no other respect have social scientists been so criticized by nonsocial scientists as they have been about their so-called "jargon." We do not intend to engage here in a polemic in defense of the technical vocabulary social scientists have developed and find useful. Like any other technical vocabulary, it is employed for purposes of precision and specificity as well as a sort of shorthand that increases communication between members within the profession, much as medical and nursing terminology serves the same functions. Nurses and doctors would not only find it time-consuming in their professional communications but inaccurate to substitute for the meaningful and precise term "colostomy," for example, "an opening of the bowel through a hole in the belly!" Yet, while those in the medical and nursing professions view their right to use technical terms as inviolate (even if patients are often bewildered or irritated by them), and are willing to share the prerogative of using an esoteric language with physicists, lawyers, and even stockbrokers, they are often exasperated when the social scientist employs his!

One of the problems, as social scientists are only too well aware, lies in the similarity of much of their terminology to words in popular usage. For the social scientist terms such as stranger, culture (complex), role, class, and social organization are basic concepts with specific connotations. And the manner in which they are used by him may be quite different from the way they are used by the layman. Confusion is further compounded by the fact that the several social science disciplines may employ different terms for the same concept, such as drive, need, or attitude, or one term for different concepts like status or institution. Obviously, this is puzzling to nonsocial scientists as well as a source of considerable misunderstanding.

If, then, the social scientist is to achieve his objectives in disseminating knowledge of human behavior to nurses and physi-

cians, it behooves him to make his terminology as clear as possible but without sacrificing accuracy. In conferences, lectures, reports, and published findings directed to physicians and nurses, social scientists too often engage in obscurity. There are some, it is true, who find it difficult to communicate with others than those of their own guild. There are others, however, who deliberately engage in a form of pedantic doubletalk in the spurious belief that it sounds impressive. This is of no advantage to either profession and it may actually do harm. Resistance to social science may develop, and social scientists may be viewed with the kind of skepticism that was reflected in the words of a medical educator who said to the writer, "I hope you won't be one of those social scientists who try to add a lot of new jargon to our vocabulary!"

APPLICATION OF SOCIAL SCIENCE BY NURSES

In the interest nurses have shown in the social sciences, there lies a potential danger which must be guarded against. It would be a mistake if, after being exposed to these disciplines, nurses should start shedding their uniforms for the robe of the social scientist. Yet there is a tendency for some, who after a course here and there of the kind commonly offered in schools of education, to assume that they are adequately prepared to take over. But these courses are generally geared to discussions of a wide range of material, and while invaluable in many respects, they do not develop depth of learning or disciplined thinking. They are more likely to develop superficial knowledge that results in glib usage of social science concepts without full comprehension.

It might well be asked, "Why shouldn't nurses after a few courses teach some social science since this helps to spread its application over a greater area?" Moreover, it is usually added that nurses, just as others, must begin somewhere to learn to use new knowledge. The answer is not that the nurse should not teach social science material, but that she should be fully aware of *what* she is teaching.

Sensitivity to the implications of the cliché, "a little knowledge is a dangerous thing," is perhaps greatest among the practitioners of medicine and nursing. They know only too well the costliness

and dangers of not knowing enough. It is quite true, however, that learning must take place somewhere and not be ruled out because there is not enough. A little learning, as Margaret Mead has observed, if it is first learning, is the way in which men move on to new knowledge. It may be regarded as dangerous, however, when used by those who share only part of a growing tradition, and at the same time overestimate their knowledge. In other words, "learning is not dangerous because there is only a little of it, but it is dangerous not to know just how little there is."¹

As nursing instructors begin to see the applicability of social science content for teaching, some may be strongly tempted to preempt certain parts of it and to run too soon, too fast, and too far with it. Cross-cultural material in particular, not only because of the interesting subject matter with which it deals but because it appears relatively easy to handle and teach, is likely to be selected for use. In the hands of those who have had no training in this field, however, such attempts may be abortive.

A newly appointed instructor decided to give her class of pre-clinical students an assignment dealing with differences in child-rearing practices in contemporary cultures. The idea was suggested when she heard reports on the subject by third-year students who had already taken the social science course. However, with no foundation for a critical approach to this material, her students did what might be expected. They lifted from the total cultures concerned a series of isolated phenomena. These they treated as totally discrete items rather than as relevant and integral parts of a *whole* system. Lacking sufficient knowledge and scientific objectivity, their discussions were characterized by comparisons made on a superordinate and subordinate basis. Customs and behavior were judged as inferior or superior, odd, or amusing. The instructor, finding herself unable to interpret the data or to draw proper social science generalizations, was admittedly in trouble. What had previously appeared to be an innocuous but interesting assignment turned out to be a boomerang. Worse still, the social scientist would later have the task of

¹ Mead, Margaret, *Male and Female*. William Morrow and Co., New York, 1949, pp. 436-437.

covering the same material and trying to correct the impressions students acquired through premature exploration.

Here we see how improper handling of social science content can operate to the disadvantage of students and jeopardize the work of the social scientist. If the task of the latter is to coordinate the integration process, it is essential that he be kept informed of any planned innovations that directly concern his program. If this is not done, collaborative efforts may be temporarily disrupted as they were in the preceding instance.

Probably, because of the prevalence of courses in schools of education on *how* to teach a subject rather than in the subject matter itself, nursing educators are inclined to look for knowledge in capsule form, which can be applied both to teaching and patient care. After a short seminar or course on what is intended as a general orientation to some aspect of human behavior, they will say, "Now give us three or four principles we can use." While theoretically acknowledging the need for accuracy and precision in teaching students anatomy, physiology, or nursing techniques, instructors are likely to be less mindful of the need for similar precautions in the teaching of the psychosocial and cultural aspects of nursing. Moreover, if they are not instructors in the former subjects, they are more likely to admit that they do not know the answer to a question and to avoid giving information in a specialty not their own. In connection with the behavioral subjects, however, the dangers of misinformation, unqualified statements, and speculation are less well recognized.

