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HUMAN RELATIONS IN NURSING

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Preface

The purpose of this book is to arouse interest and curiosity about matters which are so familiar that they are often overlooked. Students are encouraged to detach themselves as completely as possible from their own society, and to look in upon it much as a stranger would do.

A second object of the book is to provide the student with much better equipment for observing society than most strangers would have. Students are introduced to a systematic plan for viewing the orderly relationships in society, and they are given the principal concepts by which they are able to analyze social systems in considerable detail.

In order to advance these objectives students are continually reminded of their previous social experience and guided in their reflection upon it as a key to understanding the general ways of life. After studying each chapter students may find it profitable to utilize the suggestions made for simple observations and investigations of some current experience. It is believed that some class periods devoted to systematic observations and interpretations of particular social situations will advance all the objectives of the book which have been mentioned up to this point.

These aims are preliminary to the primary objective. The book is designed particularly to help nurses gain maximum insight concerning the human relationships involved in their professional service. The second part of the book is applied entirely to this end. Nearly all of the situations in which nurses are related to the colleagues in health services, to varied types of patients in diverse social situations, and to the larger community relations are explored for maximizing understanding of all social factors involved. Upon such analytical foundations courses of action which promise the optimum health of society are set forth.

The eclectic nature of this book makes it a debtor to many authors who are not named, as well as to those who are quoted or named as sources. We wish to express our deep gratitude to all of them and especially to those authors and publishers who have granted permission to use material from their works. At the same time these

persons are absolved from responsibility for any interpretation or synthesis which occurs in this work. Any analogies which may have been strained and any interpretations which may seem unorthodox have been made for pedagogical reasons under our responsibility.

Only a few persons who helped with the book's production can be singled out for expressions of appreciation by us. Those who assisted most are Dr. Albert J. Reiss, Jr., John Ball, Dr. Jay Artis, Mrs. Mary Ann Papuchis, Mrs. Joyce Lovell, Professor Virginia Crenshaw, Dr. James A. Quinn, Louise Flynn, Christine Whitney, Marie Freier, Lois Mills, Patricia Johnson, Rabbi F. A. Doppelt, and Mrs. Toyo Kawakami.

WAYLAND J. HAYES
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PART ONE

Sociological Orientation

Chapter 1

FOUNDATIONS FOR UNDERSTANDING SOCIETY

Have you ever found yourself in what amounts to a new social world? Many students who had been in a School of Nursing less than a year were asked whether they found life in the school different from their past experience; and, if so, in what ways. Since they were given an opportunity to indicate whether they found nursing school life practically the *same* as their past experience, or only *slightly changed*, or *very different*, it was notable that about three fourths of them found professional school life *very* different from the familiar ways of their homes, communities, and former schools. They were impressed with differences growing out of dormitory life; differences in the ways classes were conducted and the place of books in the process of learning; differences in the way they were treated as students; differences in standards of many kinds; differences in interests; differences in their association; and, above all, they noted rapid changes in themselves. They found their outlook on life changing in many particular ways and their experiences were adding up to a whole new social world.

NURSING SCHOOL—"NEW WORLD" OF EXPERIENCE

It is not the purpose of this introduction to make a detailed summary of the "new world" which many students found after entering the professional school of nursing. Many were impressed with the change from home or arts college to dormitory life, bringing increased association with persons of the same sex, near the same age, and with a continuous emphasis on the dominant professional interest. The association with persons having similar goals and activities intensifies experience so much that the content of conversation, and even gossip, becomes different from that of the past.

One of the most notable changes is, of course, in school work itself. In place of the emphasis on materials found in books these

become only aids to observation and learning directly from experience. Students must not only gain knowledge about things but must become directly acquainted with things and learn independently through doing things. Because of the changed emphasis, more physical effort is connected with demonstration, laboratory, and bedside observations than with reading. Students find they are increasingly placed on their own responsibility to learn, and they gain confidence in their own judgment and competence. Many speak of a new-found freedom in the very process of self-discipline in contrast to restraints and controls by others. They find standards high and get satisfaction in maintaining them through satisfying and rewarding work, in contrast to following somewhat blindly what others consider important. One student expressed surprise to find so many who want to learn.

Another thing which has impressed many of the neophytes in nursing is the wider interests found in their new associations. They are learning new facts and gaining new points of view, not only from their teachers but also from their fellow students and from the patients they are beginning to meet. They see that, in addition to nursing itself, many professions contribute to the equipment of those who expect to become professional nurses—doctors of medicine who are specialists, chemists, biologists, psychologists, sociologists, and psychiatrists. They also become aware of differences in moral and religious ideas and standards among those with whom they are now associated. They are waking up to the fact that the persons they meet are products of varied experience; and, when these are associated in one school situation, influences and relationships become complex. Many students find their own outlook broadened and feel themselves becoming rather different persons. Some speak of it as becoming more mature.

QUEST FOR BASIC UNDERSTANDING OF EXPERIENCE

This brief sketch of the new ways of life which impressed many students who had recently entered a nursing school indicates that social relationships may be observed and may be stated or recorded. It also indicates that social experience has a very definite influence on persons—even to changing their behavior and outlook on life. The brief glimpse of nursing school life suggests that observations of social relations may be carried much further. Not only are there many more phases of nursing school experience which might be observed, but there are the relations of the school to the hospital to which it is attached. Here the relationships become more extensive

and complicated. But these lead on to the hospital's relation to the community which supports it and to its relation with the families from which the patients come. A whole chain of complex relationships is suggested by a brief excursion into those which influence one immediately and obviously.

BEHAVIOR INFLUENCED BY SOCIAL EXPERIENCE

Since social experiences influence ways of acting, thinking, and believing, these become clues to understanding ourselves and others. Thus, if society is a sort of chain or web of inter-connected relationships, we need to study it. We shall probably not be able to understand the place of hospitals and other similar social agencies, nor the healing arts of medicine and nursing, nor our relations within and without our profession, nor our patients, nor ourselves, until we learn our interlinkage with others to form groups and the larger society beyond.

Before we can trace these connections and try to understand them it is necessary that we have some systematic framework for relating them. We can go on endlessly making observations such as we may have made concerning brief or long experience in the nursing school, or the influence of persons and situations upon us. But we shall not get the meaning of these things just by noting them. The difference between those who gain understanding from experience and those who do not is largely a matter of fitting things together—by recognizing that relationships do exist and things do hang together in systems. We must have what is called a frame of reference, or a conceptual scheme, if we are to unlock meaning. Our study of Sociology in the first part of this book is concerned with the mastery of concepts and systems of relationships which will help us understand the social order and controls in the "hospital world" as well as the social life from which our patients come, and how these influence our patients and ourselves. In the second part of the book many specific problems will be studied.

ALL KNOWLEDGE IS RELATIVE

All knowledge and the pursuit of knowledge must be relative to some basic systems or points of view which have been developed. It is sometimes said that "facts speak for themselves," as though the meaning of anything which may be observed is readily understood. Actually, of course, detached bits of information and chance observations may have no meaning. When we say that we understand why we have night and day, why the seasons change in regular

order, and why the tides rise and fall at regular intervals, we really mean that we have a conception of these things in relation to the form, position, and movements of the earth, as well as the relation of the earth to the sun and other bodies in the solar system. We only know or understand in the sense of recognizing relationships. There are many things we do not know or understand at all. By this we may mean that we do not even have a starting base or frame of relationships into which we may fit our observation or our awareness of something. Thus, cancer, war, and an endless number of things we experience or observe are not understood. Furthermore, failure to understand many things frequently results from utilization of a frame of reference which has no bearing on what we want to know. It will be pointed out later that many matters are "blamed" on or referred to biological heredity or politics or economics which do not fit into what is known concerning these theoretical fields. Many people erroneously insist upon "explanations" which do not throw any light on facts or rest on accumulated study.

DETERMINING FACTS OF ILLNESS

Many persons who become ill, or feel they are not as well as they would like to be, consult a physician. Each one who does this hopes and believes that Doctors of Medicine are able to discover the basic disorder or malady and prescribe a program of treatment which is most likely to bring relief and recovery. In the course of consultation the patient is likely to tell many things about himself—when he began to notice his condition, under what circumstances his difficulty developed, just what indications of trouble or disorder exist, and what history of other illness can be remembered. The physician may then make a routine examination of the patient. This will include measurements of temperature, blood pressure, and pulse rate; as well as observations of conditions of skin, eyes, ears, nasal passages, and throat. Various instruments are utilized to aid the accuracy of observations, such as the stethoscope to examine the condition and performance of heart and lungs. These early examinations may be followed by quite a number of more detailed tests and views, gained frequently through the use of more intricate and delicate instruments such as x-ray, fluoroscope, electrocardiograph, and the like.

While the patient is undergoing either relatively simple or complex examinations he has little or no idea of why he is being subjected to such varied experiences of bodily exposure, uncomfortable or painful probings, frequent questioning, and applications of instru-

ments and machines. He thinks the physician will be able to arrive at some meaning from it all. That is exactly what the physician is trying to do.

FACTS INTERPRETED BY REFERENCE TO SYSTEMS OF ANALYSIS

The physician's ability to understand the patient's difficulty rests upon the systems of reference he has learned. He comes to the examination of each patient after many years of training and experience. He rests his judgment concerning the condition of each patient upon this learning and experience he has previously had. He must think of the patient as being similar to other patients in many ways; but he must be able to interpret just what peculiar condition the patient presents in terms of what he has learned about patients in general. He must refer particular observations, tests, measurements, and other findings to systems of meaning he has learned before.

For instance, in his undergraduate days he had general and specialized courses in biology, chemistry, and other systems of theory and knowledge. When he reached medical school he continued these studies, but with greater focus on human structure and life. Thus, a student may be introduced to anatomy through detailed dissection of the cat or rabbit. But the medical student must develop a very detailed knowledge of human anatomy. Not only must this include the gross anatomy whereby the human body is seen as a whole and as a system of related parts, but each part, or organ, must be dissected still further to reveal the tissues which enter into this sub-structure. The point is that analysis is carried on until every type of cell and the place of every type is recognized as a part of a sub-system, and the place of every major part or sub-system is recognized in its relation to every other part and in relation to the whole anatomical system. The study of anatomy provides basic knowledge of the character, form, size, position, and function of every part of the whole structure. By necessity such knowledge of structure is obtained by dissection and separation of parts in a body which is dead; but this makes it possible to know all the detailed parts and interconnections which exist in a live body. A foundation is laid for studying the functions of all the parts as well as the processes of respiration, circulation of blood, digestion, and many other activities which characterize life. This again is a study of systems in action, and of the interactions of systems, which we know as physiology.

When we again think of our physician examining his patient we can understand that he is referring the conditions he finds in each of his patients to the systems he has learned. Through his previous studies he has learned what may be regarded as normal, or what is to be expected when parts are functioning in usual order. Not only has he learned something of anatomy, physiology, biochemistry, biophysics, bacteriology, parasitology, pharmacology, and other complex systems, but he has been compelled to learn the interrelations of each of these to the others. When he is confronted with the illness of his patient he must not think of him as first an anatomical specimen, then as a physiological mechanism, and as a host for bacteria. He must regard the patient as a unit whom he is to understand by referring first one and then another fact to the separate systems he knows; and he must also come to a judgment about how they may be related in such a way that symptoms appear as they do. Of course numerous cases of disease have been studied and their symptoms charted. Knowledge of diseases and the characteristic course of their action have been learned by the physician through clinical studies and bedside observations, together with checks against autopsies which have been made and recorded. The physician thus has a frame of knowledge concerning specific instances and types of disorder to supplement his understanding of what relations mean good health.

CONTINUOUS EXPANSION OF BASES FOR MEDICAL INTERPRETATION

It is important to remember that systems of knowledge to which we may now refer were not discovered at one time but were developed slowly over many years. Thus, the history of medicine, of nursing, or of any other profession reveals an ever-expanding horizon. Matters have become known and understood in one generation which were quite mysterious before. The germ theory of disease and the accumulating knowledge of bacteriology has opened up an entirely new basis of understanding. Similarly, each student is engaged in learning a more adequate frame of reference by which he may gain new insight.

MORE UNDERSTANDING OF HUMAN RELATIONS NEEDED

The professions of medicine and nursing are now seeking more understanding of human relations. Systematic views of such re-

lationships must be combined with the insights which have been named. Bernhard J. Stern states:

> The focus of medical practice has shifted from the disease to the patient. Moreover, because of the trend to supplement the curative aspects of medical care by the preventive, interest has developed in the social relations of the patient. Today the physician is increasingly associated with the forces in society which recognize the close interrelation between individual welfare and social welfare and which seek to create a social environment conducive to the development of the fullest physical and psychological potentialities of the population.[1]

The family doctor of a generation or more ago has received much favorable comment in recent years. His technical knowledge and the facilities with which he worked were quite limited by comparison with present standards. Yet he had certain advantages which are now being sought. He was so situated that he knew his patients in all of their relationships and he could see connections which are not easy for the modern specialist to see. Although the specialist commands very refined techniques and can detect many conditions of the patient by the utilization of highly sensitive tests, he is inclined to interpret what he finds in terms of his specialty. He may even tend to ignore or miss many important aspects of the case before him, including the ideas and feelings of the patient. If he wishes more complete information about a patient and his social relationships he finds it difficult to obtain. Whereas the family doctor knew entire kinship units and had assisted with the birth of many related persons, the modern physician deals with people in relatively detached, complex, and continually changing relationships. The social conditions which contribute to many forms of illness also operate to make diagnosis and understanding difficult.

The beneficial phases of specialized training and practice must be preserved; but ways must be found to overcome or counteract its disadvantages. Not only must the personal relationship between physician and patient be retained, but more accurate foundations for understanding social situations must be found. The days of the family doctor will not return, although the number of general practitioners may increase. In any event, time will be too short for the doctor to acquire his understanding of human relations by working out a system of understanding from day-to-day experience. Those engaged in the healing arts must expand their systems of reference to include a basis for understanding society

[1] Stern, Bernhard J.: *American Medical Practice.* New York, The Commonwealth Fund, 1945, p. 44.

and the significance of social relationships, especially when these concern the control of disease or promotion of health.

PUZZLING NATURE OF "HUMAN NATURE"

It would be marvelous indeed if we could "explain" or "understand" all or most of the problems we run into. Advancements in the application of scientific knowledge, especially in the arts of healing, are little short of revolutionary. A superficial view of man's accomplishments and of his many provisions for human need often leads to the popular impression that knowledge either is available or can be obtained to solve almost every kind of difficulty. Actually, man is still baffled by the complexity of the relationships in which he finds himself.

For many years teachers tried to understand some of the disturbing behavior of their students in classrooms in terms of "instincts." Even now, much "school discipline" and many "reform" and "corrective" programs are based upon an oversimplified frame of "incentives." The problem of incentives seems puzzling to many. Why some people strive for certain things and have little desire for others is an interesting question. And why many seem satisfied, as in the words of the song, "I got plenty of nothin' and nothin's plenty fo' me," may seem difficult to explain. Any reader of these lines can add a long list of experiences he has had in relation to other people and observations concerning what others do and say which are very puzzling indeed. Many may avoid any effort to explain by saying, "It takes all kinds of people to make a world," or "Now, I have seen everything." By common sense, puzzling questions are frequently disposed of by saying they are due to "human nature," without much of an idea concerning what is meant by human nature. This is just the frame of reference which is needed. Professional people, especially, are recognizing the need for some systematic knowledge concerning "human nature." A systematic view of the nature of society, human groups, human interaction, and human personality is needed if we are to intelligently study and hope to understand human relationships and experience around us.

Many doctors and nurses, who have had considerable education in the laboratory sciences and have made extensive observations "at the bedside" and in clinics, often find these to be inadequate bases for dealing with many of the problems which confront them. They may find themselves attempting to refer many observations to theoretical bases which prove inadequate or irrelevant. There

is an endless number of questions for which understanding or explanation is needed. Many patients will resist and fight against doing things recommended to them and recognized by them as being helpful. Others appear difficult to "reach" and help toward any recognition of their situation. In a study to determine the practical difficulties and problems encountered in the profession of nursing this matter of irresponsiveness and indifference to suggestions was listed as the most frequent. Problems growing out of family demoralization and disunity and the insistence upon racial subordination also showed high frequency.

THE CASE OF "UNDERSTANDING" FATIGUE

Without any further listing of miscellaneous problems for which a proper frame of reference is needed, the problem of fatigue is treated in some detail in order to illustrate the point. Everyone has experienced fatigue. It is also a common problem in the worlds of business and industry as well as in medicine and nursing. The complaint of being tired is heard among industrial workers, clerical and business workers, shoppers, soldiers, patients, and even among those who do no gainful or essential work. Professor Elton Mayo, an economist, states:

> Current business theory bases itself on a very simple assumption, which economic theory seems to justify. This assumption is that "work" is something that is "taken out of" the worker; wages are paid him as compensation for the vaguely conceived loss. Wages are paid by time, consequently the loss must be continuous; perhaps some such conception of a continuous loss is at the root of the business-economic idea of "fatigue."
>
> One might say, for example, that all physiological "work" consumes fuel reserves and that after a working day such reserves are at least in some degree depleted. The objection to this is that it does not in any sense represent the problems actually encountered in industry or in the physiological laboratory.[2]

Professor Mayo reports exhaustive studies of the question which demonstrate that "there is not a single simple form of organic fatigue, there are many fatigues."[3] With respect to one situation it has been demonstrated that both fatigue and production are primarily based on human relationships which exist in the work situation. In many instances persons turn out more work with less evidence of fatigue when they are working with others in a congenial group relationship. It has been discovered that when persons work-

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[2] Mayo, Elton: *The Human Problems of an Industrial Civilization.* New York, The Macmillan Company, 1933, p. 22.

[3] *Ibid.*, p. 168.

ing as a group feel that they are recognized as individuals who are important in the business organization and not considered mere instruments in a great impersonal machine, they accomplish more work and feel more fit even if some working conditions such as lighting and ventilation are not highly favorable.

In an experiment a special room was equipped for the assembly of telephone relays, an operation performed by women. Girls experienced in relay assembly were selected, and in groups of six were assigned work in this room. The experiment consisted of varying such factors as lighting, working hours, rest periods, and wage incentives. "The general upward trend in output independent of any particular changes in rest pauses or shorter working hours was astonishing."[4] Lighting was varied from very bright to moonlight level, but the production of relays either remained constant or went up during the various experimental periods. Perhaps the major factor accounting for the high production even under poor conditions was the prestige the girls felt they received from being members of the experimental group, and the friendly relations and high morale that developed in the group. The authors concluded that hours of work and wage incentives did not in themselves have an independent effect upon employee efficiency, but rather were only parts of a total situation the effects of which could not be predicted apart from the total situation.[5]

It seems safe to assert that many who are in positions of professional responsibility fail to "understand" the nature of much fatigue because they refer specific instances of fatigue to either physiological or economic bases. These remain, of course, frames of reference which must be utilized. However, such experiments as the one sketched above demonstrate that sociological relationships must also be examined if many instances of fatigue are to be understood.

Although this discovery is in one sense new, it is not very surprising. It checks with the experience of nearly everyone. Who has not found himself suffering extreme fatigue, even from fairly light work, in an unfriendly or objectionable social situation? And, who has not been exhilarated and found hard work borne lightly when he is associated with those whom he likes and with whom he wishes

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[4] Roethlisberger, F. J., and Dickson, W. J.: *Management and the Worker*. Cambridge, Mass., Harvard University Press, 1950, p. 86.

[5] *Ibid.*, p. 185.

to identify himself? It may seem a little farfetched to mention here, but it will be shown later that people not only are relieved of fatigue under certain group relationships; they may even recover from some illnesses simply by becoming associated with a congenial group.

NURSES IN CHANGING SOCIAL SITUATION

Nurses, like doctors, are becoming more concerned about their patients as persons who have been taken out of their social relationships by illness and must find their way back to normal living through their social ties with others. Nurses are, therefore, seeking to understand human nature and human relations in order that they may work more competently. At the same time, however, they find themselves in need of some of the same kind of consideration their patients require. They realize they could work much more effectively in a social situation of mutual respect, confidence, and responsibility. In place of the traditional authoritarian control which places the nurse in an inferior categorical position, those engaged in the profession find their production and satisfaction advanced when they are regarded as colleagues. In analyzing the factors causing the nursing shortage, Dorothy V. Wheeler expresses the belief that job dissatisfaction, and not insufficient remuneration, is the cause of the shortage of nurses. She states: "The nurses want to feel that they have a share in what the hospitals are accomplishing and are not just a small segment which takes orders. They want a part in matters of policy."[6] The human aspect of nursing is further suggested by Esther Lucile Brown. She calls attention to the significant difference in the satisfaction and attitude toward their work which nurses develop when doctors extend the courtesies usually accorded to women. Such simple matters as opening doors and assisting with physical burdens are usually performed by gentlemen for ladies when no loss of efficiency is involved. Certainly words of encouragement and recognition of worth and helpfulness injure nothing but an authoritarian order. Even in authoritarian armies these gestures occur in the interest of maximum morale. It might be inferred from the experiment on the production of telephone relays above that chivalrous gestures and words of encouragement are not enough. Persons must be incorporated in and become rec-

[6] Wheeler, Dorothy V.: "What's Really Back of the Nursing Shortage?" *New York Medicine*, Vol. II, Issue 18, p. 11, Sept. 20, 1946.

ognized as essential participants if maximum satisfaction and production are to be achieved. In this connection, Esther Brown states,

> Nothing short of a revolution in the philosophy and practice of many hospitals and their nursing schools will produce an environment sufficiently free and permissive for the nurse to have an opportunity to grow toward the gentleness, kindness, inner quietness and security, and sensitivity essential for performing the healing art. Given an altered environment, however, and the recognition of the nurse as the physician's colleague in ministering to the total needs of the patient, larger numbers of young women of greater educational and emotional maturity might be attracted to professional nursing. Conceivably these changes might also provide a challenge to men, many more of whom are seriously needed in nursing.[7]

NURSING RESPONSIBILITIES ARE CHANGING

In the second part of this book considerable attention will be given to Nursing as a profession. It will be pointed out that one of the chief characteristics of a professional person is the assumption of responsibility for expert and specialized judgment based upon extensive and tested knowledge. Professional persons not only must acquire superior skills in how to perform the services they render, but they must also have sufficient theoretical training to understand what appears to be the best procedure and why it is proper. They must develop bases for making observations and forming judgments. They must have freedom commensurate with their responsibility.

There are many highly skilled mechanics and artisans who render very reliable and dependable services. They not only know how to work with metals, woods, and other substances; they have also learned to perform exactly and efficiently the tasks which are to be accomplished. Thus, a skilled painter puts on coats of proper shades of paint, enamel, and other surface coverings to produce pleasing and desirable effects. It is not necessary for such a person to know anything about the chemical properties of the goods with which he works nor why one product is resistant to certain exposures and not to others. Many artisans, through experience, develop a "feeling" for the proper relationship of things and can make good shoes, or boats, or tempered steel without being able to tell how they are able to do these things or why they get the excellent results they produce.

In the past skilled artisans and craftsmen learned on the job as an apprentice under the direction of a master craftsman. At present

[7] Brown, Esther Lucile: *Nursing for the Future.* New York, Russell Sage Foundation, 1948, p. 91.

many skilled tradesmen and technicians get their basic training in trade schools or through in-service training provided by industry. Many persons trained in engineering schools engage in routine specialized operations of a highly technical character, but do not have any part in solving engineering problems or accept responsibility for decision or judgment in complex relationships.

Until recently, nursing service was similar to a craft or skilled trade, and much of the training and work of nurses was much like that of technicians who carry out routine operations under the direction of their superiors. Historically, the "trained nurse" received most of her instruction on the job under the strict discipline of superiors who concentrated on the mastery of technique. Even the dress and symbols of the training system emphasized subordination to authority, and the exchange of service by an apprentice for training under masters.

GOALS AND FUNCTIONS OF NURSING

In recent years, however, changes in the goals and functions of nursing have been taking place. These, in turn, call for extended horizons and basic frames of reference. Nurses can no longer depend upon traditional and routine techniques which they are ordered to apply. They must accept responsibility for courses of action which they judge to be correct upon the bases of tested theoretical knowledge. Some of the changes which have thrown increasing responsibility upon nursing includes: (1) acceptance of health maintenance as a positive goal for medical and nursing services rather than limited emphasis upon treatment and cure; (2) the broader conception of health; (3) transfer of many routine services to practical nurses, maids, and technicians; (4) transfer to nurses of many services formerly rendered by physicians; (5) teamwork and cooperative labor in health service rather than complete dominance and responsibility exercised by an individual; (6) supplementation of inadequate supply of physicians by competent nurses; and (7) increasing demand for essential investigation and reporting by the nursing profession.

These and other changes will be rather fully set out within the development of this book. Only a few of the high spots can be mentioned here. For instance, health is coming to be defined positively as a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity. Emphasis is being placed on the "normal" person, and on sickness as a deviation from the "normal."

The broad and positive conception of health changes the goals and functions of nurses. Lulu Wolf states:

> Where formerly the attention of the nurse student was focused upon mastering the bedside nursing techniques associated with the sick patient, recumbent in the hospital bed, today, her attention is focused upon learning how to rehabilitate the patient in the various environmental settings in which he is found. . . . If schools of nursing are to produce graduate nurses prepared for community nursing service, they must provide educational experiences for students which will incorporate in the nursing care of each patient, a consideration of all those influences in the community which have to do with preventing disease and promoting health.[8]

This means of course that nurses must not only understand the condition and needs of the patient themselves, but must also be able to educate the patient. Patients must be helped to understand themselves and their situations in order to "get well and stay well." As more is learned about disease and its relation to conditions which bring it about, it becomes clear that much disease can be prevented—that much suffering and loss from pain, fear, and weakness need not occur. The role of nurse calls for teaching parents, children, young people, workmen on the job, groups, and communities. But, in order to teach, one must know and understand.

EDUCATIONAL CHANGES DEMANDED

The change in the goals and functions of nurses leads directly to their need for a wider system of reference and for a greatly expanded theoretical education. One immediate educational need is that of a more adequate understanding of social change itself. Some of the most fundamental institutions and agencies in society are undergoing relatively rapid change. To fit in with these changes, professional personnel must have some educational guidance. Esther Brown[9] states that so few nurses are able to do more than give general bedside care that many hospitals, public health agencies, and other health efforts in communities are inefficiently and inadequately operated. If this is true, the much needed expansion and development of such services must wait for a sufficient number of nurses to obtain the requisite educational and professional background. The same author spells out in some detail the kind of understanding that is necessary. She mentions two major types of preparation which are needed. The first concerns the continuing growth of perspective on the part of each nurse concerning the long

[8] Wolf, Lulu K.: *Nursing*. New York, D. Appleton-Century Co., 1947, p. v.

[9] Brown, *op. cit.*, pp. 42–43.

record of human development, the emergence and change of human institutions, the cultural patterns which condition human behavior, and insight with respect to one's own motivation as well as that of others. These should move the student toward positive health and integration of personality. In addition, competence in methods of obtaining data, skill in the rational analysis of problems, habits of reflection, and the ability to communicate effectively through spoken or written language must be developed.

She states further that the more specifically technical training for professional practice must transcend that for the care of the hospitalized sick.

> It must be preparation for the broad field of community nursing service. Besides the other relatively well-defined components of the course of study, should be included understanding of the effect of nutrition, housing, employment, economic income, class and caste structure, recreational activities, and so forth, upon individual and national health; some knowledge of the principles and functions of social work and of how nurses and social workers can most effectively act as a team; experiments in analyzing the health needs of individuals, families, and communities, and in initiating action to meet these needs; and preparation in the art of teaching health to persons, whether sick or well and whether individually or in groups.[10]

Emphasis is placed, as it should be, on "the laying of a foundation that permits continuing growth . . ." Students of nursing will experience continually growing satisfaction if they learn very early in the game that they may unlock difficult problems and get insight concerning reality as they expand their basic conceptions and systems of reference. Nursing can become not only an adventure in constructive and creative service with endless value to society, but a delightful and revealing series of discoveries as well. Unless one experiences intellectual growth in connection with professional service, work becomes dull indeed.

THE CHALLENGE OF THIS BOOK

It is the purpose of this book to help students lay one of the most helpful foundations for ever-increasing understanding. Students are invited to make continual observations and utilize their past and current experience in the process of building their own system of judgment. It is the hope of the authors of this book that students will come to understand what is really meant by society, socialization, social control, and many other terms which may now seem quite abstract and technical. But it may be well to keep in mind

[10] *Ibid.*, p. 139.

the waggish definition of sociology that it is the "science of how we get that way." The fact is that "how does one get that way?" is a good question to ask about everything one observes in his own behavior, in the behavior of others, and in the "set-up" of every situation or experience one has. It might seem inappropriate to go to the table for one's meals and begin to ask such questions as why do we have three meals a day rather than one, four, or some other number? How did the content of breakfast get to be so nearly standardized in some places? How did each of the utensils used in eating come to be used for just the things they are? And so on for meals. One might also find it instructive to take a wedding ceremony apart and try to discover how each detail came into existence and what it was for. One who develops curiosity about the ways people do things and why they do them is on the way to important understanding. This is especially true when one comes to recognize that such nonmaterial things as the words people use, their manner of speaking, and their thoughts and beliefs can be "explained" in much the same way that behavior at the dinner table or a wedding can be understood. Let the student begin to ask why, what, and how concerning social experience, and a beginning will be made toward the systematic knowledge and theoretical foundations which this book will emphasize.

Students may profitably review in detail their membership in groups, cliques, and associations just previous to their entering professional school. They may recall what they were interested in and what they valued most, as well as what they were engaged in doing from day to day. This relatively simple, free life should be compared with the present life in groups, cliques, and associations in the professional school. The sudden change which most students experience in what they are expected and required to do when they enter professional school is sometimes rather shocking. It is almost like entering a new world. Contrasting the two worlds of recent experience is an excellent introduction to the fact that differences in experience among people is truly comparable to living in different worlds. The understanding of human nature is largely a matter of learning to put one's self over into the other fellow's world and trying to see and think as he does. It is somewhat like taking a difficult part in a play in which one must get ready to act as the character he represents would do. Students should begin immediately to think of their patients as persons, and try to discover the important experiences each has had previous to the current illness which brings him to the need for the healing arts.

If students will do these things their understanding will increase through study of the succeeding chapters of this book.

FOR INVESTIGATION AND DISCUSSION

1. Compare your own and your classmates' experience with the report given in this chapter of others who have recently entered nursing school.

2. Ask a number of people what idea or ideas they have concerning human nature. State any agreement you may find, as well as points of disagreement. What seems to be the significance of your brief inquiry, if any?

3. Cite instances of actions, beliefs, attitudes, ethical judgments, or conceptions of one's self, one's work, or one's social standing which have been changed by entering a new situation or having new experiences.

4. List as many of the required or most frequently expected practices connected with a wedding, and try to account for origin, purpose, or meaning of each as suggested above.

5. Make some observations with respect to manners of speaking, dominant beliefs, preferred foods, marriage ideals, life goals, or some other ways of acting or thinking on the part of eight or ten persons you have recently met. Judge whether you have any systematic basis for explaining them.

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Chapter 2

ANALYZING THE BASIC STRUCTURE OF SOCIETY

COMPARISON WITH DISSECTION AND STUDY OF HUMAN ANATOMY

It was suggested in Chapter 1 that doctors and nurses find it valuable to study anatomy as one of the foundations for their understanding. Thus, they engage in more or less detailed dissection and description of parts of the human body in order to learn the characteristics, position, and function of parts in relation to each other and to the whole. While such study is being carried forward the emphasis is on structure, but it is taken for granted all along that this becomes a means for understanding the living and acting organism.

In a similar fashion an understanding of society and social relations may be greatly aided through a study of social structures. It is quite helpful to think of society as a system of ways of acting, thinking, and believing, which is made up of many sub-systems which can be dissected into numerous detailed parts. We may analyze and view the anatomy of society. Such understanding would be so extensive that only specialists could spend the years required for increasing such knowledge. But, just as one must have some rudimentary knowledge of human anatomy if he is to know much about human life, so it is desirable to know something of social anatomy or structure if one is to gain insight into the functions and relationships which characterize social life.

COMMUNICATION, "CORRECT" FORMS

Such dissection of society can begin with simple matters and lead into the complex systems, and these lead into the whole; or, the other way around, it can begin with the whole and break it down into the simple components. One of the many things nearly everyone learns is the ABC's. Parents buy all sorts of devices by which their children may learn the twenty-six letters of the alphabet. The

letters are printed in large and small sizes, on paper, on blocks of all kinds, and associated as initials of familiar objects such as *Apple*, *Box*, and *Cat* by means of attractive pictures. In fact, much energy and ingenuity are expended on efforts to get children to learn the alphabet, and similar concern is given to learning the numbers from one to ten. After these are learned there is almost endless process of learning to put the letters together to form correctly spelled words. There are readers of these lines who still have difficulty with the correct spelling of many common words, and if spelling gives trouble how much more is found in mastering correct usage of words! Words fall into classes as parts of speech and thus have special functions to perform in sentences. Sentences, too, must be related to each other in proper manner if they are to convey the thought which speakers or writers hope to express. And the paragraphs which are built of sentences must "hang together" in such a way that lectures, speeches, papers, chapters, and other units of speaking or writing convey the meaning which is intended.

This brief citation of learning the alphabet, spelling, grammar, and rhetoric which forms the foundation of communication may serve to illustrate what is meant by social structure and the dissection of such structure into minute parts. It is evident that each letter of the alphabet is an invention of man to stand for, or symbolize, a sound made by the vocal cords of the human throat. The whole alphabet stands for twenty-six sounds as well as some modifications of these. Thus, a system of symbols stand for the basic sounds which are utilized in speech. And these may enter into almost endless combinations of spelling to symbolize the combinations of sounds which make up words. Words, as we know, have been added through centuries of time and are constantly growing in number to stand for the experiences which man has and for which he has invented these systems of symbols. In the course of his invention of words, man has used some as names or symbols of objects, whereas he has used others as symbols for acts, qualities, and so on.