Nursing, like the teaching profession in earlier years, has accepted and incorporated psychology and psychological concepts in its educational programs. But as Theodore Brameld, professor of educational philosophy at New York University, writes:

. . . The trouble with the educators is that they get hold of an idea and then wear it to a frazzle until it becomes nothing but a cliché. Then it becomes an obstacle rather than an aid to effective theorizing and therefore to effective practice. This happened twenty years ago when educators got hold of the concept "felt needs." Now the cliché "culture" is beginning to replace that of "felt needs."¹

¹ Quoted in *Education and Anthropology*, edited by George D. Spindler. Stanford University Press, Stanford, Calif., 1955, p. 266.

We have already pointed out elsewhere in this book how the frequent and superficial use of the term "psychological aspects" in the clinical areas had made it almost a term ad nauseam for students. A similar danger is arising as nursing adopts the concepts of sociology and cultural anthropology. Without sufficient training in the fundamentals of these disciplines and in using their concepts, nurses may give them the wrong emphasis or apply them inappropriately. For example, in a lecture on the emergency treatment of patients with third-degree burns, the instructor discussed important factors to be considered, namely, pain, shock, fluids, and infection. Then she prodded the students for "one other important factor they should take into account." Failing to elicit the expected answer, she informed them that it was the "cultural background of the patient!" Obviously, one's cultural background is singularly unimportant in such an emergency. But the lesson here is clear. Inappropriate usage, like meaningless repetition, weakens and even destroys the usefulness of a concept. Moreover, it reduces, in the eyes of students, the value of the discipline from which it comes.

The point we are endeavoring to make is that it is neither necessary nor advisable for nurses to attempt to become "little social scientists." Nor should they expect to encompass and evaluate the large amount of social science material available. At the same time, however, there is need for them to develop both a certain degree of competence in it and a self-conscious use of it.

If nurses take progressively more and more training in the social sciences beyond that offered in the basic program, as now seems likely, what kinds of courses should be taught? If they took complete training in a social science department, they would presumably be behavioral scientists. But what should social science courses include that are made part of the program for obtaining a *higher degree in nursing*? This question is just beginning to receive some systematic study and cannot be answered yet. We are of the opinion, however, that a few courses offered by nonprofessional social scientists, together with watered-down textbooks on sociology or psychology for nurses, are inadequate. On the other hand, courses that are particularly designed to relate social science to nursing and health education should be

useful. From them, nurses could learn the countless possibilities in patterns of behavior. They could learn, too, what to look for and how to avoid mistakes. Courses should be geared to help nurses make more discriminating choices of available social science literature rather than to select anything falling under the rubric of social science, and regard it as somehow sacrosanct. Furthermore, such courses should provide what the anthropologist, Sol Tax, recommended for government administrators: anthropology courses that would provide them with enough knowledge of the major theories and methods of the different disciplines so that they can learn how much they need to know in order to appreciate that they are not becoming social scientists.¹

Nurses who plan to teach social science in the basic program should take additional and more advanced courses of the kind offered by the graduate departments of universities in order to acquire a facile grasp of social science concepts and material. There should also be courses for nursing educators and research nurses that are aimed at more rigorous training in research methods and techniques, and the development of a greater respect for scientific skepticism and precision.² This is important for several reasons. If such nurses are cognizant of the different methods and techniques offered by the various disciplines, they will be more critical of research methods when they evaluate studies. They will be able to select the sound from the unsound and they will be less likely to accept unquestioningly the latest fad in techniques. They will develop a wariness of projects conducted by those who have a vested interest in the outcome and/or the methods used; of reports of findings that lack substantiating data; of findings based on interviews conducted by the untrained. Finally, before undertaking studies of their own or collaborating with others, they will know the kinds of questions to ask, the pitfalls to avoid, and the necessity for rigorous research designs, and procedures.

¹ Tax, Sol, "Anthropology and Administration" in *Readings in Anthropology*. McGraw-Hill Book Co., New York, 1955, p. 391.

² See, for example, the program outlined in "An Experimental Program in Nursing Research" by Eleanor Bernert Sheldon, Dorothy E. Johnson, and Margaret A. Slusher, *Nursing Research*, vol. 8, Summer, 1959, pp. 169-171.

In the current drive to raise the professional status of nursing, research is viewed as a direct means for achieving that goal. So firm is this conviction that the very term "research" has come to have an inordinate fascination for nurses. Encouraged by their professional organizations, journals, and schools, by available and tantalizing funds, and by the prestige value of the word itself, they are eager to learn the methods of research and to do it. In many instances, however, research for the sake of research, or research undertaken at the instigation of others rather than because of a burning need to find the answer to a problem, has resulted in studies of questionable value and in an abuse and perversion of the scientific method. Equally deplorable, because it prevents the level of nursing research from rising, is the tendency of some nursing educators to gloss over the need for intensive training. As Amy Frances Brown points out:

In their eagerness to establish, through lists of researches done by nurses or in nursing, that nursing is a profession, many nursing educators have tried to simplify research, have tried to make it seem less formidable by using the term frequently, and have even made statements to the effect that anyone can do research, and that we are all essentially doing research when we simply think through ways of doing our own jobs better. There is probably no better way of losing what academic respectability nursing education has been able to establish. In entering academic circles, it is most important that nurses maintain the level of scholarship maintained by other disciplines. Just as it is not possible to become liberally educated through any series of short and easy steps, so it is not possible to do bona fide research except through certain exacting processes.¹

What seems to be required at the present time is not the encouragement of more and more research, but an insistence upon raising the quality of it. This demands not only more intensive training in methods and techniques, but what is of paramount importance, the ability to select both significant problems and problems that are researchable.