It is certainly not the purpose of this chapter to go into further details about the structure of language. But it is hoped that the illustrations will show that such a complex system as that of language may be broken down into sub-systems and each of these into parts as detailed as the separate letters of the alphabet and the separate sounds for which each of these stands. Furthermore it should be evident that these systems which enter into language furnish the *normal* or "correct" usage. There is a correct order or series for the

letters of the alphabet and there are lower case and capital letters. There are normal orders of letters to form the spelling of words. Thus, by dissection or analysis we learn not only the relation of parts but what is normal or expected.

Social structure may be studied as systems apart from actual social living, just as language structures exist and continue whether all persons in society share in their use or not. The fact is that many persons will speak and write incorrectly more frequently than otherwise; but this can be recognized only in relation to the normal system, or system of norms. Hillbilly speech is normal for hillbilly life, and may serve to express about all that people have on their minds. But, by reference to standard usage, it is not considered normal or correct. By the analogy with anatomy, it would be comparable to the presence of defective or abnormal parts.

ALL PARTS HAVE FUNCTIONS

Coupled with this brief suggestion of the structural nature of language some mention should be made concerning the functional nature of each part of the language system as well as the function of language itself. It has been noted that every mark or printed symbol which we call a letter of the alphabet represents a sound or sounds, and that by combining the letters a combination of sounds is represented. These combinations are called words; but words are products of group experience and come into being or usage when a group of people hit upon them or agree upon them as symbols of meaning—i.e., symbols of the significance of experience. Thus the word n-u-r-s-e is a definite sequence of letters of the alphabet which represents a combination of sounds and at the same time a combination which may refer to a certain person, a kind of care which is given by able persons for those who need it, a professional service, and so on. The word is, then, a symbol invented and utilized by persons to communicate the meanings of experience which have developed through care of those who are weak by reason of illness or otherwise. Thus, a word gathers meaning and may even change in meaning as group experience continues from generation to generation, but every word serves the purpose of communication or interchange of meaning in group life. It would not be straining the comparison too much perhaps to say that language is the life blood of society, with words being similar to blood cells, and that communication is as necessary to the life of society as the circulation of blood is to the life of the organism. Students are aware from their own experience that language is a complex system or structure in

itself; and since it is basic to all communication it is interrelated or tied in with all other structures which give form and organization to society.

CULTURE, THE TOTAL WAY OF LIFE

Since attention cannot be given to detailed dissection of all systems which enter into the complex whole of society it is important at this point to get a total view, somewhat akin to that of gross anatomy. This view of the "total way of life" has sometimes been referred to as the "universal culture pattern."[1] It has been found that the culture, or the inherited structures of societies, has the same general form in all parts of the world at all times of history. Since some of its details have been suggested already, language is mentioned before other major systems in Table 1.

Table 1.

1. Language system may include both
   - (a) oral forms
   - (b) written forms
2. Ways of defining and utilizing materials as
   - (a) food
   - (b) clothing
   - (c) shelter
   - (d) technology (tools and machines)
     - (1) fabrication
     - (2) transportation
     - (3) communication
3. Ways of conceiving, organizing, regulating, and otherwise operating system of
   - (a) family/marriage/kinship/inheritance/control
   - (b) religion/magic/science
   - (c) education/formal/informal
   - (d) property/land/capital goods/stocks/finance/commerce
   - (e) government/political forms/judicial procedures/"machines"
   - (f) recreation/arts/games/amusements
   - (g) war

It is well to keep in mind the outline of the major systems which enter into the total way of life or culture of a people, as shown in Table 1. It will be found useful later as a schematic approach to the analysis of the way people live in a single community or area. It may prove useful in becoming acquainted with the life of people who may be isolated or set apart by physical barriers such as moun-

[1] Wissler, Clark: *Man and Culture.* New York, Thomas Y. Crowell Co., 1923, pp. 73–97.

tains, streams, swamps, and the like; or set apart in cities in concentrations of such ethnic groups as Mexican, Polish, Italian, Chinese, and others. However, it represents nothing more than the gross structure and must be further analyzed if social forms are to be more fully understood. As a sort of exploratory exercise any student may utilize the outline as a basis for describing in as much detail as possible the ways of life of some people he thinks he knows most about, such as French, French Canadians, Mexicans, the foreign quarter of a city, or even one's own community.

TOOLS FOR DETAILED STUDY OF CULTURE

Trait, Complex, Pattern, and System. To get an accurate idea of structure and organization of a society it is desirable to have some tools or ideas with which to analyze the forms of action which may be observed. For instance it is a common observation that friends take flowers to persons who are ill. But it is equally commonplace to take flowers to friends in other situations, such as to a lover, to one who is graduating from school, to a business concern celebrating its anniversary or some new development. This indicates that the taking of flowers may be utilized to express many different things. A separate item or detail of this sort is thought of technically as a *culture trait.* When taken alone it might form a part of any number of combinations of behavior. Taking flowers to the sick is frequently combined with a friendly visit and may be followed later on, as the patient improves in health, by the presentation of delicate food, some book or other reading material, or the loan of a small radio set. Thus the flowers, food, reading material, and other symbols of concern and interest in the welfare of the patient are all related to each other. They may be combined still further with simple nursing services such as sitting in the room with the patient and arranging pillows, giving sips of water, and so on. These related acts are all appropriate to relationships among groups of friends and relatives when one of their number is ill. Technically, these *related acts* or *traits* are referred to as a *complex.* But close relatives and friends express their concern and cooperation with each other not only in times of physical illness. They care for each other at all times, and they do not expect payment for their services to each other. They lend their help and mutual support in good times and bad, and frequently combine festive acts with work. Thus, the complex of acts which occurs at the time of illness is combined with similar complexes of helpful acts at times of other emergencies of extra work, loss by fire, financial loss or need, and grief, as well as at special

times of festivity and rejoicing. The whole related structure of *mutual aid* is technically referred to as a *pattern.* Our pioneer ancestors helped each other with clearing forests and lands, planting, harvesting, building, as well as in nursing the sick, carrying on the work of those stricken by grief, and cooperating with those who undertook unusual enterprises. In all these relations there was no accounting or demand for even return, or payment. It was assumed that the mutual aid was like a reservoir into which all would contribute according to ability and receive according to need. It is difficult, perhaps, for some readers to believe that closely knit groups of people can learn to live with little thought of personal reward except the mutual help, respect, and affection of others. Many families and kin groups behave thus even today. When such structure occurs it is referred to as the *pattern* of mutual aid.

The reader may now go back to see the traits, complexes, and patterns which were set out in the previous discussion of language; and it will be easy to recognize that patterns combine to form *systems.* Thus language and communication patterns form systems and these combine to form the larger system of communication. The major systems of society will be referred to later in this chapter as *institutions.*

Social Norms: Folkways, Mores, Laws. There are still other concepts which help us to observe and understand the culture, or "total way of life" of any particular society. When the day-to-day acts of countless numbers of people are observed the uniformities among them are so common and expected that attention is provoked only by variations and violations. From the time of getting up in the morning to the time of going to bed at night the days are filled with acts on the part of most people which are thought of as expected, or routine, or customary, or normal. These may be referred to as *social norms.* It is only when persons act quite differently from the expected or normal that gossip and news begin to "flash."

Nevertheless, if clearer understanding of the structure of society and the nature of human behavior is to be gained there must be close observation not only of the detailed ways of people, but also of the attitudes and ideas which go along with the ways. It is not difficult to discover that the habitual acts which characterize the daily behavior of people differ in definiteness of expectation and, also, in the strictness with which conformity is required. Furthermore, there are decided differences in the penalties for not conforming to the norms of behavior.

To illustrate, everyone is expected to wear clothes when appearing in the presence of others. At nearly every level of society persons prefer to wear clothes which are regarded as appropriate for particular situations and, also, those which are in line with current fashion. Many persons sacrifice other personal wants and needs in order to dress as nearly as "fashion seems to dictate" as they can. If they can't meet standards of quality they frequently try to be satisfied with cheap imitations of what they regard as "stylish." In spite of all these prescriptions about clothing nearly all varieties and conditions of clothing are worn, from the patched, ragged, ill fitting, and outmoded which cover the bodies of the poor, to the opposite extremes of those designated as the "best dressed." Upon closer analysis it becomes evident that clothing appropriate to particular occasions and "in style" is preferred by nearly everyone, and persons who can afford it feel they must live up to the expectations of others so far as clothing is concerned. An enormous amount of talk and communication among people concerns matters of clothing. And those who do not conform to the expectations of others will be talked about unfavorably and are likely to be laughed at and ridiculed for their nonconformity. Much gossip about others is concerned with the way people dress and care for their appearance. Mirrors are consulted many times a day for fear of the unfavorable comments which may be made not only by associates but by people generally.

This illustrates the classification of ways, technically known as *folkways*. They are the ways which are expected and preferred by nearly all members of a given society, and which are enforced by means of gossip and ridicule communicated directly or indirectly to those who fail to conform. At the same time it must be recognized that folkways are not sharply defined, and a wide variation in performance is permissible. Many people who dress neatly may habitually appear in clothing which shows wear and is somewhat out-of-date without exciting much gossip or disapproval by their associates or others who see them. Furthermore styles and fashions in dress are themselves not strictly defined, and a degree of variation in each type of garment is desirable to attract favorable attention. The point is that *folkways* are quite elastic so far as definition and enforcement are concerned; but despite these rather vague characteristics they are sufficiently powerful to set bounds for uniformities in thousands of ways of responding to situations. Students may explore the meaning of folkways by listing numbers of situations and stating the ways of responding they regard as normal, i.e., expect to occur.

They may also recall how they were taught etiquette and proper ways of doing everything from eating to courting.

To appear in public without any clothing is forbidden, and, under certain circumstances, to appear without what is regarded as sufficient or proper clothing is considered indecent and immoral. Here are prescriptions concerning clothing which are more definite than the *folkways*. It is not a matter of preferring certain ways of behavior and expecting a reasonable degree of conformity. Neither is it merely a matter of gossip and ridicule which is feared in case of not doing what is expected. People are taught from their youth that certain ways are essential to the general welfare and that these ways are particularly and specifically appropriate. Such ways are frequently regarded as sacred, and their violation is accompanied by feelings of guilt and shame. When violations occur persons are severely punished by such means as reprimand, infliction of physical or mental pain, or by disgrace, and persons may even be ostracized or excluded from further association with those who have expected and demanded conformity. Readers may recall instances of careless or thoughtless behavior of their own in childhood which was regarded as serious and shameful by their elders. They may have had long conferences with parents or teachers to impress upon them fully an understanding of how significant their acts were. In addition, they may have experienced severe punishment. Such ways, which have been specifically forbidden or required, and for violation of which some severe punishment is applied by one's associates, are technically referred to as the *mores*. (The singular of this word is *mos*.) The Ten Commandments form a basic moral code which is recognized by many societies in addition to the one which put it into the scriptures. These and all the other prescriptions which command or imply "Thou shalt" or "Thou shalt not," and for which one's own groups will severely punish nonconformity, are the *mores*. Forbidden ways or negative mores are referred to as *taboos*.

It is important to recognize that all prescriptions of ways of doing things are not as informal as the folkways and mores. There are *laws*, which are specific statements of requirements and prohibitions, together with provision of specific punishments for violations. Special persons, as police, are charged with detection and arrest for violation. Courts with proper officials are responsible for judging guilt and fixing the form and amount of punishment. Still other special agents and personnel must administer the punishment.

If an illustration from requirements concerning clothing is chosen, it is known to be a violation of law for a man to habitually falsify

his identity and conduct as a man by wearing women's clothing. It is similarly unlawful for a woman to represent herself as a man by the persistent wearing of clothing appropriate to men. The enforcement of these laws relative to clothing is handled by police, courts, and penal agencies rather than by citizens directly, as is the case when *folkways* and *mores* are concerned.

Before a discussion of these tools for analyzing social structure and organization is completed one point must be emphasized. A social structure consists not only of the ways or acts which may be observed, but also of the *attitude* toward the act and the *value* which it has been given through group experience. The *folkways*, *mores*, and *laws* are all concerned with expected ways of behaving which have become established. But the distinction of each class of action lies in the interpretation and attitude of the one who acts coupled with the consequent interpretation and reaction of others with respect to what is done. The unseen phase of social structure must be recognized, as well as ways of acting.

Social Institutions. Nursing services are vitally concerned with the ways persons are influenced by the relationships which exist even before birth and throughout life. For this reason nurses are particularly interested in the family, in education, in recreation, in religion, and in other major systems which make up the culture, or total way of life. Specific chapters in this book will be devoted to some of these. At this point it is desirable to review briefly their structural character and to recognize them technically as *social institutions*.

If the many folkways, mores, and laws connected with the day of the week called Sunday are reviewed and these are combined with a similar analysis of the ways which characterize behavior previous to, during, and after the religious observance of such events as Easter and Christmas, we can begin to grasp the vast network of religious activity. In connection with this activity is found a very extensive supporting equipment in the form of buildings and furnishings which facilitate all the expression of religious purpose. The physical structures associated with religious activity and the activities which may be seen and analyzed have no meaning apart from the system of subjective beliefs and desires. These are as definitely structured or established as the forms which may be seen. Furthermore, the whole complex structure rests upon a central purpose and central idea. Members of religious groups not only participate in religious activities and maintain the details or religious organ-

ization but they view the whole set of relationships as necessary to salvation or to the realization of the major purpose of life itself. Religion rests upon man's recognition of his weak and finite position in the universe and his desire to find meaning for himself and mankind in relation to the whole. He invents or hits upon various formulations of his ideas about it and evolves systems of acts to express his desires, feelings, and beliefs. Any institution or system is built from simple to more complex forms through additions by succeeding generations of participants.

If this brief treatment of religion has helped the student to get some understanding of the nature of a social institution he might go on with a similar view of some other institution. If the family or education or government is perceived as an institution a basic purpose and idea will be found at the center of each; and the vast organization of material structures and the patterns of expected ways of thinking and acting will merely spell out the underlying purpose of the system. This means that although the family institution in various societies may differ greatly in detailed practices, the essential purposes and the idea for the existence of family organization are quite similar whether the family is found in America or in "far away places." The family system anywhere would include parents and children as well as the kinship group—grandparents, grandchildren, aunts, uncles, cousins, and so on. The folkways, mores and laws which define what is expected of each of these in relation to each and all of the others are quite complex. But the reader may recognize that his own behavior, since his earliest remembrance, has been acting out his parts in the family organization.

DEFECTS AND DISORDERS MAY DEVELOP IN CHANGING SOCIAL INSTITUTIONS

Persons engaged in the nursing profession are interested in health and disease. They recognize these as relative matters. Health is regarded as an optimum functional and structural relationship, whereas disease is some degree of disorder in the normal relationship. In any case, disease represents a change in the organism which prevents or upsets normal functions. It may result from defective or inadequate structural conditions, or it may be due to the introduction of organisms or substances from the outside.

In similar fashion the structure and organization of society may be upset to varying degree or extent. Under some conditions changes occur in some parts of the culture which sufficiently disturb normal

social relations as to produce unsatisfactory and inadequate functioning. Thus many social problems become the symptoms of a disturbed and badly functioning social order.

A more complete analysis of social change in relation to the normal organization and functioning of society will be made in Chapter 5.

SUMMARY VIEW OF SOCIAL STRUCTURE

It has been the purpose of this chapter to help the student recognize the general form of society, including both the detailed and the more complex parts which compose the total way of life. Emphasis has been placed on viewing social forms entirely apart from living persons or groups who have their lives defined and ordered by the forms. An attempt has been made to see the drama as it is written out by the playwright with all the props, stage settings, words, and directions for action; but without the presence of actors and action. The drama, thus set out, gives the structure and form of action as it is expected to take place. It may be performed year after year from early times to the present, and always with some variation in action and interpretation. In fact, new details and directions are likely to be added to the earlier version from time to time; but the general form as well as the old and new details may be recognized, analyzed, and even more thoroughly understood without players and action.

At this point, nurses might begin to analyze nursing itself as a social structure. They might try to formulate the basic idea and basic need on which all nursing is built; and they might try to see the whole of nursing as a system of relationships which has developed over a long period of time. In order to spell out these relationships in detail they might see what uniformities or norms in nursing service fall under the classification of *folkways*, *mores*, and *laws*. The dissection might be approached, also, through the recognition of *traits*, *complexes*, and *patterns* which form the system or *institution* of nursing.

HOW CULTURE AND SOCIETY ARE RELATED

If, as suggested above, we can simplify our view of culture by comparing it to a vast drama with all stage settings and props described and all the words and acts of characters written out, we might think of society as the actors and corps of workmen who actually "put on the show." They behave in the expected ways which are set out for them, but never exactly the same. As the

"show" is repeated time after time changes are made in the play itself. "Good" actors and "bad" actors, as well as technicians and critics, influence the way things are done. We must now go on to the study of persons and groups which compose society, and of how they act according to cultural expectations.

FOR INVESTIGATION AND DISCUSSION

1. Analyze the marriage practices you have observed in terms of folkways, mores, and laws.

2. What are some traits, complexes, and patterns peculiar to the structure of nursing?

3. Describe situations in which certain types of conversation are taboo. State any taboos which seem to contribute to healthful living and others which appear to be injurious.

4. Pick up the suggestion on page 23, and try the outline of the Universal Culture Pattern as a scheme for describing your home community, the region from which you come, or the life of some ethnic group you think you know pretty well. Do you find your observation and memory of the matters covered in the outline rather complete or very scant? How long a paper could you write to develop the outline about the ways people live and their dominant beliefs and thoughts? What do you conclude from your consideration of these matters?

5. To be a "good actor" what must be learned besides one's "lines" and the "stage directions" which are to be followed?

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Chapter 3

SOCIAL LIFE OCCURS IN GROUPS

Many students who leave their homes to attend college at some distant place find many others, like themselves, who are strangers and unattached to any group. For a time they may feel a touch of homesickness, or a longing for the friends and groups which anchor their lives. They feel quite uncertain about what to do or expect, and about what, if anything, is expected of them. During this period of "feeling outside" and trying to define the new situation certain persons are likely to be "thrown together" or "drift toward one another" in the process of chance communication. From one or more initial contacts small congenial groups are likely to emerge. Among first-year students in nursing schools such small groups may be originally based on matters of chance, such as being assigned rooms on the same floor; having the same class schedules; being interested in religion and going to church together; studying together; having similar tastes for dancing, playing cards, going to movies, and the like; having former acquaintances or friends in common; and so on, almost indefinitely.

Some persons may find their way into any newly formed group very slowly, and may not become very deeply involved even when they are accepted by others. A few, indeed, are likely to participate in the general and formal affairs of the whole class but practically "go it alone" so far as getting into any small informal group is concerned. We must pay attention to those who are relatively isolated later on.

INFORMAL GROUP FORMATION

It is interesting to watch the groups which spring into being. Some will hold together a very short time, while others will continue for longer periods—even to become relatively permanent. This may serve to remind us that the most permanent groups we know anything about had a fairly simple beginning some time in the past.

However, the opportunity to observe the formation of new groups helps us to observe the process by which the essential characteristics of human groups come about.

In the first place, it is evident that people join together in groups in order to achieve some purpose or goal which seems desirable to all concerned. One of the simplest objectives or goals for which a group may exist is the provision of companionship or fellowship. Thus, the students who happen to be assigned rooms on the same floor meet each other frequently and may find in their very association, and the necessity for using facilities jointly, a basis for identifying themselves with each other. As time passes they may develop understanding among themselves concerning such matters as quiet periods for study, recreation periods for stunts and singing, having parties or picnics, and other things which seem to be needed or worth while. When these objectives or goals are hit upon it may be observed that some person is taking the lead in proposing what shall be done; and others are taking an orderly part in the consideration of what to do, as well as carrying out what has been decided.

In the process of the formation of a group to achieve certain goals and purposes, the relations of leading and helping develop among the members. Each person comes to have a standing or position with reference to others, as well as a particular role or job to do. It is evident that, if goals are to be achieved, certain ways of doing things must be set in motion. These become understood and expected by each member of the group. They are the norms and standards which can be depended upon to give the group relations stability. The working together of all members of the group in accordance with the norms which have been developed to achieve the ends which are desired means that the group is organized or has organization. The group may smooth out or perfect its organization so much that all members develop confidence and pride in their joint operation. Such confidence and pride may be compounded through further experience with group sentiment and loyalty to produce a maximum feeling of solidarity, determination, and organization called *morale*. Morale, of course, may become low as well as high.

CHIEF CHARACTERISTICS OF HUMAN GROUPS

Certain characteristics may be observed in the development of human groups. (1) The *original purpose* calls for acting together. The group may be temporary if this purpose is quickly achieved.

However, if some time is required for the attainment of the original goal, if this goal is altered, or if *sub-goals* and additional *goals* develop, the group becomes relatively permanent. (2) If this occurs, *leadership* becomes evident. (3) This means that the *status* and *role* of every member becomes clearer. (4) The ways of doing all that is done, when repeated, accepted, and approved, come to be expected and standardized. These are the *norms* which have been developed as the means for reaching goals of the group. (5) As the members of the group carry out their roles or functions in the manner which has become prescribed, and move toward the achievement of goals, the group proves to have *organization.* (6) When group members through their experience together develop a marked feeling of unity, understanding, and confidence so that they can withstand difficulties together, it may be said that *morale*, or spirit, has emerged.

Not all groups come to have all of these characteristics, but certain groups develop all of them and more. (7) It is not surprising that after continuing over a long period of time a group develops a rich body of experience, which is treasured so much that it is taught or passed on to new members through generations. This body of experience or *tradition* becomes a powerful influence. (8) It shapes the *attitudes and values* of persons who are added and incorporated as members. (9) Some groups find it desirable to express their major purposes and their attitudes and goals in rather specific terms in the form of a written *code.* But it is not necessary for a group to write out or express its code in specific terms. Group members are frequently guided, even unconsciously, by the objectives and standards which have become "natural" or "second nature" to them. (10) At some point in their experience groups are likely to select and adopt a physical sign or *symbol* to represent their collective being. Particular gestures—special handshakes, words, flags, coats of arms, and so on—have meaning for members of particular groups. They provide a means of quick recognition so that common understanding and values may be assumed, and communication can take the normal course peculiar to the group involved. (11) Although communication has not been mentioned as a characteristic of groups, it has been implied throughout everything which has been said. When the form and much content of communication itself becomes peculiar to a specific group, it is referred to as a *universe of discourse.* Nurses and doctors not only carry on extended communication in technical terms peculiar to their way of life, but they use many

abbreviations and initials in place of words, and some nontechnical terms develop standard usage in these professions. (12) In summarizing group characteristics it is important to list the *recruiting and induction of new members*. Some fraternities and sororities seem to be engaged in little other than keeping the group in existence. But all permanent groups must develop patterns for attracting, selecting, initiating, and assimilating "new blood." (13) It is quite important to observe that members have *group consciousness*, whereby each distinctly identifies himself with the goals, organization, and total relationship with the others.

AGGREGATIONS AND CLASSIFICATIONS ARE NOT GROUPS

It should be clearly understood that not all combinations and collections of people constitute human groups. It is obvious that not all have the characteristics which have been listed. Nevertheless, many errors may develop from referring to those placed in the same occupation, race, sex, and so on, as if they composed a group. Farmers, laborers, soldiers, and many other census classifications are referred to as if each had the same goals and were clearly organized to achieve them. This may be true of some farmers, laborers, and soldiers, but classification of vast numbers in one category does not automatically indicate group relations. Furthermore, biological classifications by sex, race, and age may be falsely used as if groups existed. Thus, statements are sometimes made about what women "demand," how adolescents would be likely to vote, what the aged think, and so on. One of the most frequent errors of this sort is to treat people of a particular race as if all were race conscious and had set up goals and norms peculiar to themselves. Some attention will be given to crowds and masses later on, but it should be made clear at this point that aggregations of people on streets, in parks, on campus, or elsewhere do not necessarily form groups, and they should not be referred to as such unless they develop some of the characteristics which have been summarized.

CLASSIFICATION OF SOCIAL GROUPS

It has already been indicated that some groups exist for a very short time while others are relatively permanent. It has also been pointed out that groups are formed with respect to an almost un-

limited number and variety of purposes. It would not require much effort on the part of any reader of this book to recognize literally hundreds of groups. One can think of recreational, religious, political, civic, professional, educational, business, and many other varieties of human groupings. It is clear indeed that groups may be classified in numerous ways. Any classification is justified which promotes analysis and clear understanding. Furthermore, the same group might fall under a number of classifications. A Boy Scout troop, for instance, might be viewed for certain purposes under such classifications as adolescent groups, boy groups, "character-building" groups, primary groups, and so on. Besides numerous classifications which may be made for particular purposes, some general classifications seem basic to a clear understanding of human society and human behavior.

PRIMARY GROUPS

We are indebted to Charles Horton Cooley for the basic idea and description of *primary groups*.[1] He pointed out their occurrence in all human societies everywhere, and referred to them as the nurseries of human nature. Family groups, play groups, and neighborhood groups are primary, and they are found everywhere throughout the world. They are primary in a number of ways. They come first in experience, and it is no exaggeration to say that they come first in influence. It will be shown later that the basis for one's very self and for the conscience one develops is laid in primary group experience. The significance of primary group experience was caught by Walt Whitman in "There Was a Child Went Forth."[2] Only a few lines can be quoted here:

> There was a child went forth every day,
> And the first object he look'd upon, that object he became,
> And that object became part of him for the day or a certain part of the day,
> Or for many years or stretching cycles of years.
>
> . . . . . .
>
> His own parents, he that had father'd him and she that had conceiv'd him in her womb and birth'd him,
> They give this child more of themselves than that,
> They gave him afterward every day, they became part of him.

[1] Cooley, Charles H.: *Social Organization*. New York, Charles Scribner's Sons, 1925, pp. 23–57.

[2] Whitman, Walt: *Leaves of Grass*.

The mother at home quietly placing the dishes on the supper-table,
The mother with mild words, clean her cap and gown, a wholesome odor falling off her person and clothes as she walks by,
The father, strong, self-sufficient, manly, mean, anger'd, unjust,
The blow, the quick loud word, the tight bargain, the crafty lure,
The family usages, the language, the company, the furniture, the yearning and swelling heart,
Affection that will not be gainsay'd, the sense of what is real, the thought if after all it should prove unreal,
The doubts of day-time and the doubts of night-time, the curious whether and how,
Whether that which appears so is so, or is it all flashes and specks?

. . . . . .

These became part of that child who went forth every day, and who now goes, and will always go forth every day.

The meaning of this refrain, "they became a part of him," will become increasingly clear as the meaning of primary groups and the meaning of socialization are explored. There is a reciprocal relationship whereby persons have a part in groups, while these groups are becoming a part of the persons who compose them. If this seems vague or mysterious it must be made clear. We must come to understand that human nature is acquired nature, or group nature. We are what our groups make us, and we join with others to make our groups what they are.

Since practically everyone has spent much time in *primary groups*, a statement of their essential characteristics may be confirmed by experience. One student who heard them described expressed doubt about their existence. His case is so interesting that we shall return to it after defining and describing primary groups.

Relationships in primary groups are (1) quite *personal* and *intimate*, as well as (2) *numerous* and *various*. These characteristics are well illustrated in the family wherein the members are so close to each other physically and emotionally that there is a minimum of formality and a maximum of intimacy and feeling. The interests and goals of the family are so numerous and various that members of the family are interdependent and held together by many ties. (3) Communication in primary groups is so *direct* and *based on such mutual insight* that members can often perceive the inner thought and feelings of each other by means of gestures, body postures, and inflection of voice without the use of words or formal language. The relations were described by Cooley as face-to-face; but it must be clearly understood that primary groups are not necessarily dissolved when members are separated in space and must communicate by

mail or other indirect means. Family and neighborhood ties may even be magnified in meaning and value by occasional or prolonged separation of members. However, the general effect of separation, especially if association with others is prolonged, is to weaken primary group ties and influences. (4) *Mutual aid* and *sympathetic care* occur frequently in primary groups. For a number of years the needs of children are provided by members of their families. Parents, older children, and sometimes other relatives may continue to sacrifice their own immediate interests in order to extend educational opportunities to youthful family members. In turn, children may assist their parents in many ways when the handicaps and infirmities of age come on. Mutual aid is characteristic of neighborhood life as well as of family life. Neighbors carry on such activities as borrowing and lending when many types of emergency needs arise, help each other in times of stress, and express *sympathetic understanding* when bereavement and various forms of loss occur. (5) The process of *socialization* is not confined to primary groups, but it is so certain and effective in them that it stands out as a major characteristic. Much more will be said about it in connection with chapters on personality development and the family. It must be noted here that persons learn how to walk and how to talk, what is right and what is wrong, what is good and what is bad, what to do and what not to do, what to strive for and what not to strive for, and who one is and who one is not, in primary groups. It is in these groups that the basic norms and expectations for social life are learned. There is a minimum of formal or conscious teaching, and most of the learning is done without conscious effort. The process is so informal and subtle that it is next to impossible to trace when, how, and why particular matters are learned. It will be noted later that many things which are learned in primary groups are erroneous or harmful and would have been avoided or corrected if there had been any awareness of them at the time they were learned. (6) It may not be amiss to doubly emphasize one part of what has been said about socialization—the part dealing with inculcation of standards and what are sometimes called primary virtues. All primary groups tend to reinforce each other with regard to *instilling and enforcing the mores*. The approval and disapproval shown by neighbors and play groups are effective instruments in teaching children conformity to right ways of behaving and the abstention from wrong ways. Objection is sometimes expressed concerning the strictness and narrowness of much socialization which goes on in many primary

group relationships. The purpose here is not to evaluate the process, but to emphasize its effectiveness in making persons what they are and making them behave the way they do.

PRIMARY GROUP EXPERIENCE MAY BE LIMITED OR ABSENT

A student who heard a lecture on the general occurrence, characteristics, and functions of primary groups expressed doubt about their actual existence. His own experience certainly did not include much intimate personal concern for him. He had received excellent care, but it had been formal and impersonal, and with little evidence of sympathy or affection. He had been born in a modern hospital under excellent conditions. Upon leaving the hospital he was looked after by successive nurses whose competence insured the best physical care and normal physical development. Tutors were provided early in his life to foster his intellectual and moral growth. As soon as he was old enough to attend a boarding school for boys he was placed in one of the best available. He was then graduated to first rate preparatory schools. He had attended two different colleges by the time he reached his junior year. All through his life he had gone home for brief holiday vacations, but he had spent his long summer vacations in good camps which had excellent counselors. In his earliest experience and during his short visits to his home he had seen and talked frequently with his parents. Although they were busy people and had many appointments, they showed interest in their son and watched his development and the reports on his progress with concern. But little intimacy or participation in joint activities was possible. It is small wonder that he doubted the existence of small intimate groups in which members care a great deal about and for each other. Neither is it hard to understand that he exhibited little concern for others and little enthusiasm for his work or for the future. He had been going to formal schools most of his life, but he had formed little attachment for any of them or for anyone connected with them. He did acceptable academic work, but it seemed to be an end in itself so far as he was concerned.

Children who spend a number of years in formal orphanages have limited primary group experience. Their days are spent largely in accordance with formal schedules. Even their play may be directed and supervised, so that informal play groupings of children are not encouraged. The intellectual, physical, moral, and emotional development of such children is likely to be consciously

planned for and formal efforts made to bring them up according to plans. In some orphanages children are patronized by visitors, and when they go outside they are frequently made to feel that provision for their care by others should be appreciated, and expressions of gratitude should frequently be made to caretakers and to their benefactors. When children are regimented in dormitories for sleep, in large dining halls for food, and in mass physical and mental activities, they never quite fit into internally directed groups and free society. Some of the better institutions may set up "cottage plans" and other devices to approximate primary group life. It has been found that foster home care is generally preferable to institutional care of orphaned, neglected, or delinquent children. The lack of personal, intimate, and affectionate care tends to produce warped or inadequately socialized persons. This is by no means equivalent to saying that all family situations are adequate or superior to institutional care.

An unofficial report may be used to further illustrate the relations between primary group experience and a sense of obligation, or conscience. In the course of training men for the recent war it was found that a significant number were indifferent and would put forth little effort to prepare themselves for military duties. Appeals to their supposed patriotism induced no favorable response. Neither did they display any loyalty for their particular army unit. Suggestions that they ought to do what they could in love and defense of their homes made no impression. Furthermore, the deprivations and punishments which were inflicted on them for failure to obey and cooperate were relatively ineffective. It was frequently found that these men came from those parts of our cities where neighborhood and family groups are most disorganized and unable to function. Many persons in such areas have little primary group experience except in anti-social gangs. They may demonstrate the powerful loyalties and conformity to codes which occur in primary groups, but these run counter to the loyalties and codes approved by the larger community.

SECONDARY GROUP LIFE MAY BECOME DOMINANT

The conditions under which primary groups have existed in the past are now changing. The time spent in family and neighborhood relations has decreased for most people, and situations favoring the development of spontaneous play groups are more limited[3] than

[3] Lynd, R. S., and Lynd, H. M.: *Middletown, A Study in Contemporary American Culture.* New York, Harcourt, Brace & Co., 1929, pp. 132 ff.

they were under less urbanized conditions. While these changes are under way efforts are being made to retain or recapture the values of primary group life. Groups such as the Boy Scouts and Girl Scouts have been organized to socialize and "build character" in youth. The "laws," "oaths," and various "merits" which may be attained in Scouting are formalized attempts to achieve by conscious means some of the results which in former generations were left to informal and spontaneous groupings.

Secondary groups are not new forms, by any means, but they are becoming the vehicles through which the greater number of social activities are currently channeled. These are the groups in which relationships are: (1) *impersonal* and (2) *formal;* and in which (3) *communication is indirect.* In general secondary groups have (4) *large numbers of members*, who are often (5) widely *separated* in space from one another. And the purpose or goals of secondary groups are generally (6) *specialized* and *limited*, rather than various and numerous as in primary groups. (7) Furthermore, because of their impersonal relationships, largely devoid of sentiment or feeling; and their large and often widely scattered memberships, secondary groups must be held together by means of clearly stated *rules and regulations*, especially by definite laws and contracts. And the administration of these calls for (8) highly detailed *routine* and (9) *coordination.* As a matter of fact, the organization of secondary groups frequently becomes so complex, and the formalized structure becomes so detailed and stratified, that the special character of (10) *bureaucracy* develops.

The local or parish church was once a neighborhood affair, wherein members knew each other personally and entered intimately into each other's lives. In rural areas and small towns it may still be so. But the churches in larger places have grown so large, and their activities so complex, that impersonal and formal relations prevail. Efforts are made to preserve neighborly and brotherly concern by such symbolic acts as systematic greetings at the door and provision for numerous clubs, circles, and so on. Furthermore, local churches have their policies and purposes largely determined by the broader denominational association which includes many churches scattered over a wide area. Communication within the whole is carried on by means of letters, bulletins, papers, radio, and other devices. Numerous officials, specialists, and clerks at many levels down to the parish are necessary to keep the whole organization in existence and moving toward goals of religious nature.

Anyone familiar with political parties can recognize a similar

vast setup which embraces the whole nation and extends from a central National Committee outward and downward through a chain of subdivisional committees to the small precinct and the individual voter. In the political party grouping some gestures are made by precinct leaders and captains to exhibit personal interest and understanding for voters and their families. But, actually, the political party is a tremendous impersonal organization which often tends to develop the illusion during campaigns that the interests of individuals and localities remain paramount. This means, of course, that government, which emerges from the activity of political parties, is a vast association of units from lowest to highest levels of operation. The objectives at all levels are to provide services which would be difficult to effect through other means, and to regulate all relationships in the public interest, or to achieve the optimum welfare for all concerned.

BUREAUCRACY

It should be fairly obvious from this brief sketch that the large and complex relationships of religious denominations, school systems, political parties, city, state, and national governments, large business corporations, and an unlimited number of national associations must have (1) centralized policies and controls, which are (2) communicated through a chain of delegated authority outward and downward to everyone involved. The whole relationship is called bureaucratic because of the rigid, detailed, and impersonal division of labor.[4] Persons tend to become merely the means or devices by which end-results are achieved. Bureaucratic relations, in addition to the characteristics listed above, are thought of as: (3) clearly defined jobs to be efficiently done, (4) at definitely scheduled times, (5) to the exclusion of any other considerations or interest, (6) in accordance with printed rules, specifications, and directions, (7) by individuals selected for their specialized competence, (8) to work under rigid discipline, inspection, and supervision; (9) communication in writing, frequently in multiple copies, moves from the top downward, and is (10) checked, inspected, and filed at levels and with bureaus concerned.

Whatever personal relationships may develop under bureaucracy must be outside the formal system and be, more or less, out of harmony with it. Although many of the relationships in modern

[4] Williams, Robin M., Jr.: *American Society, a Sociological Interpretation.* New York, Alfred A. Knopf, 1951, pp. 177–179.

society are highly specialized, routinized, and depersonalized, it is probable that many informal, personal, and primary relationships develop to offset these.

In the second part of this book some of the most frequent situations which occur in the profession of nursing will be outlined. In this connection the various secondary groups which enter into these situations will be set forth, and the bureaucratic nature of hospital and health services will be described in some detail. At the same time, the informal system which arises under these circumstances will be suggested, and some of the types of small cliques and primary groups which frequently emerge will be mentioned. Both the personal and impersonal relations which involve patients will be described, including those of patients' families and friends. In hospital and clinical situations the forces of primary and secondary group relations may be readily observed, and their complications analyzed.

GROUPS RELATED VERTICALLY OR HORIZONTALLY

By way of further study of culture it seems desirable at this point to introduce a relationship which must be kept clearly in mind in the study of groups. It has to do with the structural relations of groups to each other in society; and also to the structure within each group. We must learn first the meaning of *diversification* and then of *stratification.* After these are quite clear we can take up the matter of *mobility.*

Diversification refers to the existence of many and varied kinds of groups which may be thought of as side by side in the organization of society. For instance, all readers are familiar with the many and varied religious groups in society. Of more than two hundred separate religious groups, Catholics, Jews, and Protestants are well known for their separateness. And among Protestants, the Episcopalians, Baptists, Methodists, Presbyterians, and Lutherans are differentiated still further. These groups may be thought of as existing side by side or non-ranked with respect to each other.[5] This type of arrangement may be applied to business and labor groups, to political groups, and so on. If groups are thought of in parallel columns or slots as suggested by Table 2, we can get the idea of one type of differentiation to be compared below with stratification.

[5] Sorokin, Pitirim A.: *Society, Culture and Personality.* New York, Harper & Brothers, 1947, p. 276.

Table 2. Diversification of Religious, Economic, Political, and Civic Groups

RELIGIOUS GROUPS			ECONOMIC GROUPS			POLITICAL GROUPS			CIVIC-SOCIABILITY GROUPS		
Protestant		A Methodist	Owner-Manager		A Banking	Parties		A Democrat	Clubs and Societies		A Rotary
		B Baptist			B Manufacturing			B Republican			B Kiwanis
		C Presbyterian			C Merchandising			C Socialist			C Lions
		D Episcopalian			D Transportation						D Exchange
		E Lutheran			E Agriculture						E Altrusza
	Catholic	F Roman	Labor		F A F of L						F B.P.W.C.
		G Greek Orthodox			G CIO						Etc.
	Jewish	H Orthodox			H UMW						
		I Reformed									

It should be apparent that persons are members of several different groups, each of which has different objectives. This implies that the meanings and values characteristic of each group tend to be distinct or concerned with a compartment or aspect of living. Since life is a unitary and continuous process not lived at one moment as religious, at another as economic, at a third, as educational, and so on, any particular person is likely to belong to groups with compatible meanings and values. If not he is likely to subordinate or ignore the values in one or more of his groups as less significant than those of another. If, for instance, his religious group meanings and values are inconsistent with those of his economic group, he may put them aside as ideal but impractical or find some reason to subordinate one to the other under particular circumstances. Later it will be shown that many personality problems grow out of the conflicts produced in one person's mind by his inability to reconcile the meanings and values of his diverse groups. In such cases there is a microcosmic replica of social or community problems in the mind of one person.

STRATIFICATION OF GROUPS

Another aspect of social structure which equals diversification in significance is *stratification.* Within every group there is a hierarchy

Table 3. Some Bases of Social Ranking

	CLASS	OCCUPATION	EDUCATION	AGE	RACE	SEX
Higher	Upper Upper	White Collar: Proprietor	Post-graduate	Elders	White	Male
	Lower Upper	White Collar: Professional / Manager	College Graduate	Middle Age		
	Upper Middle	White Collar: Clerical / Technician	Junior College	Young Adults		
Lower	Lower Middle	Blue Collar: Skilled trade	High School	Youth	Colored	Female
	Upper Lower	Blue Collar: Skilled trade / Unskilled trade	Elementary School	Children		
	Lower Lower	Blue Collar: Unskilled trade	Primary School	Infants		

of persons who are graded with respect to responsibility, authority, respect, and honor. In other words, there are graduations by rank with implications of superiority of some persons with respect to

others. Stratification to some degree is an inescapable by-product of organization, without which a group cannot achieve its values and objectify its meanings. Organization is the system of interdependent orderly relationships and the process of interaction by which the goals of society are realized.

Not only are groups stratified within, but stratification among groups is also commonplace. The most extreme examples are found in caste and feudal orders in which the whole society is set up in well-defined levels with norms and devices to insure rigidity. There is a sort of "local aristocracy" in little places as well as a "400" in larger places. Thus, we may think of slots running horizontally, with people in differing ages, classes, races, and so on being placed at levels of authority, prestige, responsibility, and privilege. Table 3 shows some of the attributes to which rank is ascribed.

Diversification and *stratification*, taken together, constitute a sort of latitude and longitude for locating people in the community. Persons occupy certain slots running vertically and certain others horizontally. But location of persons in sociologic space cannot be designated with anything like the pin-point exactness which characterizes the mathematical expression used to indicate latitude and longitude.

MOBILITY

Persons do not permanently retain membership in the same groups, nor keep the same positions within those to which they belong. Neither do groups continue always to occupy the same position with respect to each other. Changes in position are referred to as *mobility*. Changes in position upward or downward are referred to as vertical mobility. There can be little confusion at this point, because movements up or down involve changes in rank. A common expression refers to climbing up the "social ladder" or the "ladder of success." It is good to keep in mind that a ladder has vertical sides with rungs or levels running between these. Thus, vertical mobility constitutes a change in horizontal level; whereas horizontal mobility refers to movement across at the same level. Changing one's associations from carpenters to mechanics, or from Methodists to Baptists, would not be a change in rank, and would be horizontal mobility. On the other hand, promotion within one's group or ascent to a higher class would be vertical movement.

It should be noted at this point that there is an incessant struggle by persons of lower strata to rise, and there is a tendency for persons

in upper positions to keep those in lower places from rising. There may be inflated and deflated ambitions, rivalries, jealousies, envy, hatred, and such consequences as conflict between members of different strata for obtaining differential shares in the advantages to be gained. It should also be noted that some persons achieve high status occupationally but are low because of race, or are high in family prestige and kinship but low in economic position, as is the case of "broken-down aristocracy." The *nouveaux riche* are high in economic position and power but achieve little recognition and social prestige among the intelligentsia and élite. It should be recognized that most people who compose given strata accept their position and organize their lives in terms of meanings and values of class. Thus, an occupational class, age class, race, or other stratified segment may become conscious of its position and protect whatever advantages it has already achieved.

IN-GROUPS AND OUT-GROUPS

It has already been pointed out that group members are bound to each other by many bonds and develop feelings of pride and loyalty with respect to their purposes, achievements, and membership. The very fact of membership in a group carries certain favorable assumptions on the part of each toward all persons who compose the group. Members of the *in-group*, whether it be primary or secondary, are assumed to be similar to each other in many ways and, therefore, one member assumes others to be much like himself. Members are identified with each other, with the traditions and symbols, and with the future developments; thus each person gains importance from the groups to which he belongs and also contributes his own importance or feeling of personal worth to them. His self-importance augments and is augmented by his group's importance. He finds satisfactory self-expression in his groups, and shares pride and enthusiasm of the whole. Thus, members tend to feel that their own groups are more satisfactory, and, therefore, better than similar ones to which they do not belong. They not only feel that they are outside of certain groups and within others, but that these are mutually exclusive.

William Graham Sumner, the early American sociologist who gave us our greatest insight concerning folkways, stated:

> Ethnocentrism is the technical name for this view of things in which one's own group is the center of everything, and all others are scaled and rated with reference

to it. Folkways correspond to it to cover both the inner and the outer relation. Each group nourishes its own pride and vanity, boasts itself superior, exalts its own divinities, and looks with contempt on outsiders. Each group thinks its own folkways the only right ones, and if it observes that other groups have other folkways, these excite its scorn. Opprobrious epithets are derived from these differences. "Pig-eater," "cow-eater," "uncircumcised," "jabberers," are epithets of contempt and abomination. . . . For our present purpose the most important fact is that ethnocentrism leads a people to exaggerate and intensify everything in their own folkways which is peculiar and which differentiates them from others.[6]

A few illustrations from Sumner's work are:

When Caribs were asked whence they came, they answered, "We alone are people." The meaning of the name Kiowa is "real or principal people." The Lapps call themselves "men," or "human beings." The Greenland Eskimo think that Europeans have been sent to Greenland to learn virtue and good manners from the Greenlanders. Their highest form of praise for a European is that he is, or soon will be, as good as a Greenlander. The Tunguses call themselves "men." As a rule it is found that nature peoples call themselves "men." Others are something else—perhaps not defined—but not real men. . . . Amongst the most remarkable people in the world for ethnocentrism are the Seri of Lower California. They observe an attitude of suspicion and hostility to all outsiders, and strictly forbid marriage with outsiders.

The Jews divided all mankind into themselves and Gentiles. They were the "chosen people." The Greeks and Romans called all outsiders "barbarians." . . . In Russian books and newspapers the civilizing mission of Russia is talked about, just as, in the books and journals of France, Germany, and the United States, the civilizing mission of those countries is assumed and referred to as well understood. Each state now regards itself as the leader of civilization, the best, the freest, and the wisest, and all others as inferior. Within a few years our own man-on-the-curbstone has learned to class all foreigners of the Latin peoples as "dagos," and "dago" has become an epithet of contempt. These are all cases of ethnocentrism.[7]

These illustrations indicate that persons within groups have a simplified picture in their minds concerning every member of an *out-group*. They have an image in mind of "the heathen," "the Gentile," "the Jew," "the communist," "the dago," "the Jap," "the greaser," and so on. No effort is made to see or think of members of the out-group as differing among themselves, as many and varied types of persons. All are lumped together under one simple even type. This simplification of the image by viewing and treating all individuals of such category the same, regardless of fact, is technically referred to as *stereotyping*. It might be referred to as the

[6] Sumner, William Graham: *Folkways*. Boston, Ginn and Company, 1906, p. 13.

[7] *Ibid.*, pp. 14–15.

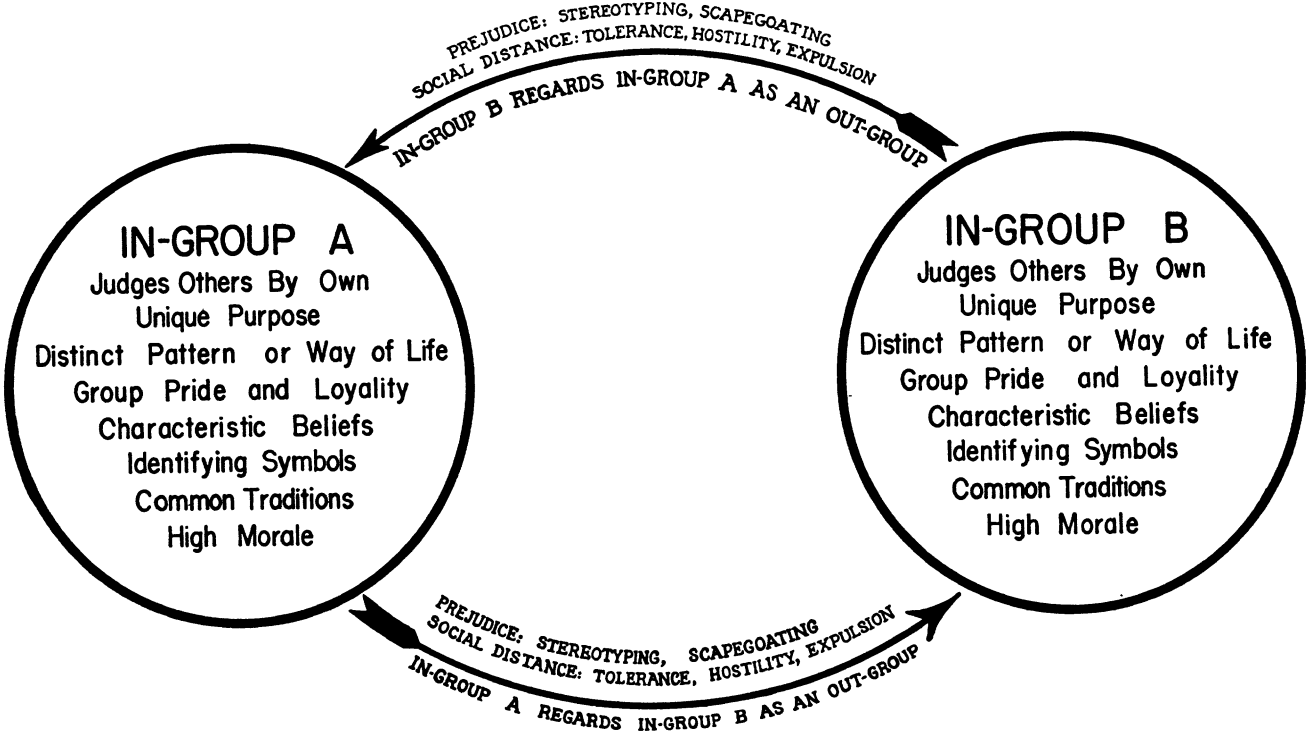


Fig. 1. Relations between in-groups and out-groups.

handle by which prejudice and irrational judgments are grasped. It enables persons to maintain *social distance*,[8] or feelings of acceptance or rejection toward all people of a different race, creed, nationality, religion, occupation, or any other basis for identification of an out-group. It should also be mentioned here that out-groups are frequently blamed for unsatisfactory or objectionable conditions experienced by in-groups. This is known as *scapegoating*, or using the out-group as a *scapegoat*. Rather than admit the possibility of internal weakness and honestly seek the sources of trouble and difficulty, it is much easier for members of the in-group to project these onto the out-groups.

Figure 1 may be helpful in the understanding of this important prejudiced relationship between in-groups and out-groups which is characterized by ethnocentrism, stereotyping, scapegoating, and tension.

As Figure 1 suggests out-groups may, upon being identified, be tolerated and even be treated with condescension or pity. "Backward" or "primitive" or "heathen" people may receive attention and help directed toward their enlightenment, advancement, conversion, or civilization. But suspicion and fear are seldom absent, and stereotyping or misrepresentation can easily lead to dislike, contempt, and even active hatred.

ETHNOCENTRISM PRODUCED EXPERIMENTALLY

A recent carefully conducted experiment not only confirms what has been said, but also suggests the conditions and process under which ethnocentrism and group tensions emerge. Although inadequate, a brief report of it seems worth while. The experiment was conducted in an isolated camp in Massachusetts. The camp site included level areas for games, a stream for swimming and fishing, and plenty of interesting areas for hiking. Although there were no lights, the mess hall, kitchen, infirmary, bunk houses, latrines, and tent equipment were adequate. The adults involved in the experiment were competent camp leaders, and maintained maximum

[8] Bogardus indicated degree of social distance on a 7-degree scale from closest relationship to most complete rejection as, (1) kinship by marriage, (2) friendship and membership in club, (3) residence on street as neighbors, (4) employment in same occupation, (5) citizenship in country, (6) allowed only as visitor to country, and (7) exclusion from country. See Newcomb, Theodore M.: *Social Psychology*. New York, The Dryden Press, 1950, pp. 164–167.

neutrality with respect to the groups which developed under camp conditions. The boys who served as "guinea pigs" for the study were selected on the basis of merit to attend the camp. But care was taken to bring together only boys who had not had an opportunity to know each other or have any connections with each other before they arrived at camp. Furthermore, boys were equated for similar backgrounds, religion, schooling, intelligence, race, and so on, in order that extraneous influences might not influence results.

The experiment was conducted in three stages. In the first stage, all activities were camp-wide and informal groupings on the basis of interest and friendship were allowed to develop spontaneously. In the second stage, the camp was deliberately divided into two groups with each assigned to a house of its own and an area of its own, served meals separately, and encouraged to carry on separate hikes, games, and other activities. Care was taken to separate new-found friends and persons who had been indicating similar interests under the informal conditions of the first stage. Thus the arbitrarily formed groups were definitely new and had no cliques or subdivisions bases on the informal stage. During the second stage activities were chosen on the basis of group interest, and rewards were given on a group-unit rather than on an individual basis. Ample provision was made, however, for individuals to use their particular talents, and thus "shine." Soon after the separation groups selected different places for swimming and worked hard to make their facilities superior to the other group. They developed secret hide-outs. They chose identifying insignia and stenciled these on their T-shirts. Members of one group began to refer to themselves as the Red Devils and those of the other thought of themselves as the Bull Dogs. Each took much pride in all their cooperative efforts, and developed strong in-group solidarity. In the third stage the two newly formed groups were brought into competitive activities for which points or credits were to be won; and situations were arranged so that not only were the actions of each group frustrating to the other, but each might even blame the other. As a result the epithets of "cheats" and "dirty players," as well as "low rotten pigs," "dirty bums," and "jerks" came into use.

According to the report on the experiment,

> . . . the consequence of these intergroup relations in competitive situations and in frustrating situations which members of one group perceived as being caused by the other group was first to solidify the in-group belongingness and solidarity, to enhance in-group democracy, and to strengthen in-group friendships. . . .

Second, the effect of these competitive and frustrating situations was to generate and increase out-group hostility, to produce derogatory *name calling* which came close to standardizing of negative stereotypes in relation to the out-group . . .[9]

After the experiment was completed efforts were made to wipe out the hostility which had been developed and reunite the two in-groups in one camp-wide group as before the separation. Although the three stages of the experiment lasted only two weeks the report says that ". . . in-groups tended to persist. Old names, old songs for the opposite group cropped up occasionally even though the conflict situations were past."[10] If this is true of in-groups so recently formed it might be guessed that any such groups with long traditions and well established stereotypes would be even slower to change.

ETHNOCENTRISM AND PROFESSIONAL GROUPS

Sumner stated that "by history, literature, travel and science men are made cosmopolitan."[11] In other words, he thought it possible to gain such breadth of view and understanding that the contribution as well as the weakness of all groups could be appreciated. However, it is well to observe that professional groups, even those with sophisticated memberships, may be highly ethnocentric. The fact is that groups composed of persons with very specialized training and assured competence may develop notions of general wisdom and superiority. It is not, after all, surprising that certain specialized scientists as a group may scorn the work and claims of other groups who may seem to be competitors. The same is true of groups engaged in health or welfare services. Students may be able to observe the phenomenon in connection with their professional training.

FOR INVESTIGATION AND DISCUSSION

1. Describe any informal group formation which may have developed among your classmates. What appears to be the origin or basis for the emergence of each clique or group you have observed?

2. If your class is organized, check its "characteristics" against those listed on pages 33–35. State why you would classify it as primary or secondary, or do you judge these categories to be inapplicable to your relationships?

3. Do all nurses, when thought of together, form a social group? What are some of the groups to which only nurses belong?

[9] Sherif, Muzafer, and Sherif, Carolyn W.: *Groups in Harmony and Tension.* New York, Harper & Brothers, 1953, p. 284.

[10] *Ibid.*, p. 287.

[11] Sumner, *op. cit.*, p. 15.

4. Do you know of any situations in which patients form social groups, or may be encouraged to form groups? Explain.

5. Can you now recognize any probable connections between social mobility and various forms of illness? Similarly, between ethnocentrism and any form of illness?

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Chapter 4

HUMAN NATURE AND PERSONALITY

It is reasonably safe to assume that every reader of these lines has looked into a mirror at some time during the day. In fact many persons carry a mirror with them as a part of their personal equipment, and they look into it frequently. Furthermore, many people seldom lose an opportunity to catch a reflection of themselves in a plate glass window or any polished surface which may serve the purpose of a mirror.

WHY WE LOOK INTO MIRRORS

We may look into mirrors for two main reasons. We may like to look at ourselves and admire the reflection of our own image. In fact, self-love may be directed toward one's image and become a form of mental illness. Most of us, perhaps, do not look into mirrors for self-admiration or worship, but rather to imagine how we appear to others. We arrange our clothing, brush our hair, and "touch ourselves up" in a way which we think others will approve. By looking into a mirror we may test our smile, facial expression, and physical bearing as we think they are seen by others. Full-length mirrors sometimes serve for posing or for a bit of acting, in order that we may get an idea of the impressions we may make by changes in posture and expression.

All this viewing of ourselves in mirrors would be relatively unimportant except for the fact that it is a means of seeing ourselves through the eyes of others. It is in their eyes and manners toward us that we really try to see ourselves. We are imagining at all times how others see us and regard us. Every one, of course, has an idea of what he is and how he wants others to think of him; but he is constantly interpreting these things by the ways in which others respond to him—receive and approve him or avoid and reject him. In response to what we feel others may be thinking, we frequently say to ourselves: "I could kick myself for acting like that," "I

certainly did make a hit tonight," "I felt small indeed," "I was really proud of myself," "I can see that I am going to get along fine with this group."

This process of trying to see ourselves as others see us, and of modifying our behavior in a way which we think is likely to be approved by those we care about, has been going on in each of us since infancy. We can examine this process more clearly, perhaps, if we pause to consider certain facts about the human infant at birth. We may then be able to trace the process by which the interaction with others involves the emergence and continual interpretation of self.

INFANTS AT BIRTH

For present purposes it seems necessary to call attention to only a few characteristics of human infants at birth. It is particularly necessary to point out some of the essentially human characteristics which babies do not have at their advent and which develop only as a result of human association and learning. When facts about "original nature" and "human nature" are briefly summarized, their actual unity must be kept in mind. Separation of the two is for the sake of clear analysis. The baby has numerous characteristics as a biological organism and with these is born into a social setting. Since much of the biological equipment is not fixed or set to operate in specific ways, but may be influenced and adjusted through interaction with the outer world, the human being or human personality becomes a product of the two systems interacting with each other. "Is it a boy or a girl?" is one of the first questions asked about the newborn. In addition to sex differences there is wide variation among babies at birth. Those who are familiar with the normal probability curve would expect babies to vary in anatomical traits such as weight, length, formation of parts, features, coloration, as well as in refinement of sensory organs and mental capacities. The fact is that every infant is unique, except, perhaps, in the case of identical twins, with respect to the peculiar combination of biological characteristics which he brings into the world. A popular illustration of this fact is found in the distinctly individual markings which may be shown by means of fingerprinting.

It is also true that no two persons are likely to have perfectly similar or parallel experiences. Thus the differences which exist at birth are compounded by variable influences to insure variations among persons everywhere. Furthermore, the physiological differences which exist at birth are significant not only in themselves, but the social interpretation which is put upon such matters as

dark skin, red hair, diminutive size, and birthmarks also has significant consequences which must be considered.

One of the most important facts about the human infant, in contrast to the young of most animals, is its original helplessness and the long duration of its dependence upon the parent generation. A few animals may not be as mature at birth as the human infant, but none require care for such long duration in order to survive and to become independent of parental care. Babies lack body covering by which they may maintain body heat; they have neither muscular development nor instinctive movements by which the basic need for food and water may be obtained. Unless babies are kept warm and properly fed for a period of years they will die, whereas animals, both higher and lower than chickens, can "go it alone" shortly after emerging from incubation or gestation.

ORIGINAL HELPLESSNESS PLUS FLEXIBILITY

The human infant's original helplessness, his lack of scales, fur, or other form of body covering for protection and warmth, and his limited automatic or fixed responses—all of these have long-run advantages. They are coupled with erect posture, hands that grasp, three-dimensional and color vision, a plasticity and flexibility of nervous organization, and almost unlimited capacity for learning. The lack of protective body covering makes it possible for him to live in all zones, provided suitable covering is found and utilized. The lack of original complex patterns of obtaining food, such as lying-in-wait or hunting, is offset by the capacity to perceive relationships and invent highly satisfying ways of obtaining far more than mere biological necessities.

Since babies do not have instinctive equipment in the sense that puppies, kittens, and other little creatures have, it is not surprising that many early bodily movements and activities of babies are haphazard or uncoordinated. The sounds produced by the random movements of the vocal cords are numerous and varied. No distinct barks, yipes, or meows emerge automatically; although many varieties of coos, cries, grunts, yells, syllabifications, and other vocalizations may be heard from a baby. Similarly, many other random muscular movements of toes, feet, legs, fingers, hands, arms, and other parts go on even before birth. There are, of course, numerous reflex movements which are fixed and automatic; otherwise, breathing, heart action, swallowing, and such protective movements as sneezing and eye winking would not be maintained. The point is that relatively few automatic activities occur in pro-

portion to the many which are random and aimless. The human infant is adaptable and educable because of the original characteristics of plasticity and flexibility in the organism, as apposed to complex unlearned patterns such as hunting, defending, and attacking behavior which are observed among many species of animals.

There are a number of theories concerning the basic motives underlying man's behavior which are presumed to explain his acts everywhere and at all times throughout history. Although certain basic needs and motivations exist, their satisfaction and expression may be quite varied. This chapter is primarily concerned with the channeling or direction of any original tendencies through human experience and learning. It is assumed that most of the particular desires and wants people have, as well as the objects and values which satisfy them, as contrasted with their needs, are learned through social interaction.

"NOT BORN HUMAN"

In taking stock of what the infant does have at birth it is important to emphasize the major characteristics which it does not have. It does not possess language or knowledge of symbols upon which human social relations and human society depend. It comes into the world without morals and manners by which human relations are guided and controlled. It does not have the sentiments and values which are so characteristic of human nature the world over. And, of course, it has no concepts or beliefs of any kind. If the institutions outlined earlier are recalled, it becomes obvious that the human infant is without religious, economic, political, educational, family, or any other complex pattern of acting toward the outer world. All of these characteristically human traits must be learned. This is the sense in which it is said that "man is not born human." The infant begins at birth, and possibly somewhat before, to be influenced by human experience. The process of developing self and personality involves years of interaction with other human beings in varied social settings. It is accompanied by pain as well as satisfaction. This process by which the baby acquires essentially human characteristics is technically known as *socialization.*

ANTICIPATION OF INFANT'S BIRTH

During the time occupied by reading the above paragraphs hundreds of babies have been born. They have been born in tents, in cabins and farmhouses in the "back country," on boats, in crowded city quarters, and quite a few in hospitals. Professor Leo

Simmons, who has studied the cultural patterns in childbirth to be found in many parts of the earth, says that it is practically impossible to find cases of completely "natural" childbirth. "Society nearly always brings, along with obvious conception, a set of cultural influences which modify the offspring and direct its destiny right from the start."[1] Practices which have grown out of ages of experience in bringing babies into the world are now being rediscovered and redefined by baby experts. The currently emphasized concepts of "rooming-in," "breast feeding on demand," "TLC," and "male childbirth" have been practiced and their importance taken for granted for many centuries in many parts of the earth. While modern medical discoveries were doing away with many superstitions and harmful practices, some highly essential matters were being lost under the complex relations of civilization.

The point to be emphasized here is that each child's birth is anticipated. The social and physical conditions existing before and at the time of its birth are as important for future development of the child as those existing after its birth. The relations of father and mother, their attitudes toward each other during the prepartum period, and their expectations and attitudes concerning their child and its approaching birth are powerful influences upon its whole future life. Sympathetic understanding and cooperation may be limited or absent from the relationships of the prospective parents. One or both may be anxious or afraid concerning the future. The fact is, of course, that the child may be desired very much or very little, and dreams for its future may be full of hope and promise, or they may be dull and even hateful. The child may be thought of as a person and be provided with a name before it is born.

The attitudes and values held by the parents with respect to its coming will largely determine how a baby is received and treated when it is born. It will experience some shock in the process of birth, but whether the mother does or not and the type shock she may have depends upon the preconditions as well as the immediate conditions of the birth. Any shock or emotional disturbance she may have may indirectly compound that of the child. If the father is present and indicates his pleasure and confidence, the situation will tend to be "normalized." If relatives and friends exhibit interest and pleasure, the event will be satisfying to the parents. But factors

[1] Simmons, Leo W.: "Cultural Patterns in Childbirth." *American Journal of Nursing*, Vol. 52, pp. 989–991, August, 1952.

which contribute to isolation, loneliness, or neglect of the mother are likely to contribute to depression and anxiety. Similarly, factors which contribute to conflict, such as interference or domination by in-laws, may set up influences which have significant results at later periods of development.

Physical conditions which prevail during the prenatal period and those which exist at the time of birth are important indeed. So far as their relation to personality is concerned, all influences must be thought of together. The health and prepartum care of the mother, as well as her physical surroundings of food, clothing, housing, and so on, have far-reaching significance for the future growth and development of her child. The physical setting, equipment, and skills exercised at birth have their importance. These physical matters are so well known and highly emphasized that they have received much detailed treatment by proper specialists elsewhere. They are mentioned here because they are a part of the whole sociological setting which is associated with entry into the social world.

SOCIALIZATION

We may now return to the mirroring process, which introduced us to ourselves at the beginning of this chapter. It is our problem now to understand how the baby develops its conception of self and of others, and how the self and others interact. We are concerned with the "riddle of personality," and how the behavior which society approves not only becomes the behavior of the person but is regarded by the person as his very nature. We are seeking clues to questions which persons might ask—"What am I?" "How am I like nearly everyone else?" "In what ways do I differ from others I know?" "Who am I?" "What is expected of me?" "What am I to do?" "How do I stand, or where do I stand in relation to others in my world?" "What do I stand for?" "What can I be depended on to do?" "Would I like to be different from what I am?" "What do I want to become?" "How may I become what I wish to be?" "Is there much likelihood that I shall become different from what I am now?"

IDEA OF SELF DEVELOPS

The baby certainly does not have such questions in mind at birth, and may seldom, if ever, be conscious of specific questions about self. But soon after ability to talk has been learned, many sentences will begin with "I" or "I am"—"I am a boy." "I am

John." "I am three years old." The idea of self is in process of development before language forms are adequate for expression. The baby can point to himself, and to different attributes of himself, before his own use of words has developed. He becomes an object to himself, and centers his interest on himself.

Relatively simple reflex actions of the nervous system enable the baby to meet the earliest demands of life. Most babies enter the world with a cry or sneeze in response to the atmosphere which weighs upon and within them. Breathing and other organic processes are set in motion. Sucking movements of the lips begin, and head turning occurs to facilitate contact with breast or substitute which adults may bring near. Aside from these basic reflexes, as stated previously, the infant's behavior is random and uncoordinated. The eyes are, at first, uncoordinated, and focalization must be developed. Movements of the vocal cords produce varied sounds, among which a cry is a reflex response to discomfort or pain. When awake, however, the baby produces a variety of sounds which adults call babbling, cooing, grunting, and so on. These are not automatic or specific and coordinated responses. Similarly, a few reflex movements of hands, feet, and body occur. But the waving and other movements of arms, the kicking and jerking of legs, and the twisting and turning of body are largely without pattern. In fact, much behavior of a random sort may be said to last for years,

At the very time infant behavior is random adults are attaching meaning to any segment of it which approximates established usage. If, in the course of producing many sounds, a baby hits upon "da, da, da, da," a very fond mother may interpret it as "daddy," and utter exclamations of approval. "Ma, ma, ma, ma," may be interpreted as mamma, "pa, pa, pa, pa," as papa, "ba, ba," as baby, and so on. But sounds of "ka," "la," "ja," and an endless number of other combinations are ignored by adults. Thus, when the baby is heard to utter certain sounds parents and other listeners are likely to show pleasure and reward the baby with smiles, hugging, patting, and the like. After multiple instances a connection becomes established, and the sounds which produce such pleasing responses in adults come to be repeated. It cannot be said that the baby has fully recognized the connection, but a dim awareness of meaning must be occurring. This process of having random acts singled out for attention, approval, and reward by adults, who interpret them as social norms, continues for many movements other than vocalization. The infant which "finds its own hands," in the sense of bringing both hands together, lays the foundations for patting its

hands together. When this occurs, adults may seize on it to cry, "pat-a-cake," and make a similar motion with their own hands. The little drama has no meaning at first, but in due time pleasure is shared all around by adult and child "patting cake." All the while, of course, the baby has no idea of patting, or of cake either. It is simply making motions which adults reward, by laughing sounds, approving glances, and cuddling gestures.