While these recommendations are admittedly broad, we believe that they are valid objectives to be aimed at in designing

¹ Brown, Amy Frances, *Research in Nursing*. W. B. Saunders Co., Philadelphia, 1958, p. 10.

courses for nurses. If properly acted upon, they would do much toward helping the nursing profession know what to select from the social sciences, and what it wants from and can expect of social scientists.

CONCLUSION

In this chapter we have pointed up some of the potential problems of collaboration between nursing and the social sciences, and have made some suggestions for solving or avoiding them. There is much to be gained by a strong relationship between the two disciplines, but the responsibilities for achieving it must be mutually shared. If nurses are to seek the assistance of social scientists in education and research, they must know what to look for and what to expect. They must exercise critical judgment in their selection of a social scientist, know what a competent one is and what is good performance. Too often the mere title of Ph.D. may seem sufficient for appointment to a teaching staff or to a research project. Yet it is unrealistic for nurses to expect from the inexperienced social scientist a professional maturity they would not think of demanding from a medical intern. By the same token it should not be expected that a social scientist who has specialized in public opinion polls or archaeology, will ipso facto be equipped to meet the particular teaching or research needs for which he is engaged.

Responsibility for successful collaboration rests perhaps even more heavily upon the shoulders of the social scientist than upon those of the nursing profession with whom he works. Not only is the task of adaptation to nursing his, but even more important he must prove himself by his deeds. As more and more social scientists participate in the educational, organizational, and research activities of the nursing profession, there will emerge those whose interests are not always motivated by real concern, but who see a field rich with possibilities for a "job" or "contract research," or for turning on one's methodology or for testing out a special technique. If the social scientist's interest in working in the field of nursing is motivated solely by such considerations, while he himself remains indifferent to, or is patronizing of,

nursing and its broad objectives and problems, the relationship between social science and nursing will be denied that mutual trust and esteem so essential to successful collaboration.

Ten years ago there were but a handful of social scientists working either part or full time in the field of medicine and health; today, the number is rapidly growing. In 1959 a count of "medical sociologists" (which includes some social psychologists and anthropologists) was shown to be 296. An increasing number of these specialists is being drawn into nursing. This, in the writer's opinion, is a critical period for the future of social science and social scientists in the field of nursing education and research. Among the latter there will be those who are motivated by reasons already indicated above; others, because they are wholeheartedly convinced of the importance of applying their scientific skills to the problems of nursing and patient care. Whatever the reasons may be, social scientists who would safeguard the future must avoid the dangers of overselling their wares or of arousing unfulfillable expectations.

It would be regrettable if nursing accepted social scientists with an "irrational trust" (to use Margaret Mead's phrase) and fell prey to unwitting exploitation by those whose enthusiasm has not been tempered by experience or understanding of the philosophy, subcultures, and problems of the medical and nursing professions. On the other hand, social scientists should not allow themselves to be pressured into participation in premature or ill-considered proposals for studies that they are not trained to handle or that would be of dubious importance. To avoid disappointments and disillusionment, it is their manifest obligation to make clear the limitations of social science and its "still developing stage of formulation and completeness."

Besides his obligations to nursing, the social scientist must keep in mind his obligations to those of his profession who may choose to work in the same field. Like the anthropologist who is the first to work among peoples of another culture, his sensitivity can enhance or his imperceptivity impair the chances of his colleagues who come after him. Similarly, in the field of nursing the social scientist must be ever sensitive to the impact of his teaching

and research upon others. Within the hospital particularly he must be aware of the effect of his presence upon others and sensitive to the possible disruptions his work may produce, such as interruptions to staff or to the care of patients. His acceptance by the nursing and medical staff will often depend in no small degree upon personality factors, such as his aggressiveness or lack of it, his rigidity or flexibility, and his special awareness in interpersonal relations, rather than on the professional status or reputation that he may have among his own colleagues.

If he has been engaged in a special study, he should not leave those with whom he has worked forever wondering "what he found out." He should interpret as best he knows how his material and findings. Otherwise, suspicion will be aroused and resistance may be mobilized against other social scientists. How strongly nurses feel about being left in the dark was expressed in a belligerent tone by a senior staff member of a large city hospital who, upon hearing that this writer was about to begin some research, said, "Oh, those research projects! They [the researchers] come in for a year or so, set up staff and offices, interview the nurses, doctors and patients, and go off. We never hear anything more!" Needless to say, it took considerable time for us to establish the well-known rapport with this woman.

In collaborative efforts in nursing, the social scientist works best who has a detached concern. That is, he must neither over-identify himself with nurses and their problems, nor should he be so detached as to be indifferent to them. In making the decision to apply his professional skills to nursing, however, he should be motivated by a real concern for the expressed desire of nurses to improve their understanding and care of patients.

There is no need here to emphasize the limitless opportunities that are offered today by cross-disciplinary undertakings between the nursing profession and the social sciences. But what we would suggest is that the key to optimal productivity does not lie merely in bringing their respective representatives together in buildings, conference rooms or committees, but that it lies in the minds of those who are drawn together by a genuine and spontaneous interest in the problems at hand.