As the process continues the baby comes to distinguish its separateness from things and persons which surround it. It can be said that meanings of objects and acts begin to dawn upon the child. He begins to recognize how those around him treat or regard objects around them, and, also, how they act and feel toward him. He not only becomes aware of others, but he comes to interpret what others think of him. Thus, he comes to observe himself and learn what he is and what his characteristics are by putting himself in the place of others. He becomes the object which others see him to be. This is the process of mirroring which was described early in the chapter. It is also referred to as taking the role of the other. The child takes the roles of his mother and other persons within his intimate world and regards himself as they appear to do. Since the process continues indefinitely, the conception of self is supplemented and modified from one situational experience to another. The self emerges and grows through interaction with others.

DEVELOPMENT OF SELF WORDS AND SPEECH

Detailed observations of the physical and social development of children from earliest infancy have been recorded. Among these we may select a few entries from the notations which Read Bain[2] made concerning the speech and vocalizations of his daughter Sheila, beginning the twenty-first day after her birth. By the twenty-third day of the third month she distinguished between her father and mother, cried when left with a strange girl, and stopped crying when taken up by her mother. She seemed to respond to her name by turning her head more quickly than for other sounds at three days before the end of the sixth month. She definitely made bids for attention early in the seventh month, and showed interest in her mirror image and baby pictures. Although she waved "bye-bye" to others several days before, she waved this way to herself in the mirror early in the eighth month. She also showed more interest

[2] Bain, Read: "Self-and-Other Words of a Child." *American Journal of Sociology*, Vol. 41, pp. 767–775, May, 1936.

in herself in the mirror than in others who were reflected with her. She looked at her mother in the mirror and grinned when she turned to look directly at her. By the middle of the ninth month she reached for things when asked "Where's Sheila's shoe?" and the like. Later, in this same month, she pointed correctly when asked, "Where's Mamma's shoe? Foot?" and the like. She responded to "Where's the baby, where's Sheila?" by covering her head and uncovering it with laughter and grinning. She definitely knew words by the middle of her tenth month, and it appeared from her responses that person-words gave her greater emotional satisfaction than thing-words. In this month she also made the sound "She-e! She-e!" and looked toward her picture on the mantel when asked, "Where's Sheila?" By the thirteenth month she had learned the names and faces of twelve relatives. She was heard saying words to herself at the beginning of the fourteenth month.

In a somewhat similar study of an older child, Jean Piaget[3] found that the child's first usage is concerned with repetition of words for pleasure with no thought of talking to anyone. It may be inserted here that, for a number of years, children talk to themselves a great deal, as if thinking aloud. And they are also found to be carrying on a dialogue or talk between themselves and some others in which they take the role of self or of another. Now, returning to Sheila, make-believe play was common early in the fourteenth month—drinking from an empty cup, giving herself a bath, and so forth. Successful action was accompanied by the exclamation, "da!" After saying "See-lah" at her fifteenth month she began to use other self-words—the proper use of "I." At first she got possessives a bit mixed or out of place, such as, "My see you" for "I see you," and "My baby go bye-bye" for "your baby." However these pronouns were straightened out, and "My name, my name is Sheebee Baim!" was said in response to "What's your name?" by the middle of the twenty-first month. At the age of two years, over 400 words could be used so that strangers understood them. By this time she was telling her dolls what her mother told her, such as "Careful, or you will hurt yourself." The correct use of "we," "us," "our," "you," "your," "his," "her," "these," "them," and so on, were mastered by the early part of the second year.

Conclusions from this and similar studies show that (1) children learn other names before their own; (2) self-feelings can only be

[3] Piaget, Jean: *The Language and Thought of the Child*. New York, The Humanities Press, 1952, pp. 11 ff.

indirectly indicated until self-words are learned; (3) first utterance of words is mechanical or mere imitation of others; and (4) actual meaning of self and its symbol, "I," can only emerge through interaction with others.

DEVELOPMENT OF MORAL RESPONSIBILITY

Similarly, we may briefly review the emergence of conscience and moral judgment through the interaction of self with others. Jean Piaget, a Swiss psychologist, has made intensive studies of the social development of children—their language and thought development, their conception of physical causality, and their development of moral judgment and conscience.[3a] All these rest upon the process of interaction with others through which the child assimilates, or develops within himself, as his own, the norms and values of society. Piaget observed that it was quite common for children in his country and many others, too, for that matter to play marbles. Although it is a child's game and is played by them with a minimum of interference or supervision by adults, it has been "handed down" by many generations from one to the next. It is structured in the sense that there is a system of rules and standards concerning the placing of marbles in proper positions with respect to proper positions of players. The objectives of the game are defined, and the code under which players are expected to operate covers all details of action by which the cooperative competition is to be carried out.

Many readers know from their own childhood experience that very young children have an opportunity to see older ones play marbles. From memory, perhaps, many are ready to confirm Piaget's first observation that young children's direct experience begins with mere handling of marbles and paying attention to their color, size, and other physical attributes. Since others have been seen playing with marbles there is a dim realization that ways of playing exist, but they are not thought of specifically or considered important and obligatory. Although the process of learning is continuous, Piaget reports his observations under four stages, the first of which he labels purely motor or individual in character. The second stage, which may occur about the fourth or fifth year of the child's life, is called egocentric. During the second period children are observed either playing alone or, if with others, not to win. They are engaged

[3a] Piaget, Jean: *The Moral Judgment of the Child.* Glencoe, The Free Press, Reprinted 1949, pp. 1–69, 401–414.

during this period in going over in their own minds the ways to play, and they are "practicing" or "trying out" their own acts as if playing. But they are not "putting things together" in a whole or system with others. They think of the rules as obligatory and sacred. They feel that one who plays must learn the rules and abide by them. They view the rules not as their own but as definitions outside of themselves to which they must conform if they want to play. In the third stage, which comes near the seventh or eighth year, children are trying to win and fit in with others in mutual control. Ideas about the rules and necessary cooperation with others are still vague, but children are beginning to learn that all who play have respect for each other and that all are entering into an action which is advanced by their own mutual understanding of what they want to accomplish and their cooperative endeavor to realize the purposes of the game. The fourth stage has been reached when, about ages 10 to 12, each child has made his part of the game and the game as a whole, and the rules by which it is played, his own. It is no longer external to him; but each recognizes his part and the role played by every other as a means of enjoying the game and enthusiastically participating in it. What was outside of himself as necessary conformity under ideas of duty and constraint is now internalized as cooperation under his own desires and aspirations. Through the process of interaction not only is the child in the game, but the game is in him.

Since the person will want to maintain the approval of the primary groups in which he had his earliest, most intimate satisfying experience, he is inclined to behave throughout later experience in accordance with the expectations of those groups which have meant most to him. Thus his conscience, or the conception of self which emerged from numerous intimate, early, satisfying experiences, is likely to become the reference he makes in determining whether action is right or wrong in doubtful or confusing situations. The conscience may expand to include acts which later familiar groups may approve. But it always remains the reference or reflection of self which is expected by the groups which have been most preferred and familiar. It is oversimplification to consider conscience "the voice of the primary groups," but this phrasing may suggest the chief source through which each person comes to have moral standards and points of view by which he lives.

LEARNING TO "PLAY THE GAME OF LIFE"

If the reader is not familiar with the game of marbles, any other game may serve as an illustration of what takes place in the learning

process. The learner begins by observing the game as something others are doing. If he becomes sufficiently interested to want to play he watches others and dramatizes within himself the way the game is played. He goes over in his mind what is expected of each player, and may try to learn the skills and rules by some "practice" of separate elements of the game. The rules are likely to be thought of as essential and rigid. When playing is first entered into the neophyte finds it difficult to "keep everything in mind" and to grasp what every other player is expecting him to do as well as his own expectation of every other person. Playing the game as an integrated or coordinated effort requires that each player put himself in the place of every other player so far as distinct role is concerned, and that he see his own role as every other player sees it or expects him to perform it. In this relationship he not only sees his own self as all others see it, but he sees the game in its entirety and the role of every person in relation to every other. This grasp of entire social relationships is technically known as taking the role of the other—*generalized other.*

It should now be clear that "taking the role of the other" and viewing the self as an object are the means by which members of groups are related to each other and to the purposes and acts which characterize them. Thus, the total game of life, although highly complicated, can be grasped as an extension of this relatively simple process which is reported by the observers of children's games. Further consideration of these observations will reveal the fact that the child will play different roles in his varied groups; and that he will, therefore, have a somewhat different conception of self in each. Nevertheless, he will manage to bring these together into a reasonably clear, permanent conception of self. The person will play the role which is expected of him in each of his groups and at the same time be able to relate these to what he comes to regard as his true or essential self.

PERSONAL ORGANIZATION

Our brief summary of socialization has indicated that infants may be graduated from utter dependence, in relationships without meaning, into maturity—into relationships with others which are understood and accepted as interdependent, and in which the person knows and performs his functional part or role. The child has learned to *define the situation,* or to grasp his relation and that of others, in succeeding experience throughout his development. He has learned that defined goals or ends exist in nearly all social [illegible] and that norms or expected behaviors by which goals

can be obtained are also pretty clearly defined. He becomes mature as he comes to understand his relation to the varied situations of his experience and as he competently performs the role which he achieves or has ascribed to him. In the process he becomes organized as a personality. Actually he performs different roles in different situations and groups; and his activities in connection with these must be varied. Although he may play the parts of father in his family, doctor of medicine in his professional relations, sportsman among his friends during leisure, deacon in his church, and so on, he organizes all these relationships so they fit into his own major objectives. Although his behavior was random and uncoordinated as an infant, through the years it has become increasingly selective and focalized. Each person comes to have a distinct system or pattern of behavior, so that what one is likely to do under varied circumstances is quite dependable and predictable. The major purposes for which each person strives are likely to become increasingly clear through interaction in social situations. Activities become sufficiently routinized and distinctive so that behavior, though varied, fits into an expected pattern. The person becomes stable and organized. Although much like others in most of his ways, each person has goals, points of view, tastes, manners of behaving, and other characteristics which are so integrated that he is a distinct personality.

FOCUS OF SOCIAL PRESSURE ON PERSON

Figure 2 may assist the student in bringing all the content of previous chapters to bear upon understanding the development of personality. The framework of major institutions (see page 23) appears on the left. We are immediately reminded, however, that these institutions are systems of detailed definitions, or norms of behavior, which differ in flexibility or range of permissive variability. These are the mores, folkways, and laws (see pages 25–28). It is understood, of course, that actual behavior occurs in primary and secondary groups (see pages 36–40). And it should certainly be clear that separate groups put into practice only those norms which they have learned and which fit into their purposes. For instance, not every family learns and practices all the norms which occur in the family institution. Thus, families within various socio-economic classes, rural or urban settings, religious faiths, and so on will vary in the institutional content which they know about and practice. The figure is constructed to indicate that the attitudes and values which actually reach any particular infant are those which

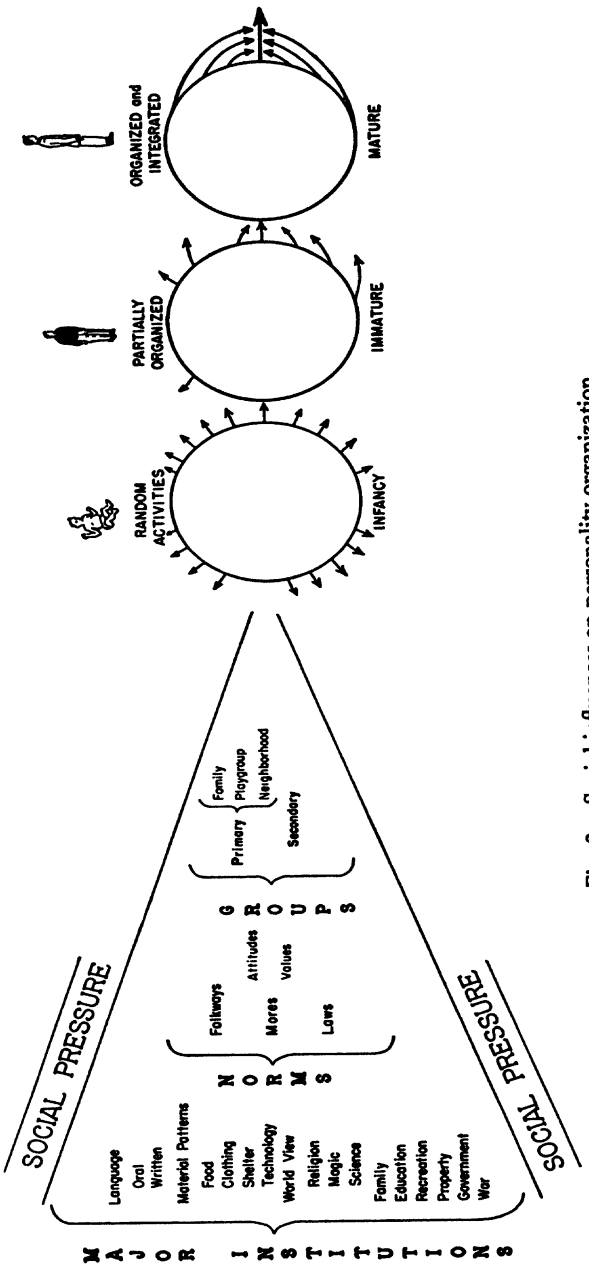


Fig. 2. Social influences on personality organization.

come through immediate group experience. The whole social system, with its complex specifications and demands upon each person, constitutes a vast pressure upon groups; but, because groups are limited by communication and can never be more than minor parts of the whole society, they become a sort of bottleneck through which selected social pressure bears upon any particular person. The right side of the diagram is intended to indicate: first, the random behavior of infancy when many acts run counter to social norms; second, the immature phase, when many forbidden ways have been cut off through discipline, some are still random but tolerated, and some are becoming dominant and organized; and third, the mature phase, in which behavior is organized and directed toward a dominant goal.

DETERMINANTS OF PERSONALITY

The general relations of culture to groups, and groups to personality formation, help us to understand why all persons have much in common and behave so much alike in many ways. Most of the behavior of persons whom we see around us can be explained or understood in terms of institutional norms. Even the variations to be found in the attitudes and values of Mexicans, Italians, Germans, and other ethnic groupings are a reflection of differences in institutional norms. However, the distinctive behavior of particular persons calls for a more searching analysis. As previously stated, each infant begins life with biological differences which make him more or less extremely distinct from others. And more important, perhaps, each person has social experience which is significantly distinct from that of others.

The very fact of sex difference at birth sets up a whole chain of assumptions, prescriptions, and influences of institutional character. But these are further complicated by interpretations which are placed by particular families and groups upon such physical characteristics as perfection of physique, deformity, race, or some distinct trait—curls, "buck teeth," quality of voice, and so on. Variations in physical stamina and illness are likely factors in distinctive personality differences. Any given physical condition is only a factor in social interaction, and does not of itself determine what influence may be exerted on personality development. Whether a crippled child whose legs are defective is encouraged to think of himself as unfortunate and pitiable, or as alert and capable of doing many interesting things, is largely a matter of whether his legs or his head receives major attention from those around him. If he regards

himself as weak and pitiable his personality may be organized around some form of begging, or some more extreme dependence. If his mental capacities have been stimulated and his talents cultivated, his life may become organized about a research or writing career. Even the subtle differences between beggars who are crippled and crippled persons who become creative turn upon minute differences in experience which are frequently difficult to trace.

The importance of "accidents" as determining influences on personality is stated in the work of Kluckhohn and Murray.[4] Since each "personality is the product of countless and successive interactions between the maturing constitution and different environing situations from birth onward," there are many events which are unpredictable on the basis of known physical, social, and cultural surroundings.

> A child gets lost in the woods and suffers from exposure and hunger. Another child is nearly drowned by a sudden flood in a canyon. Another loses his mother and is reared by an aged grandmother, or his father remarries and his education is entrusted to a stepmother with a psychopathic personality. . . . Thus, there is uniqueness in each inheritance and uniqueness in each environment, but, more particularly, uniqueness in the number, kinds, and temporal order of critically determining situations encountered in the course of life.

SIGNIFICANCE OF SOCIAL ISOLATION

While focusing upon distinct differences in personality it is well to consider degrees and kinds of isolation.[5] It is well known that children who, for one reason or another, have extremely limited social experience do not develop personality or a conception of self at all. A very few children have been kept alive through feeding and minimum physical care for a number of years, but with minimum language and other social experience. Such situations do not allow enough interaction with others to bring out reflections and conceptions of self, or the learning of self and other words. In such instances, it seems correct to say that no personality develops. Parenthetically, this could also be said of idiots and others biologically incapable of development.

Social isolation is a matter relative to the social situations in which a person's experience occurs. Children who live in mountain hollows have been reported to have no knowledge of play or games,

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[4] Kluckhohn, Clyde, and Murray, Henry A.: *Personality in Nature, Society, and Culture*. New York, Alfred A. Knopf, 1948, p. 37.

[5] Davis, Kingsley: "Extreme Social Isolation of a Child." *American Journal of Sociology*, Vol. 52, pp. 432–437, March, 1947.

and to be completely ignorant concerning the American Flag and other symbols which are usually learned early in life through the family.[6] Upon being asked, "What do you want to be when you grow up?" these children were completely mystified. They could not easily grasp the meaning of the question in a situation where there were few objectives in life other than mere existence. After extreme difficulty with communication the children finally caught some meaning in the question and replied, "a man" or "a woman," depending on the sex of the respondent. There was enough difference in the norms for men and women that the children were able to think of their future roles only in terms of sex differentiation. Such isolation is rare, occurring most frequently where small numbers of people are living in relatively inaccessible mountain hollows, swamp lands, deep forests, and so on. It must not be overlooked, however, that many families and small groups who live in cities are similarly isolated because of language, poverty, and other barriers to communication. Isolation is frequently due also to blindness, deafness, or some other physical handicap which limits or eliminates much social interaction. Furthermore, isolation is a matter of degree, and rural areas the world over represent varying degrees of "backward" or "retarded" cultural development. It is likely indeed that some mining communities and others devoted to crude agriculture in many hill and mountain sections of our nation are more retarded and "degenerate" than they were three generations ago. Self and personality development in such places is so limited that few are likely to get beyond infantile or immature behavior. It is important to understand that a large number of people who have lived to middle or old age are much like children or adolescents so far as their personal organization and maturity are concerned.

EXAMPLES OF CULTIVATION AND GUIDANCE

Just as factors of isolation and neglect limit personality development, so may cultivation and guidance contribute to maximum development. Evidence from numerous biographies indicates that some "great personalities" were given unusual opportunities and careful guidance in their early childhood. John Stuart Mill is one of the classic examples. He was taught the Greek alphabet by the age of three; he went on to master the grammar and vocabulary

[6] Sherman, Mandel, and Thomas, Henry: *Hollow Folk*. New York, Thomas Y. Crowell Co., 1933.

necessary to read many books in the original Greek by the age of eight; and he was capable of taking up logic at the age of twelve. He was taught early to take his chief pleasure in overcoming intellectual difficulties, and to realize the meaning of general terms. On the moral side, the child was almost from the dawn of consciousness instructed to regard himself as consecrated to a life of labor for the public good. The key to his remarkable development is found in his daily walks and conversations with his father, who deliberately set out to cultivate his son's mental and spiritual powers. It was said by critics that the youth did not get to enjoy the normal play and happiness of childhood, and that he was unduly warped by the way he was reared. But in his autobiography he testifies to his happiness and the enthusiasm with which he pursued his ambition. His personality proved to be mature and stable in later life when he experienced disappointment and disillusionment. He stated in his autobiography that any child could have developed similarly under similar influence and that genuine social achievement is possible for all who have proper foundations laid. It might be difficult indeed to determine what special or native endowments he possessed; but it is certain that his self-development, personality, and great achievement rested upon his unique social experience.[7]

One of Mill's contemporaries with whom he exchanged many letters was a woman. She, too, was given every opportunity for personal development, and received from her father intensive instruction and guidance strikingly similar to that received by Mill. Although she was surrounded by wealth, traveled widely, associated with most learned and prominent people, and had every opportunity to spend a life of leisure, she dedicated herself at an early age to the "service of sorrow,"—not to relieve it perhaps, but to sympathize with it. Perhaps her mother's interest in the poor, her own visits to sick relatives and friends at an early age, the religious teaching she received, and the influence of a very sympathetic friend combined to develop in her adolescent years a sense of divinely appointed mission. However, because she was expected to be a dutiful daughter and not to become engaged in service activities, she was not understood. Later, when her general purposes were brought to a focus and organized around the idea of nursing, she met with definite opposition. This brief glimpse of the personality of Florence

[7] Biographical evidence might be explored much further to discover the influence which particular persons and situations have had upon the development of "leading personalities." These might be compared with life histories of immature and incompetent persons with limited accomplishment.

Nightingale suggests how sex status may affect development, and how organization may long be delayed in fulfillment.

PERSONALITIES OF PARENTS INFLUENCE CHILD

In Chapter 8, dealing with the family, the many and varied factors which influence children in the interpretation of self, the development of life goal, and the organization of a personal pattern of behavior will be further emphasized. It should be noted here, however, that the personalities and behavior of parents have far-reaching influence on children. When parents are themselves clear of purpose, competent in what they undertake, and emotionally stable, the situation is favorable to normal personality development of children. When, however, parents are quarrelsome, egocentric, jealous, excitable, fearful, overworked, tense, dissipated, and/or brutish, any child is likely to get a distorted conception of self and of others as well. Furthermore, unjust punishment, undue praise, demonstrative sympathy, overprotection, and overindulgence are in the catalogue of parental behavior which makes attainment of an accurate picture of self and others difficult for a child. The interaction of children with each other in family relationships often accounts for the particular slant a child may get on himself and his relation to others. Thus, indifference, bullying, teasing, tattling, and other reflections of children's attitudes toward each other may, in particular instances, have significant influence on personality development.

GETTING ACQUAINTED WITH PERSONALITIES

Enough has been covered in this chapter to suggest the very great complexity of human nature and personality. Stress has been laid on the significance of particular situations and events, which may seem to be of minor importance or be entirely overlooked at the time, in the development of self and personality. These complex, subtle, and often obscure relationships make a minimum understanding of any personality difficult. Nevertheless, the interpersonal relations involved in day-to-day professional services demand as much acquaintance and insight as possible. For this reason it is well to take stock of the principal matters which must be explored if genuine acquaintance and sympathetic insight with persons are to be achieved. The areas sketched below plus the references given in footnotes will provide a working basis for acquaintance with any personality.

1. Biological and physiological data should be as complete as

possible. It is important to note not only facts of race and sex, but also regularities and irregularities of anatomical traits. The history of an individual, extending as far back as prenatal and natal events, as well as including succeeding physiological growth and impediments, needs to be covered as fully as possible. The results of intelligence and other tests are to be brought together for consideration, and if psychiatric information is available it should be included.

2. The general cultural background in which the person was reared needs to be known. And, if the person has moved from any fairly distinctive cultural milieu to one or more which are notably different, these facts need to be carefully evaluated. This is a large order, and some selection of facts must be made. Facts about communication and education, economic levels and standards, moral and world views, religious conceptions and practices, recreational and creative activities, prevailing family values and patterns, forms of government and civic participation, kinds and distribution of property, and class structure are most likely to have implications for personality development in specific cultural environments. It has been suggested that the basic personality pattern is largely determined by the prevailing institutional norms which surround the developing person.

3. The person's neighborhood and the groups of which he is a member may contribute significant clues to understanding the origins of self conceptions, the roles which the person has performed, and the goals toward which effort has been encouraged. Furthermore these data will include facts concerning the reputation of the person, or how he is thought about by different groups in which he has participated. His closest friends and associates may be identified, and their dominant attitudes and values canvassed. The judgments and expressions of feeling by these associates with regard to the person may be suggestive. Sociometric devices may be used in this connection. Out-group identifications and relationships must not be overlooked, because they may give clues to prejudices and negative values. School experiences and progress, as well as any work experience, often prove to be crucially significant.

4. Family data, of course, may prove most crucial for reasons suggested many times already. If possible, it is well to survey the highlights of family history, "to the third and fourth generation." Most families, perhaps, cannot be traced back very far; but when persons are highly conscious of their "family tree" with its status and traditions these may be potent influences on members of the "rising generation." It is equally significant, in some instances,

to know that persons in a family recognize no "roots in the past" nor status on which to base personal pride. Some may even deplore their past family connections and desire to forget or hide them.

Detailed facts on the immediate family are most significant. They should include as much information as possible concerning each member, as well as the relations of each to every other and to the whole group. Reference to family case studies will suggest much that is desirable. But the point of emphasis, when acquaintance with one person in the family is sought, is to learn what each of the others thinks of him and feels toward him. Such expression of subjective matters must be reinforced, of course, by information concerning the actual behavior and relations which members of the family exhibit in their dealings with the one under study.

5. Finally, as much as possible must be learned from the person himself. Dress, manners, poise, and speech give surface clues to deeper concerns. Preferences and goals may be revealed through numerous habits with respect to physical care, food, recreation, work, topics of conversation, and so on. One's character and disposition may be indicated by frankness, lying, temper displays, carelessness, and the like. The extent and kind of participation one has in varied groups and activities is certainly a major clue to what is being sought after. But it is only by "getting inside the person" that self and personality are revealed. Surface indications and activities may be quite misleading. For this reason diaries, letters, interviews, and refined methods of observation are needed. These constitute a complicated field of study in themselves, but all of them are focused upon how the person interprets himself in relation to others. If one can be influenced to take the role of varied persons and "act out" or express what these persons think of him he reveals not only his interpretation of his own status and role, but, frequently, his purposes and goals as well.

FOR INVESTIGATION AND DISCUSSION

1. You will recall Piaget's observation that at one point in the development of moral responsibility in children they placed emphasis on the sacredness of rules and obedience to them as external authority. But later, when these had become more fully understood and cooperatively practiced, they were no longer external but became the free and adaptable expression of the child's inner life. Can you cite evidence that some people do not get beyond the earlier phase of maturity in most of their relationships—trying to find external rules for their own guidance, and insisting also that others conform strictly to conventions?

2. Why does it seem desirable, if one wishes to understand fully the personality of another, to obtain data with respect to the many and varied social situations and relationships in the person's experience? Illustrate fully.

3. What physical defects and diseases contribute most to the social isolation of persons—and with what major results? Cite cases or specific observations concerning such isolation.

4. State as fully as you can the characteristics of the most socially isolated person you have ever known; tell what factors contributed most to this isolation and how long they have been operative. What significance or interpretation do you attach to your observations?

5. If you know of any case or cases which make it appear clearly evident to you that a parent's personality has direct influence on that of child, report details as fully as you can.

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Chapter 5

SOCIETY IS CHANGING IN MANY WAYS

Older people are much impressed with the material and social changes which have occurred in their lifetime. One of these, Bertrand Russell, writing after reaching the age of eighty, regards the period of his life as one of the most eventful of history. He thinks the weakening of the biological aspects of society such as the vanishing of aristocracy and the weakening of the family may prove to be most far-reaching changes. Biological ties are being supplanted by relations to class and state as bases of organization. Since relative peace and optimism prevailed during the first half of his life, he has been impressed with the recent world wars and the reasons for their occurrence. If ways can be found to avoid wars even more totally destructive than these, predictions for changes during the next eighty years seem fantastic indeed. But if wars go on, it is doubtful whether much of culture or society will remain.[1] Although many youngsters may be inclined to take changing conditions for granted, some are wondering how long they can keep pace with rapidly moving social currents.

"WHAT'S NEW?"

New things appear wherever people go. These range from the many little gadgets which tease the fancy of customers in dime and drug stores to television sets and other devices for mass communication, "wonder drugs," frozen foods, robots, terrifyingly destructive bombs, and airships which can be flown faster than sound. Inventions to facilitate rapid transportation and communication have been applied in world commerce and war. Thus, peoples and parts of the earth which had been widely separated throughout ages past have been brought close together in many relationships. Ways of doing things which have been well established in one part

[1] Russell, Bertrand: "The Next Eighty Years." *The Saturday Review of Literature*, Vol. XXXV, pp. 8 ff., August 9, 1953.

of the earth are being learned and practiced where their implications are not understood nor their later results anticipated. Industrialization is spreading to many parts of the earth, and machines are being applied to agricultural production where quite primitive methods recently prevailed.

PEOPLE ON THE MOVE

Accompanying all these changes is a vast movement of people within nations and among them. The recent and practically continuous wars have required the movement of millions of men across continents and into regions differing in climate, culture, and people. Occupational change and physical mobility are required not only of men who give up civilian for military service, but also of many who move from farms to factories. Regarding the movement of 27,300,000 people within the period of World War II, it was said that never before in the country's history had there been so great a shuffling and redistribution of population in so short a time.[2] Although movement of people in connection with war operations is most impressive, commercial and industrial expansion have set up tremendous migrations within nations and between them as well. Few persons indeed who may read these lines will have difficulty in recounting the travels and scattering of their own family members as well as long moves by the whole group from place to place.

THERE IS A "BATTLE FOR MEN'S MINDS"

Along with physical changes, it is possible to detect changes in ideas and beliefs. Educational and religious missions have spread thoughts and points of view from one people who accepted and believed them to those who did not. More recently all that is known about changing the minds and influencing the opinions of others has been utilized to promote acceptance of "propaganda lines" of thought. Some of these efforts are popularly referred to as "ideological" or "psychological" warfare; but aside from major efforts there are numerous minor "drives" by groups "to sell," "missionize," "promote," and "educate" in the interest of some idea or goal. It may be truly said, "there is a battle for men's minds."

With all the rapid and varied changes which are under way it is not surprising that much confusion exists. Although many of the

[2] Landis, Paul H.: *Social Policies in the Making*. Boston, D. C. Heath and Company, 1947, p. 51.

normal or established ways of meeting situations do not seem to be adequate there is a very strong tendency to cling to them and maintain them. Besides, proposals for new goals and methods are so varied and so dominated by the interest of special groups, which advocate them, that uncertainty is deepened. Much hit-or-miss and spasmodic activity consumes the energies of people. Moods of fear and anxiety are rather widespread. And the craving for stability and security is manifested in the multiplicity of nostrums and cults which so many people embrace. Books, of both inflammatory and soothing varieties, gain wide currency. A random list of such books may indicate a medley of prophets, and possibly false prophets, who reflect the critical times: *The Road Ahead, Our Age of Unreason, Peace of Mind, The Mature Mind, How To Win Friends and Influence People, Hope for the Troubled, Witness, The Neurotic Personality of Our Time, Positive Thinking*, and so on.

PERSPECTIVE MAY COME FROM HISTORY

It is possible to learn from an elementary knowledge of history that social change has been continuous as long as man has lived on the earth. Many people either have read the Old Testament or have heard it read. Although it is made up of many books somewhat like a library, it is concerned with the history of the Hebrew people. It deals with changes in economic, religious, political, and family life. It covers many wars and conflicts with out-groups as well as the captivity and bondage in the land of Egypt. Some readers may have also learned something of the history of Greece and Rome, as well as of the Middle Ages in Europe. Others know something of modern European history. And it is presumed that all persons who have completed the grammar grades know something of the history of their own country. Those who can tie these records of past time together may get a long view into the past.

However far back in time one is able to look, men may be seen together in groups, sometimes moving from place to place over the earth, always in some degree of conflict with other groups, always confronted with difficulties, and always changing the ways and systems of doing things. Man is forever clinging to his old ways and trying to maintain and defend them against change. At the same time he is forever changing them. This observation led one poet to say:

> "Our little systems have their day
> They have their day and cease to be."[3]

[3] Nicolson, Marjorie (ed.): *Selected Poems of Alfred Lord Tennyson.* Boston, Houghton, Mifflin Company, 1924, p. 156.

It is important to understand that all that now seems old was, at some time in the past, wholly unknown and, later, was new. Evidence seems to indicate that every new development was more or less disturbing and confusing at the time of its introduction. Few, indeed, of any particular significance were accepted and incorporated in culture without some resistance. For any situation to be socially undefined really means that no standard way of dealing with it has been developed, or accepted. Thus, changes, whether originating from outside or inside group life, constitute problems, or situations with which people must deal without knowing how. It should be obvious that, if changes become especially numerous and various within a relatively short period of time, the resultant widespread confusion and uncertainty might well be considered a crisis. A brief review of history, whether that of Hebrews, Greeks, Romans, or modern nations, will show critical periods and rather sharp crises. Adequate ways were found to meet some of these; in others, the total system was broken down. Although Egyptians, Hebrews, Greeks, Romans, and other peoples have descendants on the earth today, the social system which was formerly established in a particular area and identified with each has not held together, nor been further developed by them. This does not mean that what they learned and established was lost. Much of it forms the basis of modern life, such as Judaic religion, Roman law, and Grecian mathematics, philosophy, and literature.

CRITICAL PERIODS HAVE OCCURRED IN THE PAST

These brief historical allusions should make it clear that many critical periods have occurred in the past. Man has weathered many times of great confusion and anxiety. It is possible that the increasingly complex and world-wide relationships of our time, plus the rapidity with which they are emerging, confront our age with a more intense crisis than was experienced at any other time. But crises are likely to appear equally baffling in all ages. Although the power to wipe out people as well as social systems now exists, it might have seemed so before. Professor Robert Redfield states that "in time of great crisis the minds of men imagine a future that is different from the past."[4] Thus times of crisis must not be thought of as wholly filled with danger and destruction; they may also be times of greatest creativity and advance. The Renaissance and the Reformation were periods of great crises, and, thus, great development was possible.

[4] Redfield, Robert: *The Primitive World and Its Transformations.* Ithaca, N. Y., Cornell University Press, 1953, p. 124.

Men now are thinking of United Nations and World Peace. Because they are thinking of these things they may modify their old systems to bring them about.

WHY SOCIAL CHANGES OCCUR

Although norms of behavior have been learned from childhood, this does not mean that most ways of acting are as set and uniform as the execution of military drill by well-trained soldiers. Such is far from true; there are wide variations in such matters as pronunciation and usage of words, the utilization of foods, conformity to fashion in dress, and so on. Standards and practices are certainly quite different among subcultures, which might be represented by the ways of living in a backcountry New Hampshire town and in an Indian American Village in New Mexico. Robin Williams has called attention to the fact that many norms are ideal, and that actual behavior follows an alternate or evasive course. Thus, the Kinsey reports of sexual behavior indicate wide variations in practice from the prescriptions which are most frequently assumed. Similarly, many business practices contrary to public interest and general welfare are labeled as "racketeering" and "chiseling," but are tolerated under the slogan of "business is business." There are of course many variations from norms by persons who openly rebel against established usage. One might think of illustrations as wide apart in significance as nudism and communism.

Deviations May Get Acceptance. Theoretically, at least, every variation from normal or expected behavior may "catch on," or receive attention. If accepted and practiced more and more widely, social change has occurred. A new way of behaving has become normal. A few years ago the practice of smoking cigarettes was largely confined to men. Smoking by women was regarded as degrading or immoral—found among "Bohemian" and lewd persons. However, under skillful advertising and feminist stimulation, and as a symbol of freedom, perhaps, more and more women ventured to smoke. The variation graduated into wide acceptance and usage. Several other changes with respect to the place and activities of women arose as variations from common usage.

Trial and Error. It seems probable that most of the social changes which have occurred in the past were "hit upon" as solutions to current problems. In his profound book on Folkways, William Graham Sumner said:

> Men begin with acts, not with thoughts. Every moment brings necessities which must be satisfied at once. Need is the first experience, and it was followed

at once by a blundering effort to satisfy it. . . . The method is that of trial and failure, which produces repeated pain, loss, and disappointments. Nevertheless, it is a method of rude experiment and selection. . . . Thus ways of doing things were selected, which were expedient. They answered the purpose better than other ways, ... habit, routine, and skill were developed. . . . All at last adopted the same way for the same purpose; hence the ways turned into customs and became mass phenomena. . . . The young learn them by tradition, imitation, and authority.[5]

For instance, seeking of advice from experienced and competent persons by those who are having difficulty has been practiced, no doubt, as long as society has existed. Generally, perhaps, the elders of a tribe or community were the ones who gave counsel. It almost goes without saying that parents have always given advice and counsel to their children. Throughout centuries, people have turned also to their religious leaders for guidance. But, more recently, so many families have run into difficulties, and so many young people have not known what to do about vocational and other choices, that the former sources of help proved inadequate. The necessity for advice and counsel has not yet been solved, but the rise and spread of counselling services of many kinds is a decided social change. At first such services were provided here and there by persons without much special training or clear-cut understanding of what was needed. But from the trial-and-error methods in many places enough experience is developing to indicate some of the training which counsellors of various kinds should have. Out of a generally undefined situation in which needs were genuine but vague, and services were nil, rather clear and efficient counselling services are being established.

It would take a long catalogue indeed to list the changes which emerge through trial-and-error experience. Unfortunately, many of the "solutions" which are evolved and accepted through this process are either only slight improvements, or, worse still, lead to even greater difficulties by their very hit-or-miss character. Thus, the biblical statement that the last state of affairs may be worse than the first often results from hasty or ill considered action. This is especially true of regulations which are set up in times of genuine emergency or on account of unusual pressure from a special interest group. It is likely, for instance, that prohibition laws were passed before people were ready to support them. A better illustration of "established error" can be found in the patterns of punishment which were set up to reform those who do wrong and to prevent others from committing forbidden acts. Many of these are continued

[5] Sumner, William Graham: *Folkways*. Boston, Ginn and Company, 1906, p. 2.

after the reasons for their ineffectiveness are quite evident to thoughtful persons.

Research and Invention. It is quite proper to refer to changes which come about through trial and error as inventions. When man confronts a problem situation, and feels impelled to do something about it, he often comes up with a way to meet it satisfactorily. Such a small matter as passing to the right when meeting another in order to avoid confusion and collision is an invention. After it is accepted and transmitted from generation to generation the problem of those who want to go by each other in opposite directions is solved. This represents the manner in which most ways of doing things were arrived at.

But many difficulties are not quite as simple as that of by-passing those who are met on the road. Considerable thought and investigation is often necessary before any explanation and approach to complex problems can be made. A number of diseases, such as typhoid fever, malaria, and diphtheria, were baffling for many years. By rather continuous and broadly based investigations the essential relationships pertaining to these diseases were learned, and ways of controlling them were discovered. Similarly, more knowledge concerning such problems as juvenile delinquency, alcoholism, and unemployment is giving rise to inventions for dealing with them. The relation of research to invention is more clearly recognized perhaps in the steady stream of new chemicals, machines, weapons, and other devices which flow from the application of basic knowledge gained through research. The invention of new means of production, transportation, and communication seems practically unlimited. Not only have people in western nations experienced one industrial revolution as the result of the application of steam power, but they may be said to have entered further revolutions with gasoline and electricity as sources of power. The "atomic age" is dawning with even more far-reaching changes in prospect.

Borrowing and Diffusion. Western peoples have come to expect technological changes, and other parts of the world are moving in a similar revolutionizing course as one people after another learns to use modern machines. This illustrates the fact that inventions which were discovered and utilized by one people may be *borrowed* or accepted for use by another people. This spread of cultural complexes or patterns from place of origin is technically called *diffusion.* There are many factors which influence diffusion, of course. People may learn about the ways and inventions of others through almost

any form of contact or communication. We know, for instance, that missionaries become the means of spreading more than religious ways and ideas. They carry medical, agricultural, and other technological methods as well as philosophical and political ideas. Capitalists, traders, and salesmen foster new ways among varied peoples. And, in our time, all means of propaganda and counter-propaganda are utilized to spread political and economic inventions across cultural lines. In addition, of course, peoples learn a great deal from each other through war. In spite of the fact that war is a state of conflict in which groups are seeking to destroy each other, nevertheless they learn as much as possible about each other's weapons, methods of training, medicines, and techniques of healing. There is, perhaps, more osmosis of ideas and points of view among the common soldiers than their leaders like to think.

LIMITATIONS ON SOCIAL CHANGE

The Culture Base. In spite of all the sources of change which have been sketched, there are many limitations on the number and variety of changes which may occur. The state of development which a particular culture has reached is called the *culture base.* We sometimes refer to some peoples as uncivilized, or retarded, or underdeveloped. This means that people have built their discoveries and inventions up to some level which is maintained with a minimum of change and complexity for long periods of time. Robert Redfield states that "in primitive societies uninfluenced by civilization the future is seen as a reproduction of the immediate past . . . the ways of life, the things to try for and realize, remain the same."[6] The probability and the possibility of changes in a primitive society are limited by the type or degree of previous development. This is true of people who have a narrow way of life anywhere. Our American Indians, some mountain people, and those who live in swamplands or "mined out" and "cutover" regions are cases in point.

Communication. Another factor which limits the number and variety of changes which a people are likely to make is that of communication. This factor is usually expressed negatively as the factor of isolation. People are limited not only by what they have not learned, but also by lack of opportunities to learn. People who are separated by land forms, wide expanses of water, intensely hot or cold climates, and such barriers as language, religion, and educa-

[6] Redfield, *op. cit.*, p. 120.

tion are not likely to change their ways very much. There are few comparative conditions or contacts for suggesting new ideas. Isolation tends to dull awareness and slows access to new learning and new ways.

Intergroup Relations. Although the character of social relationships is too complex a matter for full analysis here, it should be mentioned that antagonism between enemies at war does not block all change, but actually promotes some. In general, however, the existence of unfriendly relations between people limits the kind of changes likely to be considered and accepted. Missionaries and salesmen are not likely to introduce many new ways among people if they are unsympathetic and unfriendly or find people similarly disposed toward them. This matter may be more clearly understood after a brief discussion of resistance to social change.

Resistance to Social Change. It has already been stated that very few changes are accepted without some resistance. A ready market for nearly every kind of gadget which is offered to the public may seem to exist. But professional salesmen constantly work against what they call "sales resistance." They find many people who pay little attention to what is offered for sale, and many of those who do show some interest give various reasons for refusing to buy. Yet resistance to new merchandise is mild compared with that which develops against new ideas and beliefs. Proposed changes in government, property, education, family, and education are often vigorously opposed. And when any changes in these institutions are introduced, resistance often continues—sometimes to the point of forcing a return to former practices.

It may be recalled that established folkways tend to persist because of general preference for whatever is familiar plus avoidance of effort required for change. The mores are more than familiar—they are revered and sacred. Thus, most of what has been learned and expected in the past is likely to offer opposition to change. Changes which break sharply with precedent often create fear and violent opposition. Louis Pasteur, who proposed the germ theory of disease and gave both public and private demonstrations to support it, was ostracized and treated as an enemy of society. Similarly, Dr. W. T. G. Morton, who is credited with the introduction of anesthesia into medical practice, was opposed and discredited by his peers and many of the clergy, who objected on moral grounds. More recently, Sister Kenny experienced much opposition with respect to her method of treating patients afflicted with poliomyelitis.

Resistance to change is, perhaps, greater among older persons.

Because younger persons are inexperienced and necessarily engaged in learning ways of doing things, both old and new ways tend to be equally acceptable. It is probable that a wholly new system of society could be taught a young generation if the young were entirely separated from their elders. The youth movements fostered by Hitler and Mussolini for the purpose of instilling fascist doctrines and methods achieved such separation to a large extent. German and Italian youth, when thus separated, came to accept ideas and practices which would likely have been resisted under the normal relations of different generations. It must not be overlooked, however, that whatever ways young people do accept tend to be rigidly adhered to. Adolescents and young adults frequently become the patrons of new cults or faithful advocates of some older system. When conviction of the proper things to believe and do becomes widespread, youth may be as impervious to change as are adults.

It has been said that we are living at a time when individuals have little power or significance. This is another way of saying that individuals are lost or lose themselves in groups, and through these groups collectively assert and seek their special interests. It should be obvious that such groups are likely to resist changes which are interpreted as contrary to their special interest. If any economic, political, religious, or other groups have obtained any prestige or advantage in the past, resistance to anything which threatens their privilege or position is certain to develop. The most apparent resistance of this sort which can be observed in almost any part of the world is concerned with class and racial advantages. Classes, races, and religious sects which have been enjoying economic, political, and other forms of dominance and privilege are threatened by changes which seem likely to alter their position. Ironically, those who resist change most vigorously are frequently the unconscious means of setting the changes in motion.

SOME MAJOR CURRENT CHANGES

The most impressive changes of our time are technological. For the most part they are not directly social. The factory system became possible because the steam engine was invented. This source of power could be harnessed to run many machines by means of a system of belts from the large drive wheel of the engine. The clustering and organizing of machines about an engine was the technological change. But, in order to operate the machines, people had to change their dwelling place and their work. They no longer pursued handcrafts in their widely separated homes or guild halls.

Some gave up agricultural pursuits and formed towns around the factory. This amounted to a social and industrial revolution because it involved changes of type of occupation and type of production, place and type of residence, kind and amount of income, dependence and relation to workers and employers, and so on through practically every detail of living. New industrial towns and cities required street layouts, sewage disposal, merchandising supply, and many other patterns which had not been needed before. Furthermore, changes were rapid and numerous, compared with the slower pace and gradual changes which occurred under rural handcraft production. The factory was relatively large and complicated, and it came into being with comparative suddenness after basic inventions had been put together.

TECHNOLOGICAL REVOLUTION

Since the steam engine was invented and geared to spinning and weaving devices, thereby displacing those operated in homes by hand and foot power, a stream of other technological changes has continued. Steadily more efficient and powerful machines have been applied to agriculture. These have been the means of releasing persons necessary to agricultural production from farms. The growth of factories has been accompanied by the flow of population, no longer needed in agriculture, to industrial and commercial towns and cities. One agricultural worker, using modern methods, can now produce enough to supply the needs of about twenty persons. These changes on farms and growing towns have been reinforced by those in transportation.

Reference to "horse-and-buggy days" is sometimes made to express impatience or contempt for backwardness. Yet the replacement of horse-drawn vehicles moving over rough roads by powerful cars, busses, and trucks traveling at high speeds over wide surfaced highways has occurred almost within one generation. Certainly, the rapid development of air transport is a very recent matter. The phenomenal changes in communication have also kept pace. The telephone and telegraph created tremendous breaks with the past since they made possible rapid communication over wide areas. But the invention of radio and television brought whole nations, and untold millions living inside the borders of other nations, within the hearing and sight of speakers and performers located at almost any spot in the world. Furthermore, the wide coverage and transmission of news to be rapidly typed and printed marks a further revolutionary change in communication among people. Regardless of where

people live, they are increasingly forced to consider their relationships with those who, until recently, seemed far away in distance and in significance.

It would certainly require more than one book to recite the major technological changes which have been widely accepted in the past two or three generations. The applications from chemistry along with other types already suggested have transformed many personal and household practices. Changes in foods, drugs, cosmetics, clothing, utensils, paints, plasters, and other categories may be listed by any person who takes time to review what he knows. The list could be expanded by consulting catalogues of merchandise or the advertising which constantly press on our sense organs from many sides.

CHANGES ALONG WHOLE CULTURAL FRONT

What has been said about current changes fits into the frame of reference which was suggested at the outset. Technological changes fall under the analysis of material patterns. The patterns of language have not been mentioned, but changes in the means, amount, variety, and speed of communication affect language indirectly. The number of words in the language is certainly expanding as new inventions and processes require names and description. Wider travel, reading, and war relations bring many foreign words into the language and widen usages which before were limited to fewer people. Any detailed or even general analysis of language changes is beyond the scope of this book. But even an amateur may find further study very interesting and worth while. Certainly the language changes within particular groups and sub-cultures might prove both useful and interesting.

Social change could be analyzed with respect to every major institution included in our basic frame of reference. It is certainly quite obvious that changes are occurring in our political and economic institutions, our educational system, our health and welfare practices, our family life, our recreation, our organization of industry, and the ways we conduct wars. Even our religious institutions are undergoing some changes which can be recognized. Although science is not changing basically, perhaps, there is no doubt about the wider application of scientific method—especially with reference to the nature of society itself. All of these cannot be spelled out in detail here. One or two seem to require brief mention.

It is understood, of course, that this book will emphasize changes in practices concerning health and nursing care. Because family

life is so basic to physical and mental hygiene, as well as to character and personality development, many changes in the family system will be described in Chapter 8.

In a sketchy sort of way some reference to changes in recreational patterns may be made. These are closely connected with technological changes in transportation and communication, and in the manufacture of games, toys, and machines for amusement. There is a further connection, in that machine production and automatic devices of many kinds have made it possible for people to have more "time on their hands" which can be applied to recreation. It is not surprising that the number and variety of recreational outlets have multiplied tremendously. Commercial recreation has been greatly expanded to provide shows, games, races, fights, festivals, and other events for the amusement of masses of people assembled together. In addition, various types of amusement and entertainment are provided through radio and television for exceedingly large masses of people who are not assembled in physical proximity. Besides these mass recreations there is a flow of toys, games, and equipment which persons are encouraged to utilize on a mass or fashion basis in one succession after another. Children may be encouraged to dress in "wild-western" garb, including hats, shirts, chaps, and shoes, and to be equipped with more or less realistic two-gun outfits. They can then run about, yelling and in pretense shooting, killing, robbing and otherwise enacting the mythical life of the past. This may be succeeded by the purchase of suitable garments and equipment to enact the mythical life of the future, with people moving about through outer space—often to continue their adventurous killing of each other. In addition to commercial enticements for amusement, many creative arts are pursued individually or by small groups.

Some attention to new methods of warfare can hardly be avoided. The involvement of the whole people in war rather than its restriction to fighting men on battlefields is the most striking change in war practice. The object of war has always been to destroy the enemy's power and will to fight. But until recently belligerents in modern warfare exercised some care against needless destruction of noncombatants and property having no utility for war. With the advent of air power and increasingly destructive bombs, "target areas" may include whole cities; and the specter of "biological warfare" includes the spread of disease and the wiping out of sources of food. Thus, the latest methods and conceptions of total war make

widespread social destruction possible—even the foundations of society could be annihilated.

SOCIAL CHANGES AND SOCIAL STABILITY

Without any further survey of the many and diverse changes which are now under way, some of the implications of social change may be examined. An understanding of these implications may be aided by returning to the former comparison of structure and functioning of society with that of a complex organism. It is known that health of an organism is concerned with the balanced and integrated functioning of all parts so that needs and objectives of life are met. Any change in a tissue or organ may disturb the normal relation and balance of other parts and processes. Changes may be introduced from the outside by the entrance of chemicals, physical objects, or microorganisms, or they may arise from inside the organism. Changes may be slight and disturb the normal balance so little that they are hardly noticed. On the other hand, changes may disturb organic balance in varying degrees, and resulting illness may even reach the point of complete disintegration.

SOCIAL DISORGANIZATION

Without straining the analogy too far, it is suggested that health may be defined in terms of organization and balance, whereas disease is a matter of imbalance and some degree of disorganization. Social organization refers to the balanced functioning of all parts so that needs and objectives of social living are continually maintained. It has been pointed out repeatedly that groups come into being and exist for the achievement of ends or purposes. Furthermore, the major institutions of society have been established through long experience as means of obtaining the major needs of man through the society he has evolved. The institutions which give structure to society, and the groups which function according to institutional norms, all are interrelated and more or less integrated. Thus, social change means that structure and function are altered. The change may be slight indeed, such as the introduction of a new toy or game. But any change which is accepted requires some readjustment. The invention and introduction of a complex mechanism such as the automobile or airplane is bound to upset many established relationships and usages. Complex adjustments to such devices may continue through a generation or more. If many and various changes are introduced within a relatively short period of

time strains will occur in social organization. Extensive and complex changes create periods of imbalance of long duration. We are now living in such a period of imbalance and disorganization. One does not have to be a prophet to predict with much confidence that the period of instability and confusion is likely to continue for many years before relative equilibrium can be restored.

SOCIAL PROBLEMS

Although the whole view of health and disease, including the germ theory, is of highest importance, we are actually confronted with specific cases of illness. In complex cases of illness, it is often difficult to clearly determine the origin of or the factors producing the imbalance. If any rational treatment is undertaken, it is necessary to get at the basis of disturbance. Similarly, it is of the highest importance to understand the nature of imbalance and disorganization in society. Actually, we are confronted most frequently with specific instances and types of disorder rather than the total disorganization of society. For practical purposes it is essential to discover specific relationships which are out of adjustment if any rational approach to problems is to be found. A stock illustration in technological relations is that of the increasing height of buildings while the width of streets remains about the same. This may be observed in almost any growing city. Because so many people want to have their stores, shops, and offices located near the business center it is necessary to erect taller and taller buildings. Since streets are not widened correspondingly a load of traffic is thrown upon them which they were not designed to bear. This imbalance between height of buildings and width of streets results in what is called a traffic problem. In order to try to solve it some cities have enforced one-way use of streets, or built double-decked streets and subways. Another approach is that of decentralization whereby subcenters are developed. These do not emerge primarily to relieve traffic congestion perhaps; but this result is achieved to some extent through dispersal.

Culture Lag. Numerous additional illustrations of technological imbalance could be cited, such as that of roads with many curves being retained while the potential speed and power of motor vehicles are greatly increased. The roads which were built to accommodate horse-drawn vehicles of another period are frequently not changed; but they are quite unsuited to high-powered vehicles of recent invention. Such instances of change in one aspect of culture without corresponding change in a definitely related part is called *lag—culture*

lag. When two or more related parts of the culture change at different rates, the lag in adjustment between the slower and the faster development creates imbalance.

Some of these lags may be direct and obvious, whereas others are indirect or derivative. A much more complicated relationship which can be pointed out, but is not fully analyzed here, is that of county size and means of transportation. In a general sort of way the size of counties was limited on the basis of convenience for citizens to make a short journey to the seat of their local government. Consequently, the greatest distance from county seat towns to the outer borders could be traversed in a day in horse-drawn vehicles. With motor-driven vehicles moving over modern roads, trips from border to county seat may be made in a few minutes. Thus, the size of county units no longer bears the relation to transportation which formerly prevailed. Also, concurrently with this change, the costs of county governments have greatly increased, and populations have increased in some counties and diminished in others. Thus, in several ways, counties as originally laid out are frequently out of balance with respect to related changing conditions. However, any proposal or plan to bring about a better balance will be vigorously opposed by those who see no connection between one pattern and another. They cling to the county unit as an end or value in itself. It may be valued as the place of birth and the homeland of families, and as such it is revered and not to be tampered with.

Social Values. Some specialists are inclined to emphasize culture lag as the chief source of social problems; others stress values and the conflict of values as the essential source. Actually, many concrete social problems are rooted in differing rates of technological change or in social change. But it is a fact that a social problem does not exist until and unless value has been given to some particular condition or relationship. This is well illustrated in matters of sanitation. Many conditions and practices existed for a long time before they were valued as insanitary. The use of the common drinking cup in public places existed a long time after its disease-carrying potentiality was known. It was only after the practice was valued as insanitary, dangerous to health, repulsive to good taste, and bad manners that it became a social problem. Even then, it remained a problem for a long time because of the indifference of some persons in conflict with the reform attitudes of others.

To repeat, new inventions and differing rates of change often produce confusion and maladjustment. Much of the confusion and misunderstanding derives from differences in valuation and inter-

pretation of what has taken place or what conditions actually exist. It is for this reason that symptoms or by-products may sometimes be mistaken or confused with central problems. Thus, staying away from school, or truancy, is contrary to institutional norms, and is valued as evil. Truants may be hunted, forced to attend, guarded, and punished to insure school attendance. Truancy is thought to be the problem, and efforts are made to "solve it" by various pressure upon the truant. Actually, the essential problem may be concerned with values placed upon education by varied families and their interpretation of the relevance of curriculum to the life needs of children, and so on.

Too frequently, perhaps, professional persons become so highly specialized that they fail to see the relation between matters with which they deal and other social problems. For this reason, the next chapter will present a brief survey of some major social problems relevant to the profession of nursing.

FOR INVESTIGATION AND DISCUSSION

1. Use the "universal culture pattern" on page 23 as an outline, and list under each heading a number of major technological, cultural, and social changes which have occurred within your own lifetime.

2. In the first chapter of this book it was stated that culture is the organization of a number of interdependent systems. If this is true, any major change in one system would be likely to produce changes in other systems. Test this as far as you can by examining the changes in other relationships which seem to be associated with the changes in transportation developed by the automobile.

3. The idea of culture lag is a well known hypothesis concerning the differential rates of change, especially of changes in material patterns in relation to non-material such as government, education, family, etc. Can you cite evidence from current changes or in the history of medicine which appear to support the hypothesis?

4. From your knowledge of history or recent current events, cite as many instances of resistance to social change as you can recognize. Do you recognize any instances of such resistance with respect to any matters connected with medicine, nursing, or public health?

5. If you recognize any instances of confusion or conflict of ideas which seem to grow out of social changes in recent times, state the pertinent facts as fully as you can.

6. Expand the list of changes which have developed from a wider acceptance of ways formerly regarded as deviant or abnormal behavior.

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Chapter 6

SOCIAL HEALTH AND SOCIAL PROBLEMS

A deeper understanding of society may be gained through a symbolism of health and illness. We judge health and vitality by the strength, endurance, enthusiasm, and alertness which persons are able to bring to bear upon the pursuits and objects of living. Unity and economy of action are due to the coordination and functioning of all interdependent elements. On the other hand, ill health is observed in those who have defects, or who develop some break or functional disorder in a part or system which is essential to organized and effective effort.

SOCIAL DEFECTS AND DISORDERS

It is more than a figure of speech to think of the defects and disorders of society as forms of illness. It has been emphasized already that what is called progress or achievement is due to the coordination and organization of various persons and groups which make up society. The combined strength, intelligence, and endurance of many people must be brought to bear if social objectives, ends, or goals are to be gained.

If the organization of persons and groups is defective in any way, or if functional relations become broken or inadequate, society may become weak and incapable of obtaining its goals and may be unable to maintain its existence. Just as physical and mental ills cannot be most intelligently and effectively treated until they are understood, it is likewise unprofitable to undertake the treatment of social disorders without making the best possible diagnosis. More important, perhaps, a thorough understanding of the nature of social disorganization and certain specific disorders may open the way to preventing their occurrence.

The meaning of social health and disorder can be more readily grasped by the person who will *systematically examine as a microscopic model of society as a whole the immediate organization of which he is a part.*

Some of his most vital relations might be concerned with a church, a business corporation, a manufacturing concern, or an educational enterprise. Since this book is written primarily for the use of nurses, and since all of them are at one time or another a part of a hospital organization, attention will first be focused on hospital life and organization. It will serve for the moment as a "model" for society. After some thought is given to hospitals and their organization it should be possible to relate them as mere parts within the total health organization of society which is aimed at maximum achievement of physical and mental well-being for the greatest number of people.

"HOSPITAL WORLD" AS MODEL SOCIETY

Physical Structure. Whether a hospital is large or small, it is a social unit organized to provide medical services and skills for people who reside in the area it is designed to serve. If the physical structure of a hospital building and its physical equipment are examined first, it may be observed that they have been planned to facilitate the social organization. The beds for patients, the supplies, and the technical devices, as well as the divisions, wards, special laboratories, and x-ray, operating, and delivery rooms, are so related to each other in space that functional relations and service aims are most economically advanced. In passing, it should also be noted that the physical structure of many hospitals makes it possible to separate sexes, races, and classes in a manner corresponding to their relations in the larger society outside. Private patients who occupy the most attractive rooms are likely to come from the upper and middle classes, and wards may be graded downward in cost or otherwise so that lower strata, ethnic groups, or races are segregated. When this occurs it may facilitate service and management, and may not necessarily be accompanied by prejudice and preferential treatment as might be likely in the larger society. It should also be noted in connection with the physical structure of the hospital that when any part becomes defective, proves to be inconvenient, or obstructs desired functional changes, it may precipitate difficulties in the social organization of the whole.

Diversification and Stratification. In order to carry out this idea of using the "hospital world" as a limited model to illustrate social organization and some of the principal causes of disorganization, several highly competent and experienced nurses were asked to cooperate with the authors. On the basis of their varied experience they were asked to construct a diagram or figure to represent

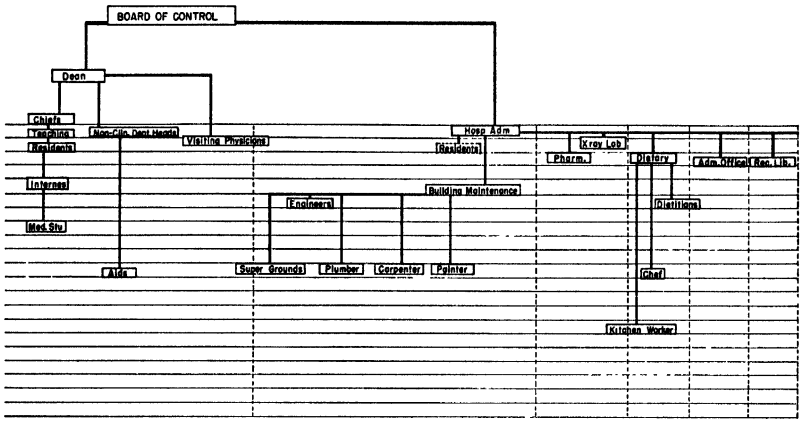
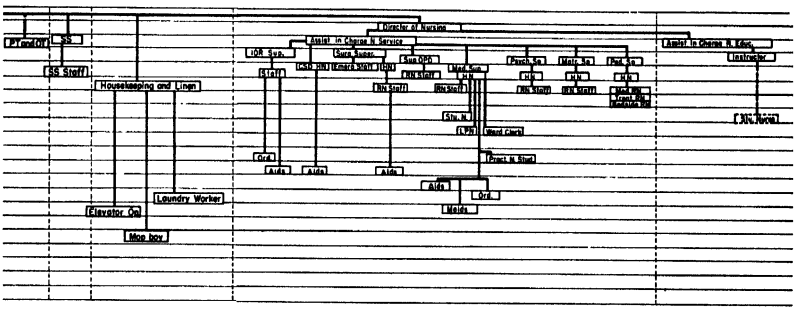


Fig. 3. Diversification and

as nearly typical hospital organization as they could agree upon. They were to show all the various services in their diversified relations to each other and the strata or levels of personnel within each. Furthermore, they were asked to let the horizontal lines running across all services represent approximately equal levels so far as prestige, authority, and income might be estimated. These lines furnish a crude determination of status or rank within the total relationships. Whether readers, experienced in hospital life, agree with all details of the "model" or not, there will be general recognition of diversification and stratification of personnel in hospital organization (see pages 43–46). Every person has a role or function to perform, and status or position, with reference to others. The organization of any hospital will be rather clearly stratified, and the separate organization of services will correspond to the major divisions of labor which enter into the combined effort focused on saving lives, curing disease, relieving pain, and restoring people to their normal occupations. Figure 3 shows a governing board at the top which is responsible for the general policies and policy decisions by which the whole is operated. Immediately under the board are the persons who administer or put into practice the policies. Responsibility for administration is lodged in one person and his assistant, but below these a number of persons are necessary to give direction to each of the major divisions into which the total work is divided. Under many of these an assistant director is required, and so on down to a level of supervisors and other heads, through various levels of specialization and responsibility, to the least skilled and specialized labor at the bottom.



stratification in "Hospital Society."

Interdependence and Organization of All Parts. Every person may be related or interdependent with others at the same level, and of course the levels are arranged so that persons at each level must discharge their responsibilities if those below and above them are to function as expected. In a very real sense any breakdown, conflict, confusion, or disorder of any kind with respect to the work of one or more persons will disorganize the whole hospital to some extent. It should be obvious indeed that a series of minor disturbances or major conflicts may disorganize the whole to varying degrees of seriousness. Smooth operation of all persons and facilities is desired even to the point of anticipating many sorts of emergencies and disasters; but there are limits beyond which disturbances cannot be met.

Problems in "Hospital Society." In order to set forth more clearly the specific character and wide variety of problems which may occur within a social organization, a number of problems within hospitals will be pointed out. Before listing these it is desirable to mark some of the most notable changes now under way in most hospitals: (1) new discoveries and technological changes which facilitate more accurate diagnosis, effect more rapid recovery, shorten stay of patient, increase costs, and so on; (2) increasing specialization within medicine and technical staff, so that interdependence and problems of communication and articulation are increased; (3) shifting of functions or redefining roles so that persons are expected to do things they were formerly not expected to, while they see others doing things formerly associated with their own "sacred duties"; (4) some tendency toward change of objec-

tives or, rather, change in emphasis whereby concern for the cure of specific ills is expanded to embrace the patient as a whole person; (5) a similar increasing emphasis upon maintenance of health and prevention of illness, even perhaps to the point of receiving more attention than curative medicine; and (6) competition of economic objectives with professional goals for dominance, with the result that the two aims may become confused or contradictory. Many chapters would be necessary, to enlarge upon these changes; and additional chapters could be written on the interpersonal and intergroup relations within a hospital which can make for smooth operation or, through conflict, upset the place from end to end. Space forbids much more than listing or briefly describing a number of situations which disorganize hospital life.

Problems of Doctors. Doctors have their troubles and some of them create trouble. Greer Williams, public relations director for the American College for Surgeons, reported on "Unjustified Surgery" in *Harper's Magazine* of February, 1954. He defines unjustified or unnecessary surgery as "an operation which is not supported by careful clinical reasoning and judgment and not confirmed in diagnosis by any disease actually found." He states that one third and possibly half of the major surgery is done by M.D.'s who fall short of accepted standards; and what he calls commercial surgery is being done mainly to enrich doctors. Only a few, of course, possibly two or three on a staff of ten to fifty, are doing much inexcusable surgery—appendectomies and hysterectomies seem to be most profitable. It is rather ironical that technological developments have made surgery so safe that "even lay imposters can get away with ordinary operations if the patient is in good condition."[1] The point is that a few persons who do not accept the trust and responsibilities usually associated with their professional roles are able to disturb the whole medical structure and organization. Tissue committees and committees to review records of practice are set up by those interested in high standards and in protection of patients through control of this internal problem of the profession.

Other types of situations in hospital relations are disturbed by individual doctors who insist upon the subordination of others to serve the dominant role of a medical prima donna, or an admiring self-taught teacher. Not infrequently the interne or resident physician feels that he does most of the work while the doctor in charge gets

[1] Williams, Greer: "Unjustified Surgery." *Harper's Magazine*, Vol. 208, No. 1245, p. 35, February, 1954.

the credit.[2] Such interpersonal conflict may not be significant in terms of hospital hierarchy, but it may be the cause of individual frustration. This frustration may find expression through impatience with subordinates and quarrels with fellow workers. Although the assertion or assumption that hospitals exist to serve doctors sets up the problem of objectives within some organizations, it can only be cited to further suggest the multiple sources of disorganization.[3]

Problems of Nurses. A recent study of role relationships among nurses and between nurses and non-nursing personnel in hospitals[4] makes possible the brief review of some further problems of hospital organization. The study is particularly significant at a time when some nurses are expected to discharge certain functions which were formerly performed only by doctors; at the same time nursing aides and practical nurses are being brought into hospitals to do things which were heretofore expected only of registered nurses. Furthermore, nursing functions are becoming more highly specialized, so that some are doing psychiatric nursing, others are anesthetists, and others may be strictly responsible for medications. It seems safe to say that all nurses must devote much more time than ever before to the keeping of records. In the course of these changes in roles or functions to be performed by nurses there is considerable confusion among nurses themselves as to what their status and role may actually be or become; and this leads some to feel insecure or to become antagonistic. They find greater demands for theoretical education and rigid training on their part without very much evidence of corresponding rewards. They also see many symbols and collective representations, such as white uniforms, being practically infringed upon by others of lesser status. Oftentimes among the administrators, there are those who like to dominate others, and who derive almost sadistic delight in repressive discipline and authoritative measures which discourage effort and lower the morale of subordinates. Some persons in top positions have not learned to delegate responsibility and perform detailed work which rightfully should be done by subordinates.

The study revealed cliques whereby certain nurses identified themselves with a particular service and held themselves aloof. They

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[2] Smith, Harvey L.: *The Sociological Study of Hospitals.* Ph.D. dissertation, University of Chicago, June, 1949, pp. 94 f.

[3] *Ibid.*, p. 81.