APPENDIX

Appendix

ORIENTALS ARE STOIC

by *André M. Tao-Kim-Hai*¹

The most peaceful moments of my first stay in an American hospital came just after my operation. Bandaged, half doped, faintly aching, I lay flat on my back between smooth, clean sheets and hazily reflected that nothing is more annoying than a fresh incision with fresh stitches in one's abdomen except, of course, two fresh incisions with fresh stitches in one's abdomen. The thought, for some reason, made me chuckle, and the chuckle made me more than intellectually aware of the incisions—the result of that morning's operation for double hernia. But even pain did not quite touch me, and in the euphoria of ether intoxication I felt at one with the whole world, whose center for me was this New York hospital. I did not expect then that only a few days later I would commit there the most unpardonable sin for an Oriental (I am Vietnamese)—that of losing face through one's own bad behavior. But lose face I did, and to this day I wonder whether my shame was caused by the hypersensitivity of an ethnic minority group reduced to one specimen, or by my secret desire not to be treated as a foreigner in my wife's native land, or by my old, ill-suppressed Oriental prejudice against being openly pushed around by women, or simply by the fact that I had never been a hospital patient before and was hopelessly unprepared for the efficient, cold-blooded, and frequently, it seemed, nonsensical routines that are so familiar and so irritating to most convalescents. I still don't know, in short, whether my behavior was a display of just indignation or a childish tantrum.

I had a nurse, of course, after my operation—a woman whose white hair was ineffectually covered by a ridiculously small white bonnet, and who fluttered around my little private room with concentrated energy and, I am sure, efficiency. Despite a few minor

¹ Tao-Kim-Hai, André M., "Orientals Are Stoic," *The New Yorker*, September 28, 1957. Reprinted by permission of the author; Copr. 1957, The New Yorker Magazine, Inc.

differences, she reminded me of a Sister of Charity whom I had known twenty-eight years earlier in the Vietnamese town of Soctrang. My brother and I referred to this nun between ourselves as the *ange de charité*—a cliché we employed with no hint of irony because we knew she worked without salary and because the two huge, triangular white wings of her coif flapped over her shoulders angelically whenever she moved. On her flat chest she wore a black wooden cross with a worn metal Christ on it, and from her belt swung a long, heavy rosary. She was gentle and cheerful, as we imagined angels to be, although she sang in a French strongly tinged with a Marseille accent, which we somehow felt was not the true tone of angels. Did my New York nurse speak French? I was too weak in the hours following the operation to find out, and too weak even to try to identify her accent, which might have been that of Brooklyn. She was plump and there was none of the selfless gentleness of the nun about her. But a nurse is a nurse, I told myself, and therefore an angel. With this reassuring conclusion, I closed my eyes and sank back into the fog of ether, thinking about how poorly my childhood had prepared me for modern medical care.

I was born in a small village on the banks of a canal, among the rich rice fields of South Vietnam. According to local standards, my father was a wealthy man, for he owned over a hundred and twenty hectares of rice fields, and our family lived in an enclosure containing a tile-roofed master house and several thatch-roofed outbuildings for farm hands, domestic servants, water buffaloes, and agricultural implements. This was an inviting world for a young boy, and I enjoyed it in an active, almost headlong fashion, collecting a vast assortment of cuts and bumps along the way. Whenever I hurt myself I would cry to get my mother's attention. She would come at once to scold not me but the object that hurt me, and then would rub my bruise or wash my cut with rain water, as the case might be (we had no clinic in our village, and no arnica or mercurochrome in our household), and tell me to forget about it. Then she would carry me across the yard to my favorite old water buffalo, and I would have an extra ride on his back all around our compound, to inspect the sparrow nests under the eaves of our red tile roof, to pass in review the dwarf coconut palms along the wide ditches where our barges were moored, or to pick hibiscus flowers from the hedge that separated our compound from the communal canal. Or, if it was raining, my mother would lay me in a hammock and swing it gently with one foot while

she sat in a wicker chair beside me and read me passages from ancient stories that were full of heroes who suffered with equanimity—including a general who had a broken arrowhead removed from one arm and the wound cleansed with rice alcohol while playing Chinese chess with his free hand.

My older brother was, in his small way, another example to me. If he had a toothache, he would hold a spoonful of rice alcohol in his mouth—a Vietnamese remedy based on the principle of fighting pain with fire—without whimpering. He would even challenge me, in sign language, to one of the innumerable games Vietnamese children have played for generations, and, leering at me derisively over his mouthful of fire, beat me, no matter what the game. The fact that he was incapable of comment or small talk only added to his importance.

After my father's death, in 1910, my education fell temporarily to my mother and to one or another of her younger brothers. Maternal Uncle Number Three was a true scholar, whose philosophy was based on a mingling of native tradition, Taoism, Confucianism, and Buddhism. Along with my letters, he taught me our fundamental Vietnamese beliefs—among them the concept of man's three souls. The Superior Man, he often told me, pays little attention to his vegetative soul, restrains his animal soul under all circumstances, and strives to develop his spiritual soul as much as possible, in order to distinguish himself from cabbages, eggplants, coconut palms, cats, dogs, pigs, and water buffaloes. This uncle had a vegetative soul plagued by a number of minor tropical diseases—malaria and various skin eruptions—but he sternly refused to take notice of its sufferings. He classified his internal troubles into two categories—those caused by an excess of internal heat, to be treated with rhinoceros horn, and those caused by a deficiency of internal heat, to be treated with ginger. The first medicine is prepared by patiently rubbing a rhinoceros horn—from which the rhinoceros has been detached, of course—across the rough inner surface of an earthenware bowl containing cold water. When the water becomes milky, you drink it until your fever subsides. The second remedy is no more than a hot infusion of fresh ginger sweetened with rock sugar. You drink it until you feel warmer, which is very soon. My uncle had no quarrel with other local medicinal products, such as deer antler, dried bumblebees, tiger bones, ginseng, orange peel, and mint, but he saw no reason to implicate his life with them when he had a rhinoceros horn stored in a tin box and ginger growing in his own yard. As for surgical operations, he considered them sins

against filial piety. Were they not mutilations of one's body, which was a precious gift from one's parents and not to be tampered with under any circumstances?

The concessions he did make to illness were rare and grudging. He bore his skin diseases without even scratching. He would drink rhinoceros-horn water and bathe himself with it from time to time, although he expected no rapid results. My mother used to bathe our mangy dogs in creosote diluted with water, and she urged my uncle to try the same cure for his skin troubles. "Of course, it must hurt a little," she said, "but it does the dogs a lot of good. You, Little Brother, have the same vegetative soul that dogs have, so why don't you try it?"

Little Brother resented this reminder of the least of his three souls. He was also an adult Vietnamese and only human, and was therefore suspicious of the creosote because it came in a bottle with a French label. But to prove to his elder sister that he did not shy away from pain he bathed himself once or twice with her dog medicine, proving simultaneously that it did not hasten the purging of his blood.

Malaria made him more cooperative with his vegetative soul. In some uncanny fashion, he knew when he was about to have a malarial seizure, and he would prepare his mat and his concoctions beforehand. As soon as he started to feel the chill, he would drink the ginger, lie down on his mat, and shake lamentably. After a time, the chill would pass, and there would be a little lull. Then the fever would seize him, and he would drink rhinoceros-horn water and perspire profusely for a while—a long while, it seemed to me. When the fever subsided he would sit up, give me a quizzical smile, half of apology and half of pride, and prepare himself a pot of Chinese tea while smoking one of the conical cigarettes he made out of black Vietnamese tobacco and the same coarse white paper I made kites with.

When I went off to a boarding school run by a group of Christian Brothers, I encountered another way of dealing with physical miseries. The *très cher Frère Infirmier* in charge of the school's infirmary was a fat man with a big red beard, and big blue eyes made bigger by thick lenses, who spoke French and Vietnamese with a Breton accent and who believed in Western medicine and Christian purgatory. Armed with a bottle of iodine and an applicator, he could make the smallest wound feel like a major abscess, and he classified our cuts and bruises as deserving, according to their size, one hundred days, two hundred days, or three hundred days of deliverance from purgatory, provided the patient offered his pain as a sacrifice to the Almighty and did not

cry or whimper. Any rise in body temperature—checked with the *cher Frère's* oral thermometer—was followed by the administration of castor oil. The patients stood at attention in a row, and the *Frère Infirmier*, a huge bottle of castor oil in one hand and a teaspoon in the other, passed slowly down the line like a fatherly colonel, explaining to neophytes that they would receive three spoonfuls of the stuff, each worth one hundred days' remission from purgatory if the medicine was bravely offered to God. Sometimes a spoonful of castor oil, through no fault of the recipient, refused to stay down. The *Infirmier* would continue his distribution as though nothing unusual had happened, but he would keep the unfortunate boy after the others had been dismissed, to console him for his medicinal and spiritual loss.

As I lay now on my hard hospital bed and tried to remember the exact appearance of the *Infirmier's* face, my half-closed eyes were struck by a strong electric light switched on over my head. Another face, tanned and kind, seemed to be floating above me. I made an effort to focus on it, and recognized it as that of my surgeon. Behind him was a group of internes.

"How're you doing?" the surgeon asked me in a gentle voice.

"I'm doing all right, Doctor," I answered.

He uncovered me by pulling down the sheet and pulling up my hospital gown. My belly was warm, his fingers were cold, and at the best of times I am ticklish. The result was that I winced, and my face must have shown an inexplicable hilarity. The internes converged on me, watching me seriously. The cold fingers poked; I wiggled and giggled involuntarily. The soft voice asked "Does it hurt?" I answered "No," partly because my flesh was still numb and partly to reassure him that my wiggling was not due to pain. The internes looked on with intense gravity, from which I surmised that I was a rare sort of hospital patient, to be observed with special attention. The examination went on like this for some time, until at last the surgeon covered me again and departed with his solemn retinue.

I had full confidence in my surgeon and liked him, although many of our earlier encounters had been marked by this same kind of foolish misunderstanding. I must admit that at our first meeting, in 1948, I had disliked him. I had joined the United Nations staff in New York in 1946. Two years later, at the conclusion of a routine physical examination—the U. N. has its own clinic and its own staff of doctors giving regular physical checkups to all members of its Secretariat—a charming French-speaking woman doctor told me that she wanted

me to see the specialist on hernia. "Just to make sure, you know," she added reassuringly. That was how I met my surgeon. He was nine years younger then, still under thirty, and perhaps a little less gentle than he is now. I was far from patient with him, not because of my youth, since I was already forty-three, but because I spoke little English and he knew no French. When he asked me to uncover my middle, I started to explain to him in my slow English that I had never noticed anything wrong. He cut me short with an impatient "Yes, but—" and plunged a long, firm finger into me. "Cough!" he commanded. I didn't feel like coughing, but I tried to oblige. "Louder!" he snapped. I did my best. He poked harder, and I began to giggle.

"There's nothing to laugh about," he said, and my blood pressure rose several points. After all, I was much older than he (in Vietnam he would have had to call me *ông*, which literally means "grandfather"), and we were of equal rank in the U. N. But my limited English prevented me from making a properly acid retort.

After a few more pokes, the doctor straightened up and asked, "How long have you had this double hernia?"