[4] Ford, Thomas R., and Stephenson, Diane D.: *Institutional Nurses: Roles, Relationships and Attitudes in Three Alabama Hospitals.* Tuscaloosa, University of Alabama Press, 1954.

regard certain services such as private duty, operating room, surgery, obstetrics, and the like as superior, whereas emergency and "service" may be assigned lower status.[5] Cliques display their attitudes by various forms of non-cooperation in such matters as lifting patients, getting work done on time, sharing supplies, accepting responsibility when not clearly defined, such as answering lights, cleaning pantry, and changing beds. This also suggests that each person thinks of himself as responsible for a certain job, but if he is assigned a multiplicity of things the definition of duty becomes blurred, and some things are evaded or overlooked. Evasion of responsibility or personal conflict may occur especially when the chain of responsibility is not clear. When it comes to the relations with non-nursing personnel, one thinks immediately of the traditional prestige and higher status of doctors which may induce fear or antagonism in some nurses. Some older nurses and students were observed to handle situations without awe, fear, or antagonism. Some doctors appear to maintain their superior position by keeping their reasons and plans for treatment obscure and refusing to allow nurses to communicate significant matters concerning conditions and progress of the patient, which in many instances would allay anxiety and promote rapport. Nurses may also find their relations to male attendants difficult, partly because of the level of understanding and competence in persons attracted to such low paid jobs, and, perhaps, because many men resent being in positions subordinate to women.

Hospital, Part of Whole Society. This catalogue of problems or types of problems within hospital organization could be extended indefinitely. It could be expanded to services and divisions other than medicine and nursing, such as the dietary or technical services. Personnel in these departments also have their troubles, and often resent the lack of recognition their contribution receives. *It has been the chief purpose of this review to develop a basis for comparing hospital life and organization with other major forms of social endeavor, and with the larger organization of society as a whole.* Highly specialized persons and groups are bound together in an interdependent relationship and must perform their separate functions in an orderly and unified manner if the hospital as a whole is to maintain its existence and reach its objectives. Any conflict among persons or groups, any independent, indifferent, or incompetent performance of roles, any unbalanced, inadequate, and disorganized services or subdivisions are likely to weaken and endanger the whole.

[5] *Ibid.*, pp. 60–65.

THE HEALTH OF ALL THE PEOPLE

Revolutionary Improvements. It may now be possible to move from hospital organization to the larger organization of health services in society. The improvement of health and general well-being of people throughout the United States during the last fifty years has been phenomenal. Through the application of increased knowledge concerning the nature of many diseases and the conditions under which they occur it has been possible to bring many of them under almost complete control. Probably the best abstract measures of the changes which have taken place and the best indication of goals which may be set up for future achievement can be found in reports and summaries of vital statistics.[6] It requires imagination, of course, to estimate the relief from suffering, prevention of disability, saving of vitality, and checkmating of premature death which are implied in statistical figures. Consider, for instance, one of the major evidences of achievement—the steadily declining death rate. In 1900, the death rate was 17.2 for each thousand of the population. This rate declined each decade after 1900, in 1910

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[6] It may prove useful to have the basic measures used in the recording and interpretations of vital statistics readily available:

$$\text{Crude Birth Rate} = \frac{\text{no. live births}}{\text{Total estimate mid-year pop.}} \times 1{,}000$$

$$\text{Crude Death Rate} = \frac{\text{no. deaths}}{\text{Total estimate mid-year pop.}} \times 1{,}000$$

$$\text{Stillbirth Ratio} = \frac{\text{no. stillbirths}}{\text{no. livebirths}} \times 1{,}000$$

$$\text{Age-Specific Birth Rate} = \frac{\text{no. births to females in age group}}{\text{Total no. of females in age group}} \times 1{,}000$$

$$\text{Crude Death Rate for Specified Cause} = \frac{\text{no. deaths from specified cause}}{\text{Total est. mid-year pop.}} \times 100{,}000$$

$$\text{Age-Specific Death Rate from Specified Cause} = \frac{\text{no. deaths from specif. cause in age group}}{\text{Est. pop. in same age group}} \times 100{,}000$$

$$\text{Maternal Mortality Rate} = \frac{\text{no. maternal deaths}}{\text{Total no. of live births}} \times 1{,}000$$

$$\text{Infant Mortality Rate} = \frac{\text{no. of infant deaths under 1 yr.}}{\text{Total no. of live births}} \times 1{,}000.$$

From Fales, W. Thurber: "Vital Statistics," Chap. XXVIII, in Emerson, Haven (ed.): *Administrative Medicine.* Baltimore, Williams & Wilkins, 1951, pp. 497–499.

reaching 14.7; in 1920, 13.0; in 1930, 11.3; in 1940, 10.7; and in 1952, slightly more than 50 years later, it was down to 9.6.[7] Behind these figures, and more significant, perhaps, is a striking decline year after year in the infant death rate, from 100 deaths per 1000 infants in 1915 to 31.4 per thousand in 1947. The infant death rate is said to be highly susceptible to variations in environment and to constitute one of the most sensitive indices of the healthfulness of the environment.[8] Thus, by conserving the lives of an increasingly larger proportion of infants, it is evident that a larger proportion than ever before may live out their full span of life; and the expectancy of life at birth has moved up from 50.2 years for men and 53.6 years for women in 1910 to 65.2 years for men and 70.5 for women in 1947.[9]

Organization and Support of Health Services. The changes reflected by these statistics and other revolutionary changes have been the result of many factors, but the fundamental reason is that people living in communities and states throughout the nation have become increasingly aware of what could be accomplished, and have learned to cooperate and organize their support for basic services. Medical and nursing services have been expanded; vast projects in sanitation have been completed, including provisions for pure water and elimination of sources of contamination; regulatory measures and standards have been set up and implemented by systems of inspection, enforcement, isolation, quarantine, and so on. It is a sobering and instructive thought to realize that none of the communicable diseases or many other sources of human misery have been so completely conquered that they might not again plague society if organized effort is at any time relaxed. By the same token, it should be equally clear that further advancement will depend, first of all, upon clearness and feasibility of objectives; and these must be implemented by the organization of educational, professional, and technical services.

SOME HIGHLIGHTS AND SHADOWS IN THE PICTURE

In a single chapter dealing with varied problems in society few details can be mentioned with respect to any one problem. In connection with the problems of health some important facts will now be cited with respect to selective service, morbidity, disability, major causes of death, accidents, and mental disease which highlight

[7] *Monthly Vital Statistics Report*, U. S. Department of Health, Education, and Welfare, Vol. 2, No. 13, March 29, 1954.

[8] Landis, Paul H., and Hatt, Paul K.: *Population Problems*. New York, American Book Company, 1954, p. 124.

[9] *Population Index*, Vol. 19, No. 3, pp. 241, 243, and 248, July, 1953.

accomplishments and point to shadows of future possibilities and limitations.

Physical Examinations of Inductees. The data obtained from the physical examination of millions of men for induction into military services will require extensive analysis before their full meaning can be determined. But a clue to health problems will emerge if there is evidence of widespread defects, weaknesses, or diseases which appear to have resulted from preventable ignorance and neglect or inaccessibility of services. Such relationships would be difficult to trace out and establish. All that can be pointed out here is that approximately 80 per cent of the rejections during 1944 were due to the ten major causes shown in Table 4.

Table 4. Ten Leading Causes for All Rejections during 1944 (in order of relative importance)*

DEFECT	PER CENT OF ALL REJECTIONS
1. Mental disease	26.8
2. Below intelligence standards	12.8
3. Musculoskeletal defects	8.8
4. Cardiovascular defects	8.0
5. Hernia	4.9
6. Ear defects	4.4
7. Neurological disorders	4.1
8. Eye defects	4.0
9. Tuberculosis	3.4
10. Mental deficiency	2.6
Total	79.8

* *Selective Service Bulletin No. 4*, p. 1.

Of some 14,000,000 who were examined for military service in World War II only 2,000,000 were up to reasonable standards; 3,500,000 were hopelessly unfit; 2,250,000 were medical 4-F's; and 6,500,000 were accepted despite physical defects. One million were discharged for defects which were discovered or which developed after induction.[10]

Since considerable knowledge exists concerning state and regional environments, the map[11] showing percentage of rejections by states corresponds with what is already known about the association of higher rates of defectiveness and illness with poverty, low levels and standards of living, low educational attainment and most limited educational opportunities, and higher percentages of Negroes and

[10] Landis, Paul H.: *Social Policies in the Making*. Boston, D. C. Heath and Company, 1947, p. 551.

[11] *Ibid.*, p. 552.

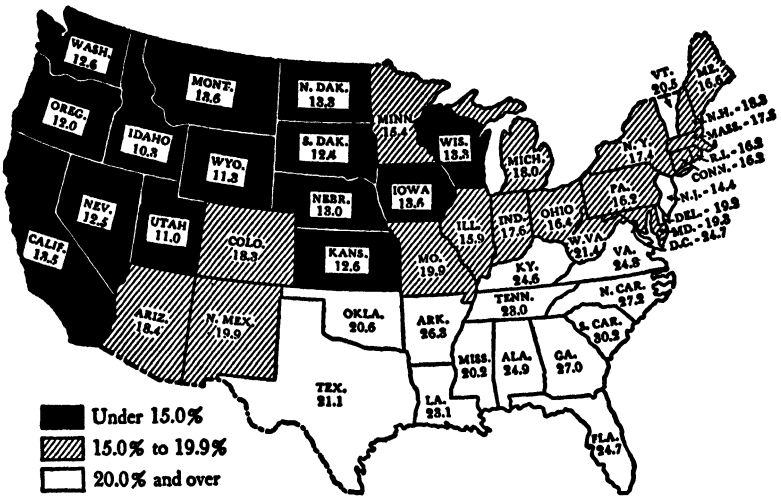


Fig. 4. The far western, mountain, and west north central areas of the United States produced the largest percentage of healthy soldiers and the lowest percentages of 4-F military rejects, according to figures released by the selective service as of June 1, 1944. Idaho had the lowest percentage of 4-Fs, with 10.3 per cent, and South Carolina the highest, with 30.2 per cent. The states in black on the map had less than 15 per cent of their registrants in 4-F, while the southern states, excepting Maryland and Delaware, reported 20 per cent or more of their registrants in 4-F. The average for the United States was 18.5 per cent rejects for physical reasons, or a total of more than 4,000,000 males 18 to 37 years old unfit for military service. (From Paul H. Landis: *Social Policies in the Making.* Boston, D. C. Heath and Company, 1947.)

agricultural workers in the population. The findings do not reveal new problems of health, perhaps; but the magnitude and extent of the problems raise grave questions concerning the actual and potential strength of the manpower for defending and maintaining the nation's position in the world. Since many of these deficiencies and defects are preventable, the question of whether the nation can afford such loss in time of peace as well as war is raised.

Leading Causes of Death. Another clue to health problems of our time may be obtained by comparing the ten leading causes of death in 1900 with those of 1948, as shown in Table 5. Such comparison confirms the earlier observation that diarrhea and enteritis and diphtheria which formerly contributed to high rates of infant mortality do not appear among the ten leading killers of 1948. In the list for 1948 it is not surprising to find degenerative diseases and those associated with adult years in the ascendancy. It is significant that the two former top-ranking causes have moved down to 6th

Table 5. The Ten Leading Causes of Death in the United States, 1900 and 1948*

RANK IN 1900	DEATH RATE PER 100,000 POPULATION	% OF DEATHS FROM ALL CAUSES	RANK IN 1948	DEATH RATE PER 100,000 POPULATION	% OF DEATHS FROM ALL CAUSES
1. Pneumonia and influenza	202	11.8	1. Diseases of heart	323	32.6
2. Tuberculosis	194	11.3	2. Cancer	135	13.6
3. Diarrhea and enteritis	143	8.3	3. Cerebral hemorrhage	90	9.1
4. Diseases of heart	137	8.0	4. Accidents	67	6.8
5. Cerebral hemorrhage	107	6.2	5. Nephritis	53	5.4
6. Nephritis	89	5.2	6. Pneumonia and influenza	39	3.9
7. Accidents	72	4.2	7. Tuberculosis	30	3.0
8. Cancer	64	3.7	8. Premature birth	27	2.7
9. Diphtheria	40	2.3	9. Diabetes mellitus	26	2.7
10. Meningitis	34	2.0	10. Arteriosclerosis	19	1.9

* Smillie, Wilson G.: *Preventive Medicine and Public Health.* New York, The Macmillan Company, 1952, p. 499.

and 7th positions, whereas those formerly in the 4th, 8th, and 5th positions now lead in one, two, three order. Another fact which stands out in bold relief is the shift in rank from 7th to 4th place for accidents as a leading cause of death. A President of the United States, himself a former war leader, made the dramatic observation that more people had been killed in accidents within the past war years than in all our wars. When this fact is combined with the knowledge that many more are hurt and disabled than are killed by accidents, the problem becomes even more highly accented.

Death Rate Due to Accidents. It is encouraging to observe, however, that the estimated number of deaths caused by accidents has been falling since 1945 when it was 68.5, to 60.7 per 100,000 in 1949. For the most part accidents are a part of the American way of life. According to Sidney Williams, it has been demonstrated that they can be reduced much further—even 73 per cent reduction has been suggested as possible.[12] He enumerates thirteen

[12] Williams, Sidney J.: "Accident Prevention," Chap. LII, in Emerson, Haven (ed.): *Administrative Medicine.* Baltimore, Williams & Wilkins, 1951, pp. 918–922.

measures—each a problem within itself—which might be expected to reduce accident rates: (1) improved industrial safety; (2) automotive and highway engineering; (3) traffic engineering; (4) improvement of traffic laws; (5) driver education programs; (6) better law enforcement; (7) home safety improvements; (8) farm safety improvements; (9) improved recreational facilities; (10) fire prevention; (11) more adequate safety education in the schools; (12) public adult education; and (13) more use of safety organization.

Disability. "How are you today?" and "How are you feeling?" are expressions frequently used in the etiquette of daily living with our friends and acquaintances. "I hope you are well and happy" or other expressions of similar meaning occur in letters and notes between friends and relatives. Much conversation is occupied with reporting and recounting of illness among neighbors, relatives, and acquaintances. These occur in such frequent and routine fashion that their meaning is seldom considered. Underlying them, however, is genuine concern and considerable anxiety for the day-to-day well-being of others. Temporary illness and feeling "below par," plus the very considerable amount of chronic illness, form in the aggregate a major problem of health. Obviously, it is most difficult to reduce these conditions to full and accurate reports and obtain very reliable statistical measures of them. There are some highly suggestive indications in the estimates growing out of a one-day canvass of 25,000 households in 68 areas throughout the United States in 1949. "For the total civilian noninstitutional population 14–64 years of age the average time lost per person per year was 17.2 days." The rates varied with age and occupational groups: school students, 8.5 days; employed persons, 9.6 days; and housewives, 15.5 days. The estimated average number of days of disability per person per year was 10–12 days for persons aged 14–34 and more than 37 days for persons aged 55–64[13]—three times as many for the latter as for the former age classification. The total number of disabled persons (one day or more) was 4.6 million, this representing 4.7 per cent of the noninstitutionalized civilian population 16–64 years of age.[14] Among the unemployed, half had been disabled for seven months or more. Most of those classified as "unable to work" had been disabled for a considerable period of time, three fourths for more than eighteen months.[15] Chronic disorders such as rheu-

[13] Moore, Marjorie E., and Sanders, Barkev: "Extent of Total Disability in the United States." *Social Security Bulletin*, Vol. 13, p. 10, November, 1950.

[14] *Ibid.*, p. 9.

[15] *Ibid.*, p. 10.

matism, heart diseases, tuberculosis, and mental and nervous troubles affect some two and one-half million persons—about 42 per cent of those ill on a given day. And it is noteworthy that one half of these are under 45 years of age and 70 per cent are under 55 years.[16] This does not include the additional two per cent of crippled persons who must be cared for. Chronic diseases lead to three fourths of the deaths, account for 70 per cent of the invalidism, and cause an estimated loss in productive work of eleven billions of dollars per year.[17]

Mental Health. It was pointed out on pages 65–69 that, as persons continue their normal development through childhood and adolescence, they come to have central or dominant goals in line with the expectations and approvals of society; and their actions come to have an orderly and organized direction toward the achievement of these goals. Personality may be understood as the distinct and characteristic organization of a person's behavior. Attention was called to the fact that personality development may not progress beyond levels of infancy or childhood, with resulting moral, intellectual, and emotional immaturity (p. 70). And it should now be added that many persons may become maladjusted and disorganized for many reasons. Internal conflict and confusion concerning goals for living and conceptions of self may be precipitated through changing and complex experience. The problem of marginal persons will be discussed as one form of personality deviation and basis for disorganization in the next chapter.

It may now be recalled that the leading cause for rejecting men who were examined for military service was mental illness. Over one fourth of the men were rejected for this cause, and 15 per cent more were rated below required standards of intelligence or were mentally deficient. Even one unfamiliar with selective service statistics is aware of unreliable employees, tyrannical and sadistic employers, quarreling and nagging marriage partners, anti-social neighbors, and the many who worry or seek relief from their anxieties. The newsstands and bookstores are filled with books and endless pamphlets or papers on some aspect of personality adjustment. Newspapers contain numerous reports of sex perverts, thieves, tramps, confidence men, and many other assorted deviations from normal behavior. These same papers, as well as many popular magazines, devote

[16] Weaver, W. Wallace: *Social Problems.* New York, The Dryden Press, Inc., 1951, p. 93.

[17] Ewing, Oscar R.: *The Nation's Health, a Ten-Year Program; a Report to the President.* Washington, Federal Security Agency, 1948, p. 168.

columns to advice from psychologists, psychiatrists, and other mental healers on the rearing of children, how to overcome fears and worries, and how to win friends or develop happier love relationships. Many churches and schools are becoming more concerned about mental illness and mental hygiene through expanded teaching and counselling services.

Truly, the presence of mental illness and the evergrowing attention it is receiving make it a major problem of our time.[18] Societies vary widely in their tolerance of eccentricities and deviations in behavior, and in the interpretation which is put upon seclusion, meditation, and other evidences of communication and participation or withdrawal. Whether there is an actual increase in mental illness is not certain. The facilities for detection and care have been greatly expanded, and more patients are utilizing available services. There is an actual demand for more services than can now be supplied. Functional mental illness, in most instances, perhaps, results from some conflict within persons with respect to their fundamental wishes, urges, or drives, and the possibilities of their gratification because of limited ends or established codes of conduct. For this reason it often is believed that increasing complexities and strains of society are inducing or producing a mounting incidence of mental illness. It has also been suggested that the lack of central focus for religious, patriotic, or intellectual values, along with corresponding emphasis upon individual ends and satisfactions, must produce much disorder within persons who are mostly concerned with themselves.

Millions who are unable to regulate their lives satisfactorily and those who may be overwhelmed with their actual and fancied misfortunes can be helped; and much of the pain and misery of other millions could be prevented. If much that is now known can be applied to the problem, improvement of mental health is possible. Here again, what is demanded is a changed way of life. Many children may fairly be said to be brought up in a neurotic way of life—overprotected, overindulged, overstimulated, rejected, unduly punished, nagged, distrusted, or otherwise subjected to lack of sympathetic insight and balanced experience. Provisions may be made for a social environment which will reduce functional disorders to a minimum and promote healthful habit formation. Through expert counseling and other forms of treatment, many who are now

[18] Horney, Karen: *The Neurotic Personality of Our Time.* New York, W. W. Norton & Company, 1937.

constantly pressed by unseen obligations and compulsions, who are always tense, loaded with morbid attitudes, or feel insecure and have exaggerated fears and worries may be freed through deeper insight and reorganization of attitudes.

Like so many other matters which have been mentioned before, public awareness must be developed to the point that efficient social organization for adequate education and treatment may be provided. Much can even be done to postpone the degenerative changes in personality which occur with aging under present tendencies to discard or reject the aged from any significant place in society. Such goals seem rather far off now, especially when there is such extensive circulation of morbid psychiatric literature and exploitation of the weak by mercenary pseudo-specialists of many varieties.

PROBLEMS OF HEALTH AND OUR WAY OF LIFE

It is becoming increasingly clear that health and disease can be truly regarded as a part of the way of life or pattern of living which people develop. This does not mean, of course, that there are not many incurable diseases, many defects without remedy, much inevitable suffering, and that decline and death are not a part of living. It does mean, however, that health is a complex matter, which varies with occupation, income, housing, sanitation, diet, racial and class position, education, recreation, goals and frustrations, and the availability and utilization of medical services. It has been known for a long time that there is a sort of vicious circle with respect to poverty and disease. But the relationship is complex. Ignorance and low standards of living are usually associated with the low levels of living which poverty implies. People at the lowest income levels hardly realize that better health is possible, and, thus, do not seem to care or take advantage of opportunities at their disposal. Their apparent indifference, frequent and varied forms of disability, poor management, and lack of prestige and power combine to produce low valuation and neglect of better ways.

It is the intent of this limited chapter to state and illustrate the fact that defects and diseases are to be expected, and practically regarded as social norms under certain subcultures. This may be underlined by reference to Table 6, which shows the relation between certain diseases and certain socio-economic classifications. These facts furnish a further frame of reference by which relations may be analyzed in respect to coal mining communities, isolated mountain folk, ethnic groups in cities, tenant farming areas, and other

Table 6. Ratio of Annual per-Capita Volume of Disability* in the United States for Low-Income Groups to That in the Highest-Income Group, 1935–36, according to Specified Diagnosis Classifications†‡

DIAGNOSIS	INCOME STATUS OF FAMILY			
	NONRELIEF			RELIEF
	$5,000 A YEAR AND OVER	$1,000–1,500 PER YEAR	UNDER $1,000 A YEAR	
All causes	100	121	166	266
Tuberculosis	100	250	388	875
Orthopedic	100	175	283	420
Rheumatism	100	138	213	369
Digestive	100	114	180	340
Nervous	100	135	204	287
Degenerative	100	109	156	268
Accidents	100	129	173	221
Respiratory	100	91	121	189
Infectious	100	93	93	124
Other	100	127	160	261

* The computation of disability is reached by multiplying incidence of a disease by days of disability.

† These ratios are adjusted for age composition on the basis of the white population in the survey.

‡Adapted from *Disability from Specific Causes in Relation to Economic Status*, Bulletin No. 9, Preliminary Reports, National Health Survey, 1935–36 (Washington, D. C., Government Printing Office, 1938), p. 9, and as reported in Weaver, W. Wallace: *Social Problems*. New York, The Dryden Press, Inc., 1951, p. 113.

varied situations. Or, the other way around, it may be observed that syphilis and gonorrhea, alcoholism, abortions, tuberculosis, industrial and traffic accidents, malnutrition, psychoneuroses, many parasitic diseases, and numerous other specific forms of illness are sufficiently associated with distinct patterns of living and attitudes toward living to be regarded as a part of the social structure and organization of subcultures. They must, however, be regarded as deviations from normal when the whole society is considered together. Figure 5 is intended to help with the grasp of this point.

"Total" and "Positive" Health. It is not surprising, therefore, that health itself is being redefined in "total" and "psychosomatic" terms. Representatives from sixty-four nations in the World Health Organization agreed that "health is a state of complete physical, mental, and social well-being, not merely the absence of disease and

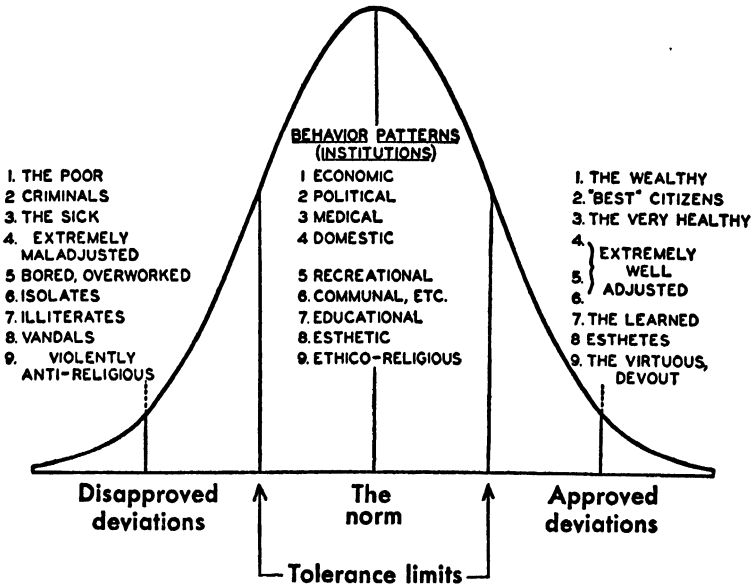


Fig. 5. Social problems and institutional behavior. (From George A. Lundberg, Clarence C. Schrag, and Otto N. Larsen: *Sociology.* New York, Harper & Brothers, 1954.)

infirmity." There is increasing emphasis on the value of positive health for all, and a recognition of the tremendous cost of illness and the amount of preventable loss of natural endowment and capacity to live more satisfactorily and productively. The costs of medical care, disability, and premature death have been estimated at $27,000,000,000 per year, but such costs may be reduced by higher planes of living and improved medical care.[19] The problem is largely a matter of vision, definition of goals, and organization. Any gains to be made must come through increasing access to medical service by something like half the population who now have extremely limited services. The very idea that all should have good medical care is so new that it has not spread widely through the population and has not been accepted by many who have considered it. Medical care is becoming a major value in the minds of more people and their leaders. It appears to many not only that much misery and suffering may be relieved but also that much loss of vitality and of potential manpower can be avoided.

[19] Weaver, *op. cit.*, p. 121.

It now appears that medical technology is adequate to conserve the health and prevent much undermining of vitality which is currently experienced. The direction of future development is indicated, to some extent, by the Ohio State Medical Association's list of twenty-five areas to which attention should be directed if adequate health is to be achieved for the public: (1) economic improvement; (2) improved housing; (3) malnutrition; (4) sanitation; (5) smoke abatement; (6) communicable diseases; (7) venereal diseases; (8) tuberculosis control; (9) health education; (10) periodic medical examinations; (11) cancer and chronic diseases; (12) mental disease program; (13) rehabilitation of the handicapped; (14) recreation facilities; (15) school health programs; (16) industrial health; (17) medical care for the needy; (18) state health department services; (19) maternal and child health services; (20) hospital facilities; (21) prepaid hospital care plans; (22) prepaid medical care plans; (23) care of disabled veterans; (24) rural health; and (25) medical education.[20]

The Price Required. Responsibility for reaching the objectives implied in this and other lists cannot be placed on the medical profession alone. This group, however, may be expected to give up the unfortunate, unnecessary, and wasteful controversy over socialized medicine which has been reduced to an irrational all-or-nothing basis. And the public may be obliged to forego or limit purchases of cars, refrigerators, radio and television sets, liquor, tobacco, cosmetics, and some other goods if the possibility of more abundant health is to be realized. There must be intelligent cooperation and competent organization to bring about a changed pattern of life.

QUASI HEALTH PROBLEMS

There is a close parallel between problems of physical and mental health and many social problems. The more we learn about personal vices, delinquencies, and crimes the closer their similarity to sickness appears. In fact, it can truly be said that in many instances such problems as drug addiction, delinquency, and some crimes are best understood as symptoms of illness. Until recently persons who committed crimes were lumped together and dealt with in a uniform manner according to the type of crime defined by law. Similarly, persons who were chronically drunk from alcohol, or who became

[20] Anderson, Odin W.: "Medical Economics and Administrative Medicine; A Review of Selected Problems," Chap. XVII, in Emerson, Haven (ed.): *Administrative Medicine*, Baltimore, Williams & Wilkins, 1951, p. 270.

prostitutes, or otherwise persistently violated moral definitions were condemned and dealt with as categories or types. Although long established attitudes and practices with respect to vice and crime are still dominant, there is a growing tendency to examine each case on its merits and deal with it in a way which seems best for both the personal and social welfare. This is the idea of diagnosis and treatment which characterizes the procedure in cases of disease, in contrast to uniform sentence or condemnation under law and mores.

Vice and Crime. It must be kept in mind that violations of the mores and laws are always acts of particular persons; but, if they are allowed to become widespread, or general, they lead to the collapse of social structure and organization (see pages 29–31). It must also be remembered that conformity to the mores and laws has to be learned or internalized through the process of socialization (see page 37). Thus such problems as alcoholism, delinquency, crime, and so on are problems of personality and socialization when viewed from one side, and problems of social order and control when viewed from another side. Actually, vice is often pleasurable or is associated with pleasure at the outset. It has been defined as "personal behavior of a sort disapproved by the moral code, particularly because of its tendency to injure the personality physically, mentally, or socially and because of its liability to contagion, either physical or social, to produce corresponding injuries in others."[21] Crimes are defined as violations of laws. There are many violations of the mores which are not to be classed as vices or crimes, but which are quite as serious so far as the stability of society is concerned. Many acts may violate no technical definitions which have been set up by law, but may prove quite injurious to the faith, integrity, and dependability which hold society together. Although the last two of the well known Ten Commandments[22] concerning false witness and covetousness have not been completely defined or covered by specific legislation, violations are not too difficult to perceive nor also are their consequences for persons and society very obscure. The commission of these and other sins may be understood in the same manner as vice and crime. Only two problems of this personal-social classification will be examined here.

Alcohol and Social Problems. It is an interesting coincidence

[21] Fairchild, Henry: *Dictionary of Sociology*. New York Philosophical Library, 1947, p. 333.

[22] *Exodus* 20, verses 16, 17

that people in the United States expend approximately the same amount each year for alcohol that they do for medical care—some eight to nine billion dollars for each. The use of alcohol in some form as a beverage is a part of our normal way of life. J. P. Shalloo has said:

> In our times it is culturally imperative to toast the bride, christen the ship, seal the bargain, welcome the guest, speed the friend, salute the New Year, celebrate good fortune, wake the dead and even symbolize and ingest the blood of the Savior through the medium of alcohol. . . . With so many forms of culturally approved drinking, the amazing result is that we have so few persons emotionally dependent upon alcohol in some form.[23]

Accurate information about this point of emotional dependence and the extent and growth of drinking patterns is difficult to obtain. It has been estimated that at least one half of the adult population, fifty-five millions, include alcohol in their consumption standards. For every thousand of these, 73 drink to excess and 14 may be classified as chronic alcoholics. Although there has been some tendency to focus upon the sad plight of the alcoholics as the major problem, there are unknown relations of alcohol with the occurrence of traffic and industrial accidents, some murders and sex crimes, much quarreling and fighting between persons, certain family tensions, absenteeism and unemployability, poverty, and so on. Any summary of the place of alcohol in society will find it associated with man's pleasurable experiences, and also with a considerable part of his misery.

The problems associated with alcohol and efforts to control them are by no means new. Reference is made to them in the Old Testament and numerous other records of antiquity. Nevertheless, it has been repeatedly stressed in this book that our industrial and urban society is increasingly complex and highly mobile. Relationships among persons and groups are in a somewhat delicate balance so that matters which would be of minor importance in a slowly moving, loosely organized society have far-reaching consequences in modern society. The village drunk or a drunken brawl in the mountains may be largely detached incidents so far as wider society is concerned. But the driver of a high speed automobile whose reflexes are only slightly anesthetized may produce havoc on the highway or in a traffic rush. At the same time, the very complexities and tensions of industrial society may increase the demand for

[23] Shalloo, J. P.: "Some Cultural Factors in the Etiology of Alcoholism." *Quarterly Journal of Studies on Alcohol*, Vol. 2, pp. 467–468, December, 1941.

sedatives and cushions against the shocks and frustrations of large bureaucratic organizations. Increased demand may be largely due to skillful advertising and emphasis on pleasurable and fashionable standards. But it is quite important to remember that the raw materials and industrial plants which are devoted to the production of alcohol make almost unlimited quantities available. These three factors—increased availability, increased demand, and increased complexity of society—set the stage for many problems associated with alcohol.

Drinkers and drinking have been and may be classified in many ways.[24] There are those called misery drinkers, who are under such compulsion to drink that they do not hesitate to consume poisonous products manufactured for fuel, or for cleansing and rubbing purposes. The suffering and pain accompanying the use of these and other raw liquors sets off one extreme type. Many persons, classified as industrial drinkers, do not seem to seek intoxication, but perhaps endurance, energy, substitutes for nourishment, and some degree of sedation. They prefer drinks with little alcoholic concentration. The class known as commercial drinkers are probably using alcohol partially as a bribe and partially to break down feelings of social distance, suspicion, and distrust. Sales resistance and hard bargaining may be melted enough to close a deal. Then there is social drinking, to reduce to a common denominator of uninhibited regressive activity many relationships which might be stiff, boring, and uninteresting.

There are many particularistic theories which seek to explain alcoholism and other problems associated with the use of alcohol. These include explanations based on heredity, on glandular deficiencies and imbalance, on repressed sexual drives, on emotional immaturity and desires for evasion, escape, compensation, and so on. All of them rest upon the interpretation of some evidence, and may prove useful in particular cases. The basic sociological theory in this as in many other problems is that the use of alcohol is learned as a part of the normal way of life. It becomes a personality problem when it occupies an exaggerated place in the conception of self and the organization of life patterns with respect to goals. And, similarly, it becomes a social problem to the extent that social goals are distorted or the structure and process of social organization are disturbed or upset. Consequently, any solutions for the problem must be approached through personality organization or the organ-

[24] Weaver, *op. cit.*, pp. 306–311.

ization of society. The procedures used in Alcoholics Anonymous[25] may combine the two in some degree. It is quite unlikely that any single or particularistic solution will be found. This means that some decisions and policies must be reached in the larger society with respect to regulating the availability, distribution, and utilization of alcohol, just as some foods and drugs are regulated. The fact that universal prohibition failed does not mean that no regulation is needed or possible. For those who become excessive drinkers or chronic alcoholics the insights of psychology, psychiatry, and medicine must be applied; the diffusion of mental hygiene may become a preventive factor in stabilizing both persons and society. This latter goal is basic. Corrective procedures and remedies related to widespread social usages and values will be limited in their effectiveness by wider processes of organization and disorganization in society.

Juvenile Delinquency. Juvenile delinquency is a much publicized problem. Newspapers carry not only many reports of crimes committed by juveniles, but also numerous articles by ministers, judges, welfare workers, psychologists, and sociologists offering various interpretations and proposed solutions. Many books have been written concerning the problem. One of the most recent of these, *The Juvenile in Delinquent Society*, emphasizes the point stressed in connection with other problems—their close relation to the normal way of life. It is stated in the preface to this book that

> . . . the problem of juvenile delinquency can best be understood on the one hand and reduced on the other hand in a comprehensive, societal frame of reference. When juveniles live in a "delinquent society," juvenile delinquency becomes a major problem of that society. By the same token, the solution of the problem, like that of other social problems, depends on an orderly modification of the American social structure, and some of the values and functions of American society.[26]

For the most part, delinquent behavior patterns result from faulty socialization, particularly faulty learning in social situations.