His tone was an accusation, as if I had known of the hernia all along and had willfully concealed it on my medical questionnaire. But again my English wouldn't come, and I could only answer him with a phrase I had learned from comic strips—"I dunno."

"Why don't you know?" he fired at me.

Nobody had asked me such a question since the days when I was a *soldat de deuxième classe* in the French Army. Sensing my rising temper at last, he tried to make me feel at ease. "You must be a real tough guy," he said.

This was no better. I had heard the epithet "tough guy," but I had always translated it to myself as "*mauvais garçon*." Again he must have seen my anger and incomprehension, because he modified his statement. "You don't pay much attention to minor pains, do you?"

After that, we got along better. He told me that there was no hurry about an operation, but I must come to him for an examination at least once a year. So for the next seven years I dutifully reported to his office, where he would poke and I would jump, and the operation would again be postponed, because, he told me, it was only the beginnings of a hernia. Last year, however, I informed him of my decision to retire from the U.N. and to move to Hawaii, and he said that the time had come for surgery. I was not getting any younger, he told me,

and I might not find such good hospital facilities away from New York. My wife voted with the doctor, and I reluctantly agreed. I did not then know what was in store for me.

One afternoon late last winter, I presented myself at the hospital, where my wife and I waited patiently and endlessly for a nurse in the admitting office to grant me an audience. At last she produced questionnaires and began to ask me a series of questions that reminded me of my first encounter with the Gestapo, in Marseille in 1943. My difficulties started with the very first questions: "What's your first name? What's your last name?"

Being intellectually scrupulous, I wanted clarification on what she meant by first and last. "First is what comes first. Last is what comes last," the bureaucrat-nurse said with infinite weariness.

My trouble was that we tradition-bound Vietnamese have been more reluctant than the Chinese to Westernize our way of writing our names, even when we live in a Western country, by reversing our usual order of family name first and given name last. My Vietnamese name is Tao-Kim-Hai, the family name, Tao, coming first. But when I became a French citizen in 1929, I was required by law to add a Western given name in front of my old name. Thus my full name, André Marie Tao-Kim-Hai, now contains two first names first, then my family name, and then two first names *last*. After much explanation on my part and bored impatience on the nurse's part, my names were written down, but I reduced the name Marie to the initial M, in order to avoid confusing the nurse as to my sex.

"Country of birth?"

This was easy, or so I thought, and I answered without hesitation, "Vietnam."

The young lady held her pen poised but refused to write. "Never heard of it," she said, as if I had just invented a new country.

Vietnam is not a new country. Its first king is thought to have died in the year 2879 B. C. Perhaps an American lady, even a professional and educated lady, cannot be expected to know Vietnamese ancient history, because the name of the country has changed several times. But how about Bao-Dai, Ho Chi Minh, Ngo Dinh Diem, Saigon, Hanoi, and Diên-Biên-Phu?

"Is it in China?" the nurse asked.

Now, that is a question calculated to drive any Vietnamese wild. The Vietnamese respect China as the seat of a very honorable culture, but they cannot forget the thousand years of war between China and

Vietnam. Historically, ethnically, geographically, and politically the lady was wrong, but I drew a deep breath and held my temper. It took me a long time, but eventually the nurse passed me, not *cum laude*, and turned me over to a male attendant, who turned me over to a cashier to pay in advance for private nurses. Finally, I was allowed to go to my room.

The room was small but comfortable and well located, with a balcony and a view over the city. When my sister-in-law was in the Soctrang hospital in 1929, she had a whole suite to herself on the ground floor, surrounded by a hedge of blooming hibiscus. Here in New York there was no blooming hibiscus but a hedge of dirty buildings, with a few skyscrapers in the background. Nevertheless, my room cost at least twenty times as much as the suite in the Soctrang hospital and at least twice as much as the room I had occupied in the Waldorf-Astoria in 1945. At that price, I decided, I could expect good service, some comfort, and a certain measure of privacy. I changed my business suit for pajamas and a robe, said goodbye to my wife, and eased myself comfortably into the one armchair and started to read.

The door opened suddenly and a voice boomed "Hi, André!" It was a Catholic priest, plump and jovial, complete with prayer book and stole. "How about Confession and Communion?"

I had told the admitting nurse expressly that although I was a Catholic, I did not want a priest, but here he was. He seemed a bit disappointed when I told him that it was not to be a serious operation, that I expected to survive, and that, anyway, I did not take death as seriously as many other Christians do. I tried to talk religion with him, but he did not seem particularly interested, and left after a few minutes.

Almost immediately, another man came in. He pointed an accusing finger at me and said with what I took to be a Middle European accent, "You have tuberculosis. You have venereal disease. You have—" There was not the slightest interrogative inflection in his voice.

"Who are you?" I interrupted.

"The anesthetist," he answered.

"*Parlez-vous français?*"

"*Oui*," he said, and resumed "*Vous avez la tuberculose. Vous avez des maladies vénériennes. Vous avez—*" as affirmatively as ever.

During that first afternoon in the hospital, many other unexpected and unknown visitors came in, always without knocking, without introducing themselves, and without stating their business—except for

the man who came to rent me a television set. I was both annoyed and amused, assuming, rightly or wrongly, that all this was the normal routine of an American hospital.

There is nothing to report about the next morning, except that a man came in to prepare me for the operation and a nurse popped in to give me a hypodermic, the significance of which I did not realize until I woke in the afternoon and discovered the incisions in my abdomen.