It is for this reason that adult and juvenile lawbreakers are not classified in the same way or subjected to the same procedural system. Until recently no such separation was made. Persons accused of crimes were tried by courts to determine from evidence whether criminal laws had been violated. If so, punishments, according to

[25] *Ibid.*, p. 325.

[26] Barron, Milton L.: *The Juvenile in Delinquent Society*. New York, Alfred A. Knopf, 1954, pp. vii–viii.

law, however severe, were applied to young and old alike. And, as a result, many children were sentenced to jails and prisons along with experienced and habitual criminals and there were subjected to physical punishments and humiliations which were drastic even for adults to bear.

It has been increasingly recognized that many children unlawfully trespass upon and damage property, steal property, fight and make violent assaults upon others, set fires in woods, streets, and buildings, engage in the transfer and sale of stolen or illegal merchandise, and commit many other crimes and misdemeanors without fully understanding the meaning of their acts in terms of moral and legal responsibility to society. It was pointed out earlier that children learn social meaning as they place themselves in the role of others and come to a recognition of their own actions in relation to the purposes and actions of others. They come to see themselves as others see them. Thus, children often act in situations before they have had an opportunity to learn the significance of what they are doing. If they have no adult guidance, as is often true of orphaned and neglected children, or if they are placed in situations where adult patterns of conduct are disorganized or antisocial, they might be expected to commit crimes without awareness of the existing moral and legal definitions of their acts. Certainly, many children violate moral and legal codes long before they have had an opportunity to develop adequate conceptions of personal responsibility. Why a few persons become delinquent rather than all who are brought up in similar social situations must be referred to the previous discussion of personality formation. It should also be remembered that detection is far from complete.

Because of the relative immaturity and differential conditions for socialization among children, a separate procedure has been instituted by the state for dealing with juveniles who violate criminal laws. The state, through special courts and allied services, accepts responsibility in place of the parents for analyzing behavior and planning treatment which is designed to reorient the development of self, redirect the attitudes, and foster social responsibility among the children. Juvenile courts are not so much concerned with organizing evidence to convict young persons of crime, although such facts are usually available and accepted. The central task is not proof of guilt, but thorough study of all facts which may throw light on the total behavior of the persons and the probable reasons for delinquent behavior. On the basis of as complete diagnosis as

possible a plan of treatment is worked out in cooperation with each delinquent and his parents or parent substitutes. Thus, a process of treatment tends to replace the former condemnation and punishment without regard to personality differences or social circumstances. Without doubt this marks some advance, but such programs are still quite divorced from the relationship they may be designed to correct. Another statement from the same preface quoted above is true indeed: "it is unrealistic to expect any significant reduction of the problem within the existing programs, agencies, and personnel devoted to treatment and prevention."

This brief statement concerning the problem of juvenile delinquency may serve as an introduction to the study of particular cases, theories, and programs.

FOR INVESTIGATION AND DISCUSSION

1. Examine Figure 4, and state how well it appears to correspond with the "hospital world" you know best—pointing out similarities and differences.

2. The list of "Problems of Nurses" on page 99 came from a report of observations made at a small rural hospital, a hospital of medium size, and another located in a large metropolitan center. Which of the problems have you observed in your situation? If some of those listed seem improbable or doubtful to you, state which and why.

3. Summarize the principal facts which came out of the physical examination of some 14,000,000 men for military service in World War II, and discuss their implications as fully as you are now able to do.

4. Examine Figure 5, and compare the meaning of deviation with respect to physical and social expectations. Is there a sharp difference between them, or do many overlap? Cite examples of approved deviations.

5. Give a highly condensed report in class of one or more of the following books, and point out contributions made to the understanding of juvenile delinquency:

Blumer, Herbert, and Hauser, Philip: *Movies, Delinquency and Crime.* New York, Macmillan Company, 1933.

Carr, Lowell J.: *Delinquency Control.* New York, Harper & Brothers, 1940.

Healy, William, and Bronner, Augusta: *New Light on Delinquency and Its Treatment.* New Haven, Yale University Press, 1936.

Hollingshead, August B.: *Elmtown's Youth; the Impact of Social Classes on Adolescents.* New York, John Wiley & Sons, 1949.

Sellen, Thorsten: *Culture Conflict and Crime.* New York, Social Science Research Council Bulletin No. 41, 1938.

Shaw, Clifford R., and McKay, Henry D.: *Delinquency and Urban Areas.* Chicago, University of Chicago Press, 1942.

Tappan, Paul W.: *Delinquent Girls in Court.* New York, Columbia University Press, 1947.

United States Congress: *Juvenile Delinquency.* Washington, D.C., United States Government Printing Office, 1950.

Wickman, E. Koster: *Children's Behavior and Teachers' Attitudes.* New York, The Commonwealth Fund, 1928.

Young, Pauline V.: *Social Treatment in Probation and Delinquency.* New York McGraw-Hill Company, 1952.

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Barron, Milton L.: *The Juvenile in Delinquent Society.* New York, Alfred A. Knopf, 1954.

Cuber, John F., and Harper, Robert A.: *Problems of American Society: Values in Conflict.* New York, Henry Holt & Company, 1951.

Elliott, Mabel A., and Merrill, Francis E.: *Social Disorganization,* 3rd ed. New York, Harper & Brothers, 1950.

Faris, Robert E. L.: *Social Disorganization.* New York, The Ronald Press, 1948.

Horney, Karen: *The Neurotic Personality of Our Time.* New York, W. W. Norton & Company, 1937.

Landis, Paul H.: *Social Policies in the Making.* Boston, D. C. Heath and Company, 1952.

Weaver, W. Wallace: *Social Problems.* New York, The Dryden Press, Inc., 1951.

Chapter 7

SOCIAL PROBLEMS (Continued)

The phrase *E Pluribus Unum* stands out in raised letters on our pennies, nickels, dimes, and other coins. It also appears on the Great Seal of the United States and on many flags and banners. When we think of its meaning we know it refers to Our One Nation being formed out of many sovereign states. Each of the states has entered into a union with all the others in order to enjoy the advantages and combined strength of the whole. Each state must, of course, accept responsibility for all the support it can give if it is to share in the economic, political, and social benefits which result from a great unified organization of effort.

STATE PRIDE

The people who live in each of the separate states are usually quite proud of their history and past accomplishments. The land, history, and leaders, both past and present, of a state generally mean more than a political unit to those who dwell in it. They identify themselves and their hopes with the name and activities of their state. They are inclined to think of the state as their group and they derive feelings of strength, pride, and personal significance from personal membership and identification. Each may be inclined to think of his state as superior to other states in many ways. Feelings of superiority may be focused on such values as ancestry, wealth, industry, sociability and manner of life, and so on. Thus, it is rather commonplace to find New Yorkers, Virginians, Texans, and Californians assuming and even boasting of superior qualities and attainments of their people. This is equivalent to saying that persons are favorably prejudiced toward their own state, or unfavorably prejudiced toward the out-states. Seldom, perhaps, are the people of a whole state lumped together and thought of as being the same, or as having the same characteristics. Texans sometimes humorously refer to themselves as being alike, and outsiders sometimes talk and

act as if this were true. Similarly, New Yorkers, Kentuckians, and Georgians are often stereotyped.

"STATES' RIGHTS" AND OBLIGATIONS

A similar tendency to group people is found with respect to sections and regions such as "The South," "The North," "The Middle West," "The Northwest," and so on. There may be a decided tendency to lump people of whole sections together and talk about Southerners, Northerners, Midwesterners, "hillbillies," and so on. Sectional prejudice, jealousy, and hostility are often indicated by scapegoating—damning or blaming a whole section of the country for some evil condition. However, state or sectional prejudice is hardly ever so extreme that other states are not appreciated and their good qualities acknowledged. In fact, interstate tourists are continually visiting across state lines in order to see the shrines, learn the history, and enjoy the scenery and opportunities to be found in neighboring states. There are, of course, conflicts of interest among states, and incidents have occurred which aroused enmity and threatened peaceful settlement of differences. This is so rare, however, that it is mentioned as a possibility rather than as any likely development. The point to be stressed is that unity of the states as a nation would break down if the separate states failed to recognize the rights of each other, the importance of each other, and the contribution of each other to the whole. If feelings of superiority were magnified to the point of emphasizing inferiority of other states and assuming any dominance over them, it is certain that hatred would develop and various forms of conflict would ensue. Constitutional and other legal provisions for the rights of states and adequate provision for the adjustment of differences, reinforced by mutual respect and recognition of worth, make national unity and organization a sort of model for the whole world.

THE PROBLEM OF INTERGROUP RELATIONS

These well known facts have been reviewed in order to introduce a most serious problem. The problem of intergroup relations[1] might constitute the vulnerable area of the larger unity which has been discussed under interstate relations. The nation and the separate

[1] Frequently, intergroup relations refers to relations between groups when one is subordinated to another, or occupies a position of inferior status, or lacks means, experience, or maturity of organization essential to full social responsibility. See Cook, Lloyd, A., and Cook, Elaine: *Intergroup Education.* New York, McGraw-Hill Book Company, 1954, pp. 7–10.

states are composed of many racial, ethnic, religious, class, and occupational and economic groups which must maintain orderly and satisfactory relations if larger organization and combined power are to endure. Gordon W. Allport states:

> There are two good reasons why we must expect people to cling tenaciously to their prejudices. For one thing, the whole economy of their lives may be erected on the assumption that certain outgroups are inferior, threatening, or contemptible. Their own sense of worth is maintained by debasing others, particularly groups that are as easily defined as Catholics, Jews, Mexicans, Negroes, refugees. Such people feel safe only on an island with their own kind. Their thinking is categorical: ingroups are good, outgroups, bad; ingroups are safe, outgroups, menacing; ingroups, superior, outgroups, inferior; ingroups, clean, outgroups, dirty. Many lives are organized in this manner. Their economy is one of restriction in human relations. It is not to be expected that such lives can be easily recentered. A second obdurate fact is that prejudiced attitudes receive continual support from the social environment.[2]

RELIGIOUS, RACIAL, AND CLASS GROUPS

It is now important to recall the earlier discussion of the diversification and stratification of groups, as well as the essential characteristics of human groups (pp. 33–35). It is also desirable to recall the ethnocentric tendency of groups (pp. 47–49). We must be aware of the great variety of religious faiths and denominations—Protestant, Jewish, Catholic, Moslem; of the many different nationality groupings which settled in America at different times and places—Germans, Irish, Italians, English, Russians, Japanese, and so on; of the numerous ethnic stocks—Scandinavian, Slavic, Latin, Anglo-Saxon, Oriental; of varied races—Negroid, Mongoloid, Caucasoid; as well as of organized laboring and managerial groups, and a great variety of professional and other occupational alignments. Any survey of groups takes account not only of their wide variety but also of their relative status, or their position above or below others. Class differences occur when level or rank is ascribed to a large grouping of persons on the basis of their wealth, dress, family, manners, and other traits. It must be remembered, of course, that differences found among people do not automatically result in their being or forming a group. Only when persons become conscious of separate identity and aware of at least some common goals, or are identified or set apart by others, does a group exist.

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[2] Allport, Gordon W.: "Resolving Intergroup Tensions, An Appraisal of Methods," in Cook, Lloyd A. (ed.): *Toward Better Human Relations.* Detroit, Wayne University Press, 1952, p. 37.

THE NEGRO IS A MINORITY GROUP

Under Slavery. The Negro is called a minority, not alone because of being outnumbered by white people, but because of domination and treatment as immature dependents.[3] Originally, Negroes were brought by force to America as slaves, and occupied the subhuman status of property and means of production. In general, they were domesticated by force; and they were bought and sold, and moved from place to place as chattels. Because of their diverse tribal origins and their later isolation from others on many separate plantations, it was certainly impossible for them to know anything about the existence of numbers of others similar to themselves and to think of themselves as a people or a race or a group. Aside from the fact that each individual slave had a monetary value and an economic use, his social or human significance was almost nil. Negroes were not expected to set up any social standards or act for themselves on the basis of biological kinship. Thus they could not have family, moral responsibility, or any other norms associated with independence and human status. Since slaves were worth more on the market and in the field or home if they learned to work well and knew the rudiments of communication, these were taught them. Some were taught so much and developed such competence that they were made responsible for the execution of skilled trades, bookkeeping, and even tutoring of others. Mulattoes, who were often preferred as house servants because of their skin color, frequently had opportunities for extended learning and were given responsibilities not enjoyed by field hands.

Humanitarian Developments and Legal Emancipation. In spite of the low status and very limited development of slaves, some masters thought of them as human and came to have concern for their welfare. Mutual respect and affection often developed between master and slaves after long association, adjustments, and accommodation. It must be understood that relations under slavery were orderly, and only recalcitrant individuals had to be severely disciplined. Besides, more sensitive masters became dissatisfied with treating human beings as slaves, and either set their own slaves at liberty or prepared them for freedom. It is quite probable, indeed, that if force had not been brought to bear by nonslave states the humanitarian sentiments and economic difficulties of masters would have led to the freeing of slaves without war between the states.

[3] Young, Donald: *American Minority Peoples*. New York, Harper & Brothers, 1932, p. xiii.

However this might have been, slaves were legally set at liberty in 1863.

Advancement Despite Social Inertia. It must be quite evident to anyone with an elementary understanding of society that a legal enactment does not immediately change social structure and social relations. The patterns and habits of belief, thought, and action continue for a long period of time. Men suddenly freed from slavery and left without financial resources or training for new relations are likely to be more helpless in some ways than they were before. The story of the educational and economic difficulties with which Negroes have had to deal since they were legally freed is too long to tell. Their achievements under unfavorable circumstances have demonstrated their deep motivation and genuine ability. Masses of them hold the lowest paid unskilled jobs on farms and in cities, and only recently have there been a sufficient number of Negroes with varied competence and skills to offer much competition for jobs at higher levels. However, their ability to live and work at minimal consumption levels of food, clothing, and shelter tends to give them competitive strength for lower positions and also to weight them against the possible achievement of others. That is, when any group is accorded a low social position and is limited in educational and job opportunities, it not only is held down but operates as a measure or weight against the competitive advantage of others. When such a group is identified it may arouse jealousy and hatred on two counts—its successful and secure hold on lowest paid jobs which others would be glad to get, and its service as a "yardstick" to keep others at low paid levels. When to these is added the high motivation which leads to increasing competence and competitive success at higher levels, the basis for jealousy and tension is increased.

Race and Group Consciousness. As stated before, Negroes who were brought originally from Africa were captured from separate tribes, and, when sold as slaves, were scattered on widely separated plantations. Thus they had no opportunity to think of themselves as a race, a people, or a group. Later, however, the experience of being regarded by others as a group, the sharing of prolonged differential treatment and segregation, and their ever-widening contacts and opportunities for education have made Negroes highly race conscious. They now constitute an in-group with the usual ethnocentrism which this implies. Leaders have studied the history of their people and called attention to their contributions to regional and national progress. Their achievements in education, fine arts, science, agriculture, military service, and other fields of endeavor

have given them confidence in themselves and in both their actual and potential contribution to society. They have become increasingly insistent against restrictions of opportunities and responsibilities because of their color and "previous condition of servitude."

Significant Changes. Major political parties, many church groups, and numerous other organizations have declared their willingness to open opportunities to all persons and let competence determine the achievement of status; furthermore, they have increasingly put these principles into practice. The recent Supreme Court decision which bans segregation in schools is a very decisive change. Educational opportunities, recognition in arts and sciences, participation in professional services, attainment of military rank, political suffrage and representation, mastery of skilled trades, trade union and other occupational affiliation, and many other relationships have been improved so far as Negroes are concerned. On the basis of such evidence it may be hoped that racial groups may be able to continually advance their mutual respect and appreciation for each other. That sympathetic insight and mutual trust are possible has been demonstrated.

The Problem Remains. The purpose of this chapter is to suggest the problem and analysis of race relations. In spite of all the advances which have been made, Negro-white relationships must be understood in terms of ethnocentrism and the relations between in-groups and out-groups previously discussed (p. 47). With respect to the dominant emphasis of this book, the problem shows itself in various ways at the professional levels of medicine and nursing. Although graduate nurses are now integrated in one professional association, Negro doctors and nurses are excluded from service in some hospitals, are allowed limited service in others, and are accepted on basis of competence in some. Furthermore, patients may be excluded from some hospitals on account of race, while in others they may be segregated by wards on this basis. Segregation may be carried even to the separation of blood plasma by race in storage refrigerators. In some places those who die wait for burial in separate morgues and for the resurrection in separate burying grounds. Residential, educational, occupational, and other forms of separation are well known.

Impact of Prejudice on Self and Personality. All such evidences of prejudice are important in themselves. But their bearing upon the development of self and personality may, perhaps, be most significant. Every baby comes into the world without any conception of self and without organization of personality. Small children

even play together without attaching meaning to differences in skin color, or other differences, for that matter. But through experience with older children and with adult persons they come to think of themselves as Negro or white. If Negro, each learns that he is excluded from many places and denied many forms of activity because of skin color and other marks. He learns that persons of his type are assumed to have inferior intelligence, lack ambition, and seldom develop or mature beyond some level of childhood. In general, he may learn to react to these definitions in certain ways. He may accept them and learn to behave much as expected; he may deny them, and learn to express his antagonism and resentment in many ways and in many relationships; or he may learn to seize all the opportunities allowed him and make every effort to improve his life and position in spite of the handicaps in his way. The white child may learn to regard himself as superior in endowment and entitled to all opportunities and privileges. By virtue of his attitudes and separation he may not learn that Negroes vary in ability and have made many valuable contributions to society which might be appreciated and admired. Rather than a positive attitude, he may learn to focus upon evidences of inferiority and immaturity, and particularly upon evidences of antagonism and aggression by Negroes.

BIOLOGICAL DIFFERENCES ARE SOCIAL SYMBOLS

The point is that prejudice and tension between racial groups tend to be more continuous and permanent than other forms of intergroup prejudice because biological marks become symbols. It will be shown that religious, economic, national, and other groups have ethnocentric attitudes and develop prejudice and tension, but these may not be easy to maintain for lack of visible evidence of differences. In the case of racial group relations the differences in skin color, hair form and color, facial appearance, and other anatomical structures become sensory bases to which social meanings may be given.

Japanese, Indians, Mexicans. Because of such physical differences Japanese people living in California and other western states, who have been made the objects of prejudice and differential treatment, cannot rid themselves of their identity. Most of them are Americans by birth, cultural experience, and national loyalty. They have been thrifty and useful citizens. It is not unreasonable to believe that they would have been fully accepted if it had not been for the marks of race by which they can be constantly identified and separated. When separated, of course, their consciousness of differential

treatment, as in the case of the Negro, tends to produce reactions and behavior which further accentuate the differences. Mexicans, too, have come into the country as immigrants, as have all other Americans except Indians. But so many Mexicans are of Indian descent that they may show racial marks. These, combined with their cultural differences and low economic status, make them easy to stereotype as dirty, uncouth, immature, unreliable, lazy, and so on. It is also well known that the Indians of North America have been segregated for the most part on reservations and treated as wards of the government. They are no longer thought of as "dangerous savages" but more nearly as "museum pieces," representing a heroic and romantic past. They are visited by tourists, artists, and government agents, but are not actually incorporated in the competitive stream of day-to-day contacts and communication. In a sense they are valued and appreciated in a positive way, in contrast to other races, who tend to be regarded negatively and antagonistically. Epithets, such as "nigger," "Jap," or "greaser," are seldom applied to them.

Marginal Persons. Certain persons within the group relationships being considered in this chapter deviate from other members in such ways as to become *marginal persons.* It is well known, for instance, that some persons of mixed racial parentage show so little physical evidence of nonwhite ancestry that they are able to "pass" into the white group. They do this by a wide change in residence and the severing of all past social connections as completely as possible. Some mulattoes who might "pass" so far as racial markings and cultural attainment are concerned prefer to maintain their identity and loyalty as members of the Negro group. However, some wish to leave the in-group with which they have been identified and to become fully accepted into membership of groups from which they have been excluded. Such persons are unhappy indeed. They lose their place or have no place in their original group, and they are not accepted by the group to which they aspire. They find themselves either outside of all groups or only partially included and accepted in some. In large cities a sufficient number of such detached and unhappy individuals may drift together and form a disgruntled, bellicose group of their own.

It must be understood that persons of mixed blood are often marginal because of the confusing social image or stereotype they present to others and because of the possibility of changed status. But the same classification applies to any others who are "caught" between reference groups. Immigrants who move from one culture

and/or nationality group and wish to be accepted in the same group as the natives among whom they settle often experience marginal status. And those who struggle to change their class position may do everything possible to sever their past connections and "climb socially" without being able to "make a dent in the upper crust." They are snubbed and humiliated, but any prospect of returning to former associations is equally painful.

It is not the function of this chapter to explore the behavior of marginal persons. Persons vary widely in their response to basic frustrations, but it can be suggested here that marginal status may contribute heavily to various forms of maladjustment. It should be considered as a factor in some of the problems set forth in the preceding chapter.

SOME PROBLEMS OF JEWISH-GENTILE GROUPS

Long History of Separation and Persecution. Jewish people have had a long history of separation and persecution in many parts of the world. Their separation has been partly of their own choosing because they wished to preserve their language, religion, traditions, and general way of life. In order to do this they have tended to dwell together in close proximity to their synagogues. Since they have tended to live in cities rather than rural areas, their separation has been quite apparent. Although they do not have universally distinct anatomical differences to qualify as a separate race, many of their number have sufficiently distinct physiognomy to serve as a type and symbol for all. Actually Jews are Caucasians who vary quite widely in physique. Their religious and cultural separation, combined with the widespread assumption that they conform to a physical type, has made it easy for non-Jews to fix upon them as an out-group and at the same time it has intensified their own in-group consciousness.

It would require too much space to review the place Jews have occupied in the life of European and other countries. The violence they suffered under the Hitler regime in Germany is both recent and fairly well known, and serves to indicate the serious potentialities of long-standing ethnocentric group differences. Jews had been the objects of jealousy, prejudice, and persecution in Germany and other European countries long before Hitler came to power. But it took the relative deprivations and shifts in power which occurred in Germany after World War I to magnify and focus the pent-up fear and hatred in rationalized efforts to exterminate Jews in Germany. In Russia, also, Jews were at various times subjected to rather whole-

sale massacre such as Indians and white settlers in this country visited upon each other after periods of relative "peace."

High Status of Many Jews. Unlike Negroes, Mexicans, and Indians in America, Jews are often found in the highest economic and professional positions. It is true that most Jewish immigrants accepted the very lowest levels of living to be found in American cities when they came to the New World, and vast numbers of them have not been able to move very high up in social and economic positions. It has been noteworthy, however, that their highly perfected mutual aid in families, their patterns of community cooperation, and their willingness to utilize all opportunities for work and education have been combined to advance many of them to high positions. It must be quickly added that not all Jewish immigrants were forced to struggle from bottom positions upward. Well educated and highly intellectual Jews from business and professional positions in Europe also emigrated for the sake of greater freedom and advantages in America.

Stereotyped Image. The characteristics frequently ascribed to all Jews, as if they fitted into a standard image, include: aggressiveness in all relationships, scheming and hard economic bargaining as dramatically portrayed in Shylock, and display of their feelings of superiority in boisterous, vulgar, and conspicuous ways.[4] Quite inconsistently, they are sometimes branded as ruthless capitalists and radical communists; and at the same time they are regarded as clannish or aloof and as wanting to push their way into gentile association. The irrational and contradictory nature of such an image is underlined by the fact that persons who accept it fail to note their debt to the Hebrew prophets, historians, and writers who contributed so much to their religion, and to Jesus, whom they claim as their Greatest Teacher and Savior. Nor do they note the many geniuses in the arts and sciences, such as Freud and Einstein, who differ so widely from the current stereotyped conception.

Some Cooperation and Friendship. It must be emphasized that all gentiles do not think of Jews in this irrational stereotyped fashion, nor do all gentiles identify themselves as a distinct outgroup. Quite the contrary. Many Jews and gentiles are associated together in very friendly and cooperative relations, and many in both groups are doing what they can to allay and eliminate intergroup prejudice. Some very promising programs designed to achieve

[4] Campbell, Angus: "Factors Associated with Attitudes toward Jews," in Swanson, Guy E., Newcomb, Theodore M., and Hartley, Eugene L. (eds.): *Readings in Social Psychology.* New York, Henry Holt & Company, 1952, p. 604.

such ends are under way.[5] But recent studies have demonstrated that there is a nucleus or hard core of anti-Jewish feeling and action among non-Jews who feel insecure for one reason or another, and who readily focus the blame for their plight upon an out-group which can be thought of as successful at the expense of others. Some of those who are most anti-Semitic have been reared under rigid and harsh discipline, have been urged to seek advanced status, and have moved into middle and upper class positions. Their feeling of insecurity and fear of others is based on relative deprivation or doubts of holding their place rather than on lower levels of living and association. They fix upon Jews as a probable threat to their status and project the very qualities of their own characters into the out-group whom they can accuse of overambition, domination, scheming, and exploitation, and so on. Such persons have not learned to relax through the enjoyment of music, reading, refined living, or friendly and leisurely association, but tend to compensate for their physical appetites and struggle for power by demands for rigid moral prescriptions and enforced conformity for those in weaker out-groups.

Most Serious Aspect of Problem. Anti-Semitism is expressed by means of exclusion of Jews from some hotels, pleasure resorts, and many other public facilities. It may also result in discrimination with respect to educational opportunities and participation in social activities. Residential segregation may sometimes be due to differential access, or preference of Jews themselves. These and other similar practices arouse resistance and effort on the part of Jews to overcome them, and, to an extent, they give some confirmation of already stereotyped behavior.

But these do not seem to be the most serious problems connected with Jewish-gentile relations. Perhaps the very existence of intense prejudice on the part of relatively few people is the most serious aspect of the matter. They continually spread the stereotyped conception of a whole people and keep the negative emphasis alive. This tends to poison the ideas and acts of those who give little thought to the source and rationality of their views. And the ready accusation or blaming of Jews for various ills by a few people can be quickly communicated in time of crisis. The most serious aspect of the whole problem is the constant threat and genuine prospect of power exercised by the most prejudiced segment of the gentile group. The open conflict which may result was exemplified in

[5] See Cook and Cook, *op. cit.*, passim, and Cook (ed.), *op. cit.*, pp. 75–121.

Germany where tremendous power was centered in a maniacal one per cent.

It would not be straining medical terminology too much perhaps to regard extreme intergroup prejudice as a form of mental illness, and to recognize that the application of our knowledge of mental hygiene may be the most promising approach to adjustment. Certainly, those who practice the healing arts of nursing and medicine will not be able to adequately treat such illness if they are strong carriers of the malady themselves.

RELIGIOUS CONFLICT MAY DISORGANIZE SOCIETY

In a book as brief as this, little space can be given to relations between religious groups. It might seem that interrelations between groups devoted to the service of man and his Creator would not be so disturbing as to upset society itself. But the history of wars, persecutions, inquisitions, and other forms of religious conflict testify to the disorganizing character of religious prejudice and intolerance. It must be remembered that religious sects or groups set themselves apart as wholly right and uncompromising with respect to some basic doctrine or creed. Each may be willing to allow others to form their own views and follow their own ways of belief and action. But there would be no separation by creeds except for the assumption of rightness of in-groups and implied wrongness of out-groups. This ethnocentric character of religious groups is similar to that found in groups separated on the basis of race and culture. There are no physical marks by which members can be identified in the case of race, nor such differences in language and institutional practices which identify persons of contrasting cultures. Members of many religious groups cannot be identified except by their attendance at particular churches, their ritualistic practices, and their adherence to certain doctrines or beliefs. They present no constantly visible evidence of their identification with a particular religious sect.

Factional Strife in Communities. Instances of social disorganization due to religious conflict are not widespread. Some local communities may be so deeply divided by religious prejudice that factional strife makes it impossible for the whole community to organize and cooperate for the common good. Thus school and health programs, recreational opportunities, and economic improvements are frequently blocked and communities paralyzed because of conflict between certain religious groups. More frequently, however, religious difference and intolerance operates in mild forms of negativism and expressions of social distance. The resultant problems are

similar in nature to those which have been more fully treated, but they are not so immediately apparent. Since many religious sects are largely confined to class levels, the ethnocentrism which develops may be based on class consciousness as well as on religious belief.

LABOR-MANAGEMENT RELATIONS

Those who own, manage, and utilize the means of economic production have not always been differentiated, nor can it be said that all are so separated now. There are millions of farmers and small businessmen who own and operate their own business enterprises. But technological changes have been so extensive that modern business corporations must bring tremendous amounts of capital together by selling shares of stock to thousands of investors. In turn, the stock is used to purchase extensive and complicated plants as well as varied and voluminous raw materials. The financial success and plant efficiency depend upon detailed subdivision and operation of men and machines. Thus, persons trained and devoted to management become responsible for the organization of men and materials in such fashion that mass production and financial profit occur together. In big manufacturing organizations those who labor own little, if any, of the means of production, and have no control over them. Laborers are dependent upon the system for work; they are unable to help or support themselves in any other way. This separation of ownership, management, and labor lays the foundation for the formation of groups with separate interests even though all are interdependent upon each other for success of the whole.

Emergence of Modern Economic Groups. Historically, those who owned and/or managed business enterprise had a tendency to regard labor as a means of production and pay out as small an amount on wages as possible in order to hold down costs. Persons who offered their labor for hire were in competition with each other for jobs and tended to receive the lowest amount which any would accept. Furthermore, owners and managers were relatively few in number compared with laborers, and were in a position to communicate with each other and often organize as a group. Without going into detailed historical development, let it be said that wages tended to be kept low. A laborer acting individually was practically compelled to take the job he could get at the wages he was offered.

Labor Organization. After a long period of time laborers began to realize their common predicament and to identify themselves as a group. As group consciousness slowly developed there were at-

tempts to organize and stand together as a group for better working conditions and wages. Such ideas and efforts were at first discouraged and then opposed. The early conflicts increased the separate identification of groups, and for two generations there were numerous strikes, lockouts, and violent encounters by the opposing groups or their representatives. In recent years the right of laborers to organize and bargain collectively has been legally recognized. Rather elaborate governmental machinery has been set up to regularize and channelize the negotiations between labor and management.

Important Facts and Issues. Both labor and management have been increasingly able to see and understand their mutual dependence upon each other, as well as the terrific loss to each other in all cases of industrial conflict and stoppage of work. There has been increased recognition of the fact that laborers are also consumers and buyers. As they are paid more and encouraged to have higher levels of living, they support industry itself. Although relations between these groups vary from time to time, their conflicts still threaten industrial order and society itself.

Some of the chief problems which remain still concern ethnocentrism and out-group–in-group relations. Laborers still resent treatment as mere means of production and assumption of domination and superiority over them. They wish to be recognized and appreciated for their competence and to share in production. They also wish to have some certainty of employment and continuous income. They want something of the security of status and income which they think managerial and professional personnel receives. They are inclined to blame management for the uncertainties and insecurities of their position. Management, on the other hand, tends to be suspicious of the motives of labor and to fear their demands, and is inclined to think labor groups would not be satisfied with a minimum wage and dependable work opportunities. It may have fears that labor groups would not be satisfied with less than participation in management.

Light May Be Dawning. Despite the seriousness of such divisions within the society, the steady improvement of relationships through the years and the gradual addition of security measures is quite reassuring. Unless some crisis is precipitated by the accumulation of international fears and actual or imagined interference from without, labor-management relations are likely to be accommodated in a satisfactory manner. Recent insights (pp. 11–13) from social

science are being applied, as in the case cited earlier; and it seems possible that technological change may eventually be accompanied by adequate social relationships.

THE BASIC PROBLEM OF SOCIAL INTELLIGENCE

Behavior Rests on Consent. None of the problems outlined in this and the preceding chapter can be dealt with intelligently unless they are understood. Neither can they be understood unless people are adequately informed and have reasonable interpretations made available for their consideration. The history of human slavery and the recent demonstrations in Germany, Italy, and Russia make it clear that people's behavior can be directed by means of physical force. In the long run, however, people live by ways they accept and assume to be correct. Certainly, under a democratic system, the ways of life rest upon consent. If this is true of relationships which now exist, it is equally important with respect to readjustments which may be desirable in problem situations.

There is need for social intelligence or informed public opinion, in somewhat the same sense as military intelligence. Armies cannot proceed intelligently unless the competence, strength, and position of all units are known and unless all units are in sufficient communication and unity of spirit that they can move together. Furthermore, military intelligence requires that the strength and location of all difficulties be known so that all will be aware of what they are up against. There is no "pussyfooting" about difficulties nor evasion of realities by sentimental meditations and daydreaming. Social intelligence would be far more difficult to come by than military intelligence, but the need for it is equally crucial.

Children Must "Know the Game" Being Played. The point was made earlier in this book that a child learns to play a game by coming to see what the game is, and what his role is with respect to every other player. His hope of becoming a successful player depends upon his keeping up with the actions of every other player and grasping the significance of each act in relation to the objects of the game. He does not know a "good play" from a "bad" one, or what constitutes a mistake or an error unless he knows "what the players on his side" are doing with respect to "what the players on the other side" are doing and seem to have in their minds to do.

The "Hospital World" Once More. In an earlier chapter the hospital was suggested as a model of organization. It was evident that hospitals are set up to achieve certain ends, and that all special services and specialized personnel must act together if goals are to

be achieved. It was also pointed out that persons and groups of persons within the hospital relations may upset and disorganize hospital operation in many ways and for many reasons. Particular emphasis was given to the importance for each person, including patients, to know not only his own place in the system of relations but also what is expected of others. There must be alertness to "what is going on" all the time if adjustments are to be made to the continual stream of developments, even emergencies, which flow through experience. The basic problem of the hospital, so far as its organization for effective action is concerned, is that of communication and understanding among all those who are engaged in its operation.