That evening, when I was fast asleep, somebody again turned on the light above my head. I looked at my watch and found that it was a few minutes after ten. Two young male internes and a young woman interne were sitting in chairs tilted back against the wall and looking at me. I recognized them as having been in the group that had visited me with the surgeon that afternoon. They smiled at me and I smiled back at them. We talked. One interne said that he had been surprised when I giggled during the surgeon's examination in the afternoon. "Orientals are stoic," he stated sententiously.

I decided that by "stoic" he meant tough, in the way my surgeon meant it when he said I was a tough guy, and I took it to be a compliment. But I wondered about "Orientals" and asked him for his interpretation of the word.

"Chinese, of course," he said.

I asked him if he thought the whole Orient—whatever geographical limits he gave to that word—was peopled by Chinese. To my astonishment, he said that he took it for granted that I was Chinese, and anyway, all yellow people were the same. I asked him if he thought all white people were the same. I saw that he was embarrassed, and I was aware that it was I who was embarrassing him. I tried to put him at ease—as if I were a host in this room, and not a man who had just had an operation and was hoping to be allowed to sleep—with the story of my adventure with some Canadian broadcasters.

A few years back, I told the interne, I had received a telephone call from Ottawa inviting me to go there as the guest of the Canadian Radiodiffusion and read a few pages of French text for a film sound track.

"Don't any of you in Canada speak French any more?" I asked.

"Yes, but we want somebody from the Orient to do it."

"What's the text?" I asked.

But it was a long-distance call, and they didn't want to go into details. I was glad to visit Canada at somebody else's expense and get paid for it besides. I flew to Ottawa, had an excellent French lunch,

and was shown the film, which was about India, and I read their text aloud into a microphone. I read it in my own French accent, which had grown out of twenty-two years' residence in France, out of my study of French diction, and out of several years spent as an habitué of the Club du Faubourg, where Parisian orators discuss everything from Paul Valéry to colonialism. When I finished my recording, despair was on the faces of my Canadian hosts. I sensed that I was a complete failure, and said I was sorry.

A French-Canadian said, "*Mais c'est de la Comédie-Française!* Couldn't you read French with an Oriental accent?"

"Which Oriental accent?" I replied. I explained that I did not know any of the dozens of languages spoken in India, any more than I knew Japanese or Chinese or Laotian or Cambodian or Malay or Siamese or Burmese, or whatever languages they speak in Afghanistan, Tibet, and Inner and Outer Mongolia. All I knew was Vietnamese, and my Vietnamese friends had told me that I spoke Vietnamese with an American accent, whatever that might be.

At the end of this story, the internes dropped the subject of race and tackled me on Oriental religions. I had a hard time explaining to them that neither Taoism nor Confucianism nor Buddhism is a religion in the Western sense of the word. They shrugged, and one of them said, "Tell us about Oriental food." But here again I had to say that I could find no common denominator for a Japanese *sukiyaki*, a Korean *pulgogi*, an Indonesian *nasi goreng*, a Siamese *mee kraub*, and an Indian curry. And so they left. They had not been unkind, but I had a feeling that they were disappointed by my inability to give them any general ideas and unhappy because they were no longer sure of the general ideas they had had.

My real troubles started the next morning. Around five, a nurse came into my room and propped both doors wide open. I had never been awakened so early in my life except once in Oxford, where an English maid woke me before dawn to serve me early-morning tea. Here, in the New York hospital, my nurse served me an early-morning thermometer, without asking my consent or coöperation. I resolved to be patient, however, and tried, unsuccessfully, to go back to sleep. Around seven o'clock, I thought it was late enough to ask for a special favor, and I rang. Ten minutes later, a nurse in her late twenties whom I had never seen before came in. Before I had time to ask her please to bring me a cup of coffee or anything hot, and kindly to close the door when leaving, she shouted at me, "Whatsa matta, boy?"

I was nonplussed by the rudeness of her tone and her vocabulary, but I managed to lodge my double request. "Breakfast at eight-thirty," she snapped, and went out immediately—without closing the door.

She went out so fast that I had no time to formulate an appropriate reply. The word "boy" had stung me more than the nurse's tone and manner. I did remember that before my American father-in-law died, my mother-in-law used to explain his occasional absence from their cottage in Florida by saying "He must be out bowling with the boys"—by which she meant a group of gentlemen who were in their seventies. But I also could not forget my personal knowledge that the French in their colonies use the word "boy" to mean "servant." They even call a female servant a "boyesse." Suddenly angry, I wanted to ring for the nurse again and explain all this to her, but then I remembered my conversation with the internes and decided to live up to their high opinion of the stoicism of Orientals.

Around eight-thirty, several nurses invaded my room, all shockingly healthy and cheerful, and chattering like parakeets. I heard a jumble of overlapping greetings and questions, such as "Hi, boy!" "How do you feel this morning, sweetie?" "He looks wonderful!" "Where did you get this beautiful silk robe?" "Here's your breakfast." "Don't you like coffee? You prefer Chinese tea?" and "Soft-boiled eggs—no chop suey here!" I was confused, and I couldn't sort out the questions fast enough to answer any of them. Then a couple of male attendants walked into the crowded room, one of them shouting at me in Chinese, "*Ni hau ma? Ni hau pu hau?*" When I did not answer, he added, "You Chinese? What dialect you speak? . . . No Chinese? Jap?" The other attendant turned on the television, which responded with a blurred image and a blare of sound.

Suddenly my surgeon came in and the nurses and attendants became silent at once and filed out of the room. Gently he examined me. When he was through, he asked, "How do you feel?"

"Physically, as good as possible," I answered. "Mentally, not so good."
"Why?"

I explained to him that I had the impression of being a rare animal in a zoo. In fact, I added, this was worse than a zoo, because in a zoo the public is not supposed to excite the animals. The surgeon tried to cheer me up, telling me that there was a lack of privacy and social amenities in almost all hospitals. He went as far as to explain the psychology of nurses and hospital workers, who tend to become

insensitive because they, fully clothed and able-bodied, habitually deal with more or less helpless patients who are stripped of their business suits and their vertical dignity.

This reasoning cheered me slightly, and I pondered over it later, when a nurse came to wash me. Her method was without consideration or kindness but efficient and thorough. No wonder nurses have a superiority complex, I reasoned as she rubbed my back, and no wonder I feel inferior, being babied like this. I quoted Spinoza to myself. "An emotion which is a passion ceases to be a passion as soon as we form a clear and distinct idea thereof."

But matters did not improve in the succeeding days. I was a "boy," I was a dumb Oriental. I was addressed in what sounded like pidgin English. I heard allusions to what the hospital staff thought of as Oriental ways and Oriental foods. Even my American wife was not spared rudeness, vexation, and humiliation. Although she had an M. A. in Greek before many of the nurses were born, these young ladies took it for granted that the wife of such a strange man could not amount to much. Several times I nearly exploded, but my wife, who can always guess my mood with accuracy, succeeded in calming me. I tried to remember my Maternal Uncle Number Three's teaching about the Superior Man. It was not my job, I told myself, to enlighten the hospital staff about world tolerance or the sensitiveness of one normal Oriental. My job was to restrain my animal, emotional soul and allow my physical, vegetative soul the best possible chance to heal my two incisions.

The moment of drama came unexpectedly. Its protagonist—the external, visible, and immediate cause—was a nurse, but as I think back on it, I realize she was no protagonist at all but only the last straw. Try as I may, I cannot even recall exactly what I said to her, or why I said it. I only remember her reply. "*I am the supervisor,*" she said. "*I am the head nurse here. I know my work and I know people like you!*"

Jumping hastily and unnecessarily out of bed and fumbling with the telephone, I shouted to the operator, "I want my surgeon! I want him immediately!" Then I raved confusedly, incoherently, childishly, ridiculously. I don't remember most of what I said; I remember only that the hand grasping the telephone shook and that my legs would barely hold me up. The nurse herself did not seem to trust her eyes; it must have been a scene she was not used to. I shouted at her, "I am a patient! I'm not a nurse! I'm not under your supervision!"

The surgeon came, and I poured out to him all my bitterness as a patient in general and as an Oriental patient in particular. In a loud, shrill tone I told him that a hospital should take care not only of the physical welfare of its patients but of their mental welfare as well, and that nurses should treat their patients as human beings, whatever their race, sex, religion, and state of health. In the middle of my ravings, I again saw the nurse staring at me, her eyes wide open, her mouth slightly ajar, and her arms hanging foolishly down. "If you have nothing to do, get out of here!" I shouted at her. "Get out of here!"

Abruptly, my excitement and exhilaration subsided, and I felt ashamed of myself. I was also angry—angry with myself, with all the nurses on my floor, with the whole hospital, with the entire United States of America, and with all the human stupidity in the world. The surgeon had listened to me in silence. When I had calmed down, he quietly asked me, "Would you like to change floors?"

His gentle suggestion made my anger flare up again, and I cried out, louder than necessary, that I would not retreat. Suddenly finding myself in command of the English language, I said that I wanted to stand my ground and fight it out, to shout back at those who shouted at me, to be sarcastic when I met sarcasm, and to make myself either respected or hated as a patient and as an Oriental.

Gently the doctor eased himself out, and my wife came in. She told me that I had been wrong. I knew she was right, but I shouted at her, too, angrier than ever. She left. I was alone for a long, long time. A feeling of shame overcame me—only shame, nothing more.

Someone knocked at my door—a thing I wasn't used to any more—and I managed a "Come in." A young nurse with red hair appeared with a tray. "Your dinner, sir," she said without any emphasis. It was the natural thing for her to say, but I felt embarrassed, as if I were being shown a special treatment that I did not deserve. Guardedly I smiled at her and thanked her. I readied myself for dinner, cooperating eagerly as she set up the collapsible table. I pointed out to her a box of liqueur chocolates from Holland and invited her to help herself. She did so with grace. I asked her if she spoke French, and—miracle!—she did. She spoke it with a Canadian accent, but it was French all the same. I felt like kissing her then and there, just as I had felt like kissing the first girl I saw in the Free Zone of France after I left Frontstalag 152 in the Occupied Zone, in 1941. In both cases, however, I did not feel that I had won a battle.

From that day on, all the nurses I encountered treated me decently, finishing all their sentences with "sir"—even their supervisor, who reappeared discreetly the next day. I knew that I had behaved badly, that I had not been even faintly civilized, and that I had reacted in sheer animal passion. But I did not know how to apologize to the head nurse without embarrassing her. To make up for my inability to formulate an adequate apology, I coöperated with all the nurses and attendants beyond the call of a patient's duty. I took my own temperature. I took my own bath, sitting on the edge of the tub in my bathroom. I ate all my breakfast, although the eggs were never the way I liked them and the coffee was too American and too weak. I shared my gifts of candy and cookies with all the nurses. My guilt, nevertheless, lingered on, and I wondered if the head nurse now tolerated me as a spoiled and incurably ill-bred boy beyond redemption, whether she hated me or possibly even admired me for my outburst, whether future patients in this hospital would profit or suffer from my wild explosion, and whether Orientals would be received here from now on with special attentions or would not be admitted at all. These were some of the questions I was left with as a result of my first experience in a hospital, and I am afraid that I will not find satisfactory answers to them even after my scars fade and are forgotten.

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