Complexity of Informed Public Opinion. In the same manner, the most important social problem, because it is basic to the understanding of all the others, is the problem of social intelligence. Unless leaders and a vast number of citizens are able to see that their problems of health, alcoholism, delinquency, and intergroup conflicts are problems of social organization, and that all groups are interdependently involved in them, there is no hope of basic understanding. If it is difficult for all persons engaged in a complex game to keep their minds on all the plays and know just what is going on, and even more difficult to grasp what one is doing in relation to the dynamic life of a vast hospital, it would seem almost impossible to learn the meaning of events and problems occurring in the community and larger organization of society. The problem of bridging the gap between the complex society and the simple capacities of persons was pointed out by Aristotle, and it has probably increased in difficulty since his time.

Nevertheless, the problem must be continually faced and efforts made to deal with it. It can be assumed that persons will act in their own best interest if they can know what is best, and if they can learn how to deal with the situations which arise. Unless they can and do inform themselves about their affairs and properly interpret the meaning of their relationships, their problems are likely to grow more serious and get out of control altogether. When Jefferson said, "man is the only animal who devours his own kind," he was thinking of persons who are willing to sacrifice the good of all for personal or group advantage. Unless there is vigilance in keeping informed, proper courses of action cannot be determined or taken. Within the hospital model of society, the malpractice of surgery was cited as an example of the willingness of a few to jeopardize the many. Only by alertness and constant checking by those

concerned with the best interests of society and the medical profession can the problem be controlled.

SOME UNDERLYING DIFFICULTIES

Static Learning and Dynamic Living. Although it is not possible to fully understand social problems apart from their relationship to the whole social organization, a grasp of such relationships is most difficult for a number of reasons. The underlying difficulty of bias and prejudice was set forth in connection with intergroup conflict. Persons are inclined to see and interpret situations and events from their own economic, religious, political, and national points of view. Unless people learn and cultivate habits of objective checking and examining of the world around them, they fail to realize the full meaning of health, racial, political, economic, and religious situations. For the most part, persons are taught from babyhood through college, if their education extends that far, to accept facts, ideas, and doctrines as more or less fixed. They may often be drilled to take a firm and uncompromising position with reference to many phases of life; and they may be taught to expect their social world to remain practically the same. They tend to learn that all things are either right or wrong, good or bad, acceptable or unacceptable, and so on without understanding that many relations are matters of degree, such as sickness and health, hot and cold, ignorance and knowledge. Few, perhaps, are taught the idea and habit of "let's look into the matter and see whether we can discover what it means." Unless people can learn to ask important questions, they are likely to remain indifferent to their problems, or to accept them as inevitable. It is possible to learn to ask why particular conditions exist, and where present trends will lead if continued for another ten to fifty years. Persons can learn to ask what courses of action are open to them other than their current practice.

Fear of Inquiry and Understanding. Unfortunately, however, there is considerable fear of inquiry and the raising of questions. Just as persons sometimes fear to learn about the condition of their own health, or the nature of their illness, so people fear knowledge of their social problems. It is well known that persons defend themselves against clear knowledge and admission of their personal inadequacies by blaming others, rationalizing their action, and otherwise avoiding unpleasant realities about themselves. Analysts and diagnosticians are sometimes disliked or attacked by their patients. It is not surprising that groups and masses of people similarly avoid

questions and investigations which might indicate the true basis for social problems. Thus many problems of public health and education, delinquency and crime, poverty and security are avoided and may not be open to inquiry. In fact, it often happens that those who make correct information available or bring unpleasant facts to light are persecuted as enemies of the people. This point was made the basis of a drama by Ibsen[6] in which the leading character, who investigates and publicizes the serious health menace of the local water supply, is himself humiliated, attacked, and finally driven out of his home community.

PROPAGANDA

Control through Advertising. In this brief sketch of a few major social problems it is impossible to continue analysis much further. But some attention should be given to deliberate and organized efforts to persuade groups or masses of people to act contrary to their own or to public interest. Many people are familiar with the necessity for controlling the advertising of foods and drugs. In spite of legal restrictions, it is difficult to keep certain business interests from making false or misleading claims about some general tonic or health builder, some reducing formula or beauty preparation, some remedy or cure for numerous specific diseases, and some preventive treatment by which dangerous consequences are to be avoided. Advertising has become an art of appealing to specific fears, hatred, desires, ambitions, and hopes which people have, in such a way that they purchase all kinds of goods as a means of satisfaction. The intent of most advertising is fairly obvious, and customers may learn to be critical and selective.

Propaganda Is Subtle. Propaganda, however, is much more subtle than advertising, for the source from which it is issued and the person or group to benefit from it are generally concealed. It is incorporated in stories for children, free materials used in schools, some textbooks, pamphlets, and other publicity materials, as well as in news reports through newspapers, radio, and television. It is inserted in text or illustrative material in such a manner that the purpose of influencing and controlling thought is not readily detected. It is so worded that popular prejudices and stereotypes, as well as basic principles and beliefs, are utilized to support the "line" which is being "put out" or "put across."

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[6] Ibsen, Henrik: "An Enemy of the People," in *Collected Works of Henrik Ibsen*, Vol. VIII, Scribner's, 1907, pp. 1–188.

Extreme Results in Germany. Although illustrations could be cited from current affairs, the fairly recent demonstration of control over people's minds in Germany may be familiar to many. This proud and powerful people in the First World War suffered not only humiliation and defeat, but also the death toll of millions of young men, vast destruction in cities and towns, and the breaking down of industrial plants and transportation facilities. In addition, enormous war indemnities coupled with charges of guilt for starting the war were imposed upon these people by their enemies. As a result, the German people were quite discouraged, fearful, resentful, and practically hopeless. Several unsuccessful efforts to reorganize the political, economic, and social life of the people were made. When anxiety was most intense and widespread, a relatively small group began to circulate the idea that Jews were to blame for most of the trouble people were experiencing, and to suggest that Germans were the superior race destined to dominate all people of the world. This racial doctrine was widely and continuously spread among the people as a means of rousing them to action against Jews within their country, and as repudiation of war guilt and financial obligations charged to them by outside enemies. It would be a long story to describe the rise of Adolph Hitler and his originally small group of Nazis to complete power over the German people and their attempt to gain world control by launching the Second World War. And through the entire drama the leaders assumed that any lie, extensively spread and continuously repeated among a people, will be believed and made the basis of action. They not only used every means to spread the doctrine of racism, but, as they gained more and more power, they made it impossible for schools, churches, theaters, news agencies, or public speakers to fully observe, to report facts, or to raise any questions or doubts about the way things were being done. Thus, people were led to inflict terrible injuries upon Jews and upon any who were accused of doubting or differing with the central authority. Propaganda plus complete censorship or suppression of counter ideas makes it possible for a single leader and a small group of followers to gain total power over the entire life of a people.

Protection against Propaganda. This demonstration of the extreme ends to be achieved through propaganda also occurred in Japan and in Russia. These occurrences suggest that similar large scale manipulation of people's thought and action is possible anywhere in the world. But they are cited primarily to suggest that lesser programs of propaganda may be carried on by any group seeking

special privileges or advantages for themselves at the expense of all the others. The only means of protection against such manipulation seem to be increased awareness of its existence, knowledge of methods used, suspicion of any "single line" of thought unsupported by evidence but appealing to fear, hate, or any particular prejudice, and insistence upon information and consideration of "other lines" of thought and evidence.

The purpose of this very brief presentation of the problem of social intelligence and its possible obstruction through propaganda is to suggest that all other problems of society are linked with this. To the degree that social intelligence is clear, the various problems of society may be understood and reasonably dealt with. To the extent that people are not clearly informed about conditions under which they live and do not correctly interpret the meaning of these conditions, they must get into greater difficulty. And furthermore, to the extent that they are deliberately blocked or misled with respect to any aspect of their lives, they lose the power to deal effectively with them. The biblical statement, "Ye shall know the truth and the truth shall make you free," seems applicable to all phases of social life.

FOR INVESTIGATION AND DISCUSSION

1. Why is it difficult to recognize or observe prejudice in ourselves? And, if we succeed in doing so, why is it difficult to talk about it or discuss it with others? If you do recognize some prejudice in yourself and if you are willing to talk about it, tell how you think you came to have it and in what situations it has affected your behavior.

2. Review the meaning of stereotype in connection with intergroup and interpersonal relations, and cite as many instances as you can of its use—from history, literature, current affairs, or your own observation.

3. In what situations may stereotyping occur with respect to patients, nurses, doctors, and service personnel?

4. Similarly, examine the meaning and function of "the scapegoat" in intergroup relations; and cite instances as you did in question 2.

5. Do you know any persons who seem to be in a marginal position socially? Describe and explain the situation in each case as fully as you can, and make some observations concerning the significance of the "undefined" and insecure relationship.

6. Make a collection of advertising materials with respect to a number of patent medicines, toilet preparations, and foods. Classify them if some criteria for doing so appears helpful in your analysis. What are the principal appeals or inducements used in them? What social significance do you attach to your analysis?

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Chapter 8

FAMILY RELATIONSHIPS ARE CHANGING

VARIABILITY AMONG FAMILIES

When one thinks of his own family in comparison with other families of his acquaintance he is likely to be impressed with the differences among them.[1] Some of them live in apartments, whereas others live in separate houses of varying sizes and styles of architecture. Some have lived in the same place for years, while others have moved several times. Some have no children, while others vary in number of children. But the most striking differences among the families which have children concern ideas and ways applied to rearing offspring as well as the relations of parents to each other and to their children. Almost complete freedom may be given to children in one family, whereas rigid control is exercised in another; in still another, parents and children seem to talk things over and work their problems out together. There is another striking contrast when the wife and mother in one family has a job outside the home and is away most of every day, whereas her neighbor may spend nearly all day in domestic activities.

SIMILARITIES BY HABITATS AND CLASSES

If one's acquaintance is limited to a rural neighborhood, small town, or homogeneous suburb, variations among families may not appear to be very wide. In some places housing conditions, work of parents, levels and standards of living, and ways of rearing children are very similar among families. Family patterns also tend to be similar for ethnic groups living in segregated areas of large cities. Italian, Mexican, Chinese, and other families living in such segregated areas have managed to retain much of their peculiar systems of family life. Negro families may, of course, vary among

[1] Cavan, Ruth Shonle: *The American Family.* New York, Thomas Y. Crowell Co., 1953, Part II.

themselves, but the dominant position of the mother which prevailed in an earlier period is still marked in Negro families.[2] The family type found in upper-class residential areas of the city has been called maternal because the father's business keeps him away from home much of the time. Thus, similarities in family patterns and interaction appear when habitats and classes are considered separately, but among families generally significant variations occur.

All this suggests that differences among families may be due to circumstances under which they live or to differences in attitudes, values, and beliefs which have been learned from past generations. It should also be clear that some of the variations are due to the fact that people of many races and cultures influence each other through their contacts and interaction in our cities. But the point which will be stressed in this chapter concerns the changes in general family patterns and in the statuses and roles of family members on account of technological changes and urbanization. The conditions under which families live have been so revolutionized that many goals and values, as well as patterns and functions of family life, are undergoing change. Since the changes are not occurring uniformly for all families, many differences may be observed among families even within one's personal acquaintance.

When we think of families we know personally or visit directly we are thinking of groups made up of persons who are interacting with each other in certain ways. However, when we think of changes in the family we have no particular group of persons in mind; rather, a system of relationships or expectations. We are thinking of the status and role of wife and mother, that of the father, and the status of the children and others who may belong to the household or of the kin dwelling together. It is the system of family relationships we think about when we consider changes in the family. Of course, any changes in the system may be registered or reflected in variations or differences we observe when we compare one family group with another.

CHANGING BASES OF FAMILY STRUCTURE

In order to identify changes in the family and consider their significance we must know the major goals, patterns, functions, and detailed expectations of the prevalent family systems at some time in the past. We must know the family system as it existed previously

[2] Frazier, E. Franklin: *The Negro in the United States.* New York, The Macmillan Company, 1949, pp. 320–321.

in order to measure or note changes which have been taking place over a period of time in response to changing conditions and influences both outside and inside the family itself. We must start with the fact that families were quite similar to each other in the early days of American history. They were similar for two major reasons. First, the majority of them were engaged in agricultural production. Family members were involved in an organized division of labor. And, second, the vast majority of early American families were descended from British, German, and other peoples of northwestern Europe. Not only were their cultural roots similar with respect to family living, but their total institutional life was much the same. These early relations did not greatly change during the first hundred years of this country's life.

If the year 1790 is taken as a starting point, we find 94.9 per cent of the nation's population classified as rural, leaving 5.1 per cent of the people in the few towns and small cities near the sea coast. One hundred years later nearly two thirds (64.6 per cent) of the people were still classified as rural, and less than half (45.8 per cent) of the people were urban as late as 1910. By 1950, however, little more than a third (36 per cent) of the people remained under the rural classification. In the most populous northeastern quarter of the nation and on the West Coast there are even fewer rural people. Thus, within about two generations, the basic manner of life has been shifted from rural to urban for the vast majority of the people. The massing of people in urban centers has been due primarily to rapid industrial growth, which required the concentration of people around terminals, factories, and offices.

It is well to remember that during this same period of increasing urbanization the ethnic composition of the nation was greatly changed by large increments of people from southern and eastern European countries. As late as 1880 over half the immigrants from Europe came from the British Isles and a very large additional segment from Germany, while Scandinavian countries, France, Switzerland, Austria, and other peoples of northwestern Europe supplied the balance. Streams from Italy, Russia, Poland, and other parts of Europe became dominant about the turn of the century. It may also be noted that the "new immigrants" tended to settle in the most urbanized parts of the nation and thus compounded the changes which were already set in motion by the American shift from rural to urban ways of life.

Thus, the changes which have taken place in the traditional

family pattern have been largely due to the impact of industrialization, urbanization, and immigration which became increasingly dominant around the turn of the century. It is important to stress the *recency* of events, because it must be understood that major changes have not become well established and the family system can best be described in transition rather than as relatively permanent or stable.

THE TRADITIONAL AMERICAN FAMILY

Extensive writing has been devoted to descriptions of the early American family. Our ideas about it come from folklore as well as from literary and historical works. It is not surprising that it has been idealized and glorified in some of these, while in others an equally unreal stereotype of rigidity and repression has been created. Only the main outlines of the system can be given here.

We must learn what we can about the dominant form of this family, how it was organized, and what was expected of particular persons who belonged to it. What were its principal goals, what functions were performed by it, and what ties bound it together? Answers must be quite general and oversimplified; but we must have a reasonably accurate "base line" from which to identify changes which are under way. Some of the most erroneous stereotypes must be corrected. And a number of details must be developed in the course of the chapter rather than as a part of the initial description.

Patriarchal in Form. The traditional family was patriarchal in form. This literally means rule by the father with wife and children subordinate to him and obedient to him. It is well to remember, however, that the father was head of the family not only in the sense of having authority but also in the sense of having responsibility for the welfare and development of the whole group. So much has been written about the authoritarian character of the father in the early family that responsibility for advancing the welfare of other members of the family by the father can be overlooked. It seems quite probable that mutual love and respect bound the members of the family to each other more often than fear and forced obedience to the father. Although the wife and children in the traditional family were subordinate to the husband and father, it seems doubtful that they were always repressed and their potentialities thwarted. The conception of the tyrannical, haughty, cruel, and otherwise self-centered and assertive father may have been approxi-

mated often enough to give rise to this as a stereotype. But it must be remembered that personalities probably varied as much in the past as they do now, and it seems quite reasonable to believe that rational, mild mannered, considerate and affectionate fathers occurred as frequently under the patriarchal system as under others to be mentioned later. Although the normal role of wife called for subordination to the will and leadership of her husband, this was often nominal. Many capable women became the actual leaders and managers of family affairs with husbands deferring to their judgment. Thus, the idealized mothers whose strength, endurance, patience, wisdom, and love inspired and guided their children toward honorable and worthy goals were not wholly fictional. The point to be stressed is that the traditional family system did not foster personal strains and maladjustments among its members because of any slave-like roles of women and children under masterful and domineering roles of fathers. The system appears to have met the needs of members in a reasonably satisfactory fashion, so that the institution itself was stable and optimum security was experienced. Some of the factors which were favorable to the integration, solidarity, and stability of the traditional family are to be discussed.

Primary Goals. The primary goals of the rural family were the rearing of children and the provision of a livelihood for all members of the group. To support these goals the family was interested in accumulating reserves in the form of property, and in maintaining stable government, religious agencies, and educational efforts in neighborhoods and communities. Families generally valued their kinship so much that much conversation was devoted to the marriages and ensuing fertility of brothers, sisters, aunts, uncles, and generations of cousins. Family reputation and esteem were valued, and achievements by individuals were often accounted to family origin and the building of family prestige. Similarly, family reputations suffered when any members deviated from normal definition of rectitude. Thus, the family exercised powerful moral control.

Agricultural Interest. The major activities of the traditional family centered around agricultural production. This tended to bring nearly all members of the family—even children and aged persons—into economic partnership and relations of mutual aid. In a period of handcraft production, the food, wood, fiber, wool, and other raw materials grown on the land were processed in farmhouse and outbuildings. Families were largely dependent upon their own combined efforts to furnish food, clothing, and shelter. The

help of neighbors might be required occasionally to build a house or barn, to harvest some crop, to nurse the sick, or to deal with some unusual or emergency task. Small merchandising and milling establishments also supplied a few needs beyond the capacity of farms. It is trite, perhaps, but important, to emphasize the togetherness and interdependence of all family members; and at the same time make it clear that every person had a particular work to do and a responsibility to meet. Some of the detailed relationships will be pointed out in connection with the analysis of traditional functions and their alteration.

Functions of the Traditional Family. The principal functions of the family have been implied in the brief descriptive outline. The reproductive, economic, socialization, and status-conferring functions have been suggested. But it seems desirable to expand the analysis to cover more detail. For the purposes of this chapter, traditional family functions and changes with respect to each will be treated in the following order:

1. Sexual expression, reproduction, and responsibility for offspring.
2. Protection and maintenance of offspring.
3. Economic production.
4. Economic consumption.
5. Transmission of name and status.
6. Transmission of property.
7. Inculcation of manners and morals.
8. Inculcation of idiomatic language.
9. Inculcation of basic arts and crafts.
10. Provision of affection and security.
11. Stimulation of creative and recreative effort.
12. Determination of vocational preference.
13. Determination of earliest "world view" and "philosophy of life."
14. Determination of earliest conceptions of self.
15. Determination of basic personality pattern.

The most significant changes with respect to each of these will now be discussed. But it must be kept in mind all the time that the changes are still under way, and that factors responsible for the changes have not influenced families uniformly or evenly. Thus, in some of the most isolated rural areas of America, family goals, structure, and functions are much like those of the basic type set out in the description of the traditional family. Families in rural areas and small towns, and, perhaps, many working-class families would resemble the traditional type in many ways. On the other hand, many middle- and upper-class urban families probably diverge

so much from tradition as to constitute a different type—emphasizing individualistic goals—to be described later.[3]

CHANGES IN ECONOMIC RELATIONS AND FUNCTIONS

Reference has already been made to the technological revolution beginning near the turn of the 19th century. The advent of the factory system called for the concentration of families in mill villages and towns. Their coming in from the countryside was made possible not only by the invention and use of power machines for spinning and weaving but also by the application of more efficient tools to agricultural production. This process of conversion from handcraft production in separate homes to machine production in factories and shops, accompanied by the application of more power tools to agriculture, has been continuous to this day. The spinning of thread and weaving of cloth may have been among the first major changes from domestic to factory production; but these have been followed by the transfer of garment making, breadmaking, drying and canning of foods, laundering, and much of the cooking of foods. It is not surprising that the serving of foods is declining as a family function since children are more frequently served at schools and recreational centers; and parents must be fed near the places of their work, shopping, or social engagements.

Technological Revolution. The technological revolution, of course, has not been confined merely to the transfer of economic production from homes to shops. Such changes are quite significant in themselves, as later discussion will indicate. But the most phenomenal changes of our time are concerned with the increase of heavy industries and the mass production of goods which are wholly new to civilization. Not before the dawn of the 20th century did changes become so numerous and various that the adaptation of man to his own inventions became a challenge. The invention of telephone, automobile, airplane, radio, motion picture, electric refrigeration, and synthetic fibers such as rayon brought epoch-making changes in the first half of the present century. Before adequate adjustments had been learned to meet the impact of these inventions,

[3] Most students of the family in America obtain their data from persons in the middle class; and generalizations are most frequently made as if the middle class family is the dominant type. Students of nursing will be interested in variations among families which might represent a cross section rather than a dominant type. See Winch, Robert F.: *The Modern Family*. New York, Henry Holt & Company, 1952, pp. 92–99.

conditions for social life were further revolutionized by the synthetic production of hormones, vitamins, and amino acids; the application of newly discovered atomic energy to war and peace; the invention of the television receiver, helicopter, and the photo-electric cell, and other basic discoveries.

New Things Become Necessities. It is well to remember that the new goods which flowed in such increasing volume from ever-growing industrial cities came to be regarded as necessities by millions. Under the earlier agricultural and handcraft economy it was not easy to produce enough food, clothing, and shelter to maintain life on a very high level. But power machines have made it possible to produce in such abundance that many things which were formerly regarded as luxuries or were even nonexistent are now thought to be necessities. In spite of the stimulating effect of advertising, which tends to create not only new wants, but desires for greater quality and quantity of goods, production is often so great that problems of surpluses develop.

Work Pattern of Family Changes. Thus, not only the work pattern of members of the family, but also the needs and consumption patterns have been altered greatly through the last two generations. The non-agricultural family does not work together at production, but each member works separately at the job he can find to do. Many women continue as in the past to devote themselves to domestic economy under urban conditions, but most of their time is consumed by maintenance functions rather than by production and fabrication of raw materials. An ever increasing number of women are gainfully employed outside their homes. Whereas females contributed only 17.2 per cent of the labor force in 1890, this proportion had been expanded to 28.6 per cent in 1950. In actual numbers the increase was from less than four million to over eighteen million.[4] Furthermore, only about half of these are single women, 24.8 per cent are married, and 36 per cent are widowed or divorced.

It is increasingly necessary for many partners to earn an income outside their home in order to maintain the standard of living they prefer. It should also be obvious that there is little for children and aged persons to do by way of production around an urban home, and they are practically unemployable anywhere else. Under modern conditions, as soon as children reach work age and achieve enough competence, they must find work on an individual basis as

[4] Winch, *op. cit.*, pp. 63–65.

others of the family do. Such separation of family members from each other for work may involve separation in interests, in association with others, in standards of living, and in budgeting of time. In spite of the fact that individual incomes are likely to vary for members of the family and there is necessity for pooling them, a feeling of independence, not experienced in the traditional family, probably accompanies individual earning.

CHANGES ASSOCIATED WITH REPRODUCTIVE FUNCTION

Responsibility for reproduction and replacement of generations has long been lodged in the family. Taboos against the birth of children out of wedlock have been made so rigid and uncompromising that both unmarried mothers and their offspring have often been treated as outcasts. Erring daughters and their families have often been "saved from disgrace" by fixing blame for fatherhood and forcing marriage with a young man by threat of shotgun. The mores have been developed to keep sexual union within the family relationship and create strong feelings of shame and guilt on the part of young people who yield to their premarital sexual desires. The burden for maintaining moral standards under the traditional family system was placed on women. They had much to gain by chastity and marriage, and most to risk from premarital indulgence and pregnancy. Their dependent economic position made marriage highly essential, and non-marriage a major failure. Men were not in such a dependent economic position or subject to so much moral restraint. In fact, they were frequent beneficiaries of a separate standard of morality on the mythical basis of greater biological impulsion. Thus, the institution of mistress, concubine, or prostitute saved the face of both moral standards and biological demands where strains existed. There now seems to be some shift toward a single standard and away from the "sex is evil" theme. There is probably little data on the extent and significance of the change, but Hollywood behavior and the content of pulp and other magazines point to some basic changes with respect to sex.[5]

Within the traditional family itself children were wanted for a number of reasons. They were evidences of divine blessing and obedience to the command, "Be fruitful and multiply." They were economic assets because their coming added little cost. They also contributed to production at an early age and to the support of aged

[5] *Ibid.*, pp. 345–348.

parents when they reached the prime of life. Most often they were loved for their freshness and newness of life and the hope for the future which they symbolized.

Children—Economic Assets or Liabilities. In nonagricultural families, especially in those of middle and upper classes, children are not economic assets. Considerable cost is associated with their birth; and their physical and educational development is a steady drain on family resources. Their inability to make any significant economic contribution in early childhood is further complicated by the longer period of dependency required before adult work can begin. Furthermore, in the largest and most congested urban centers the very matter of physical space for the accommodation of children is in marked contrast to that available to farm and small town families.[6] Some apartment owners will not rent their property for occupancy by children; and, when they are allowed, quarters are often too small for reasonable comfort and convenience. Play space is often inaccessible without going a considerable distance from the family domicile. Besides, the hazards to safety may be considerable under some urban conditions. Children may have to cross high-speed traffic lines or may easily stray from safety. Dust and other pollutions of the atmosphere, as well as the ready spread of contagions in congested quarters, may be menacing in some places.

It is not surprising that these factors discourage the birth rate and the adventure of rearing children. Furthermore, because many married women must enter the labor market and compete for gainful employment childbearing not only is put on the side of economic cost, but may also involve loss of competitive advantage for position and promotion as well. The status of women, and their role, to a considerable extent, have been changed by their independent competitive position for nearly all jobs formerly closed to them. Since birth control makes pregnancy a matter of choice, women are relatively free to interpret success in terms of higher social position and standards of living rather than in terms of pregnancy and family life. And when children are wanted, high standards for their support and training forbids having very many of them. The small family ideal of having only two or three children tends to be dominant.[7]

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[6] Lynd, R. S., and Lynd, H. M.: *Middletown, a Study in Contemporary American Culture*. New York, Harcourt, Brace & Co., 1929, pp. 94–95.

[7] See Landis, Paul H., and Hatt, Paul K.: *Population Problems*, New York, American Book Company, 1954, pp. 172–187. In this citation (p. 179) it is also noted that "an increase in the ideal size of family seems to have occurred." One study indicated that 31 per cent of women aged 21–34 in 1945 expressed a desire

Emphasis on Individualism. The revolutionary changes to high speed and high-powered machines, tremendous mass production, increasingly higher levels and standards of living, within an increasingly urbanized setting, have profoundly influenced family goals and structure. The traditional family-centered life of an earlier period is being replaced by an individualistic emphasis which makes gratification of personal ambition primary.

The former emphasis upon work, self-sacrifice, sense of duty, and obedience to moral authority tends to be regarded as unduly repressive and harmful to individual freedom and potential development. The thought of having a child is often weighed against the pain, discomfort, and inconvenience involved. Childbirth may be feared as a physical ordeal, and breast feeding may be loaded with negative and nuisance interpretations. Besides, pregnancy and childbirth may be thought to destroy youthful figures and glamorous appearance beyond the powers of cosmetologists to remedy. Childbearing and nurture of children may be avoided because they restrict the enjoyment of recreations, luxuries, and freedom to move about.

Happiness—By-Product or Goal. Individual happiness is often suggested as the major goal of the so-called companionate family, whereas happiness was regarded as a possible by-product of traditional family living. The image of happiness for the modern family is none too clear. Perhaps the popular version is displayed in Hollywood life, moving picture romances, television, weekly picture magazines, and serials in pulp "literature." The equally individualistic but less romantic version may be found in magazines especially addressed to women and to parents. At one extreme, sexual attractions and pleasures are suggested as principal bases of happiness, whereas democratic participation in family living appears at the other. These and other generalizations about changes from the traditional system are intended only as an indication of probable trends and influences.

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for 4 children and 7 per cent for 5 children, whereas, correspondingly, 21 and 3 per cent expressed similar desires in 1941. Since in recent years more women are having a third and fourth child the value of children in relation to other values may be undergoing some modification. Increased suburban residence may be a factor in this. It must be kept in mind, however, that marriage rates were highest in the 40's, reaching perhaps an all-time high of 16.4 in 1946. This in itself would be inclined to increase the birth rate, and make childbearing "fashionable"; but whether any significant reversal of reproductive attitudes and behavior has developed is uncertain at the present time.

CHANGES IN PROTECTION AND MAINTENANCE FUNCTIONS

Responsibility for the physcial protection and maintenance of children by the traditional family was taken for granted. The family was not only engaged as a unit in economic production; it was also a unit with respect to consumption of goods. At whatever level a family could provide food, clothing, and other necessities, children received their share. Families with numerous children and small incomes were frequently unable to provide more than bare subsistence at any time. When misfortunes such as poor crops, illness, and loss of employment cut down income children were likely to suffer most—not only because of their initial weakness but also because of the retarding and cumulative effects of inadequate diet, clothing, and housing. The harmful results of poverty were as serious for children in rural families as for those living in cities; but they were less obvious. Neglect, malnutrition, disease, ignorance, dangerous exposure, and many other effects of poverty on children became clearly evident in families crowded in decadent housing of cities and industrial tenements.

Welfare, Health, and Educational Services. Slowly at first, but in ever-increasing amounts, family incomes and family efforts to protect and maintain children have been supplemented by public funds through public agencies. Family welfare, health, and educational services have multiplied through the years until food, clothing, housing, medical and nursing care, recreational facilities, educational opportunities, and spiritual concerns are not left entirely to families. When and if nursery schools become more general and health services more accessible, even more of these elemental functions of protection and maintenance of children will shift from family to other institutions and agencies. This is true not only for impoverished and lower-class families, but for families of higher levels as well. As the functions shifted with respect to needy families, other families were accepting supplementary educational and recreational efforts from schools, churches, and other community agencies. Not only has there been a shift in family functions, but the conception of family responsibility has changed. It is being taken for granted that the full development of capacities and potentialities in children is of maximum importance to society. There is a growing tendency to assign responsibility for this end to any agency which is likely to be most competent. The welfare of children, rather than being limited to the opportunities afforded by family connection, is becoming a primary consideration of society.

Family as Consumption Unit. Aside from these considerations, the family remains largely a unit with respect to consumption. In spite of increased individualization and autonomy of members, most families still find it advantageous to pool their resources and budget their expenditures for both necessities and luxuries. The purchase or rental of a home, the choice of its interior furnishings and decorations, the preparation and serving of meals, and the cooperative care and insurance of weaker members against misfortunes in the future remain major objectives requiring combined planning and effort. Here again status changes for women are outstanding. Most advertising appeals are addressed to them, and their preferences largely determine the disposition of family budgets. Since they are the chief recipients from life insurance and similar securities against future needs, much purchasing power rests with them.

TRANSMISSION OF PROPERTY, STATUS, AND NAME

The transmission of property from one generation to the next is largely accomplished through the family. Some changes are in progress with respect to this function, but laws of inheritance and the rights of kin to receive property left by deceased relatives remain relatively permanent and sacred. In a discussion as brief as this, two major changes can be noted. There is a growing tendency to cut down the transmission of great wealth by the levy of inheritance taxes on a sliding scale. Thus, heirs in families with small or moderate amounts of material possessions are required to pay little by way of tax when they receive property from their ancestors. On the other hand, larger percentages are required in taxes on large holdings of property, on the theory, perhaps, that reasonable sums are left and concentration of economic power and advantage are prevented.

Another tendency, which probably bears no relation to the first, is the decreasing emphasis on accumulation of property. The traditional family placed great emphasis upon sacrifice and denial of wants in order to save and accumulate an estate. The accumulation of wealth was a means of building prestige through generations to come—even though many limitations had to be endured in the process of accumulation. This pattern has changed so much that young people have difficulty understanding what it was like to do without numerous comforts and conveniences while fully able to purchase them. The shift is so great in this respect that prestige now tends to come through spending and utilization of goods. Some families are inclined to exhaust all the credit they can get on installment buying. Except for life insurance and withholding plans,

families tend to consume all they can earn. Furthermore, parents are inclined to utilize their income for the education of their children rather than emphasize the accumulation of property for transmission. Thus, the function of the property transmission continues into the present from the past, but with considerable modification of attitudes and practice relative to it.

Family membership has a great deal to do with the status each person occupies in society. And, unless persons lose their identity by moving away from places where they are known, or unless they achieve some special distinction, their own status is largely transmitted from their family. "To the manor born" and "from across the tracks" are folk expressions which connote the status-conferring function of the family.

A word might be said here about the relation of family property and of family consumption to status. It is often believed that relative wealth and social position are always correlated. This is not true. In a number of studies of stratification Lloyd Warner and his associates have found that upper-class position is largely determined by membership in an "old family line" of kinship; whereas families "with money" who lack status are interested in "social climbing" and often seek association and marriage as a means of vertical mobility. It is also well known that the *nouveaux riche* often make themselves ridiculous by attempting to gain status through inappropriate display of wealth. Social position, like surname, is usually transmitted or conferred by family; and much effort is required of individuals who achieve higher status otherwise.

ARTS AND CRAFTS INSTRUCTION DECLINES

From what was said about the impact of industrial changes on the family it would follow that the family function of inculcating tastes, skills, and judgments concerning basic arts and crafts has been altered. Under traditional family patterns girls were taught cooking, sewing, housekeeping, and often such refinements as interior decorating, design and fabrication of clothing, and the like. Older girls frequently learned to care for babies and younger children as well as home nursing of family members who were ill. Boys were graduated to all the knowledge, skills, and responsibilities of farming. This included some knowledge and care of soils, crop plants, and domestic animals. Since construction and maintenance were associated with agricultural life boys often learned rudimentary mechanics and the operation of machines, blacksmithing, carpentry, masonry, and so on.

It may seem needless to point out that fewer children and young people learn such matters from their parents nowadays; Many learn little about domestic and manual arts from any source. Many urban apartments and dwellings do not lend themselves to the development of responsibility and techniques involved in home-making. Changing technology has made automatic operations and ready-made and ready-mixed goods rather widely available. And nearly all domestic equipment, furnishings, clothing, and the like are designed, prepared, and delivered by specialists. Acquaintance with plants and animals may be nil, or may be learned in parks, camps, zoos and botanical gardens, museums, and biology courses. In suburbs some responsibility for living things may be cultivated. In towns and rural areas arts and crafts may still be learned from parents or in cooperation with them. It must be remembered that rural life is being revolutionized through agricultural and home arts teaching in schools and young people's organizations. Besides, home demonstrations agents are going directly to homes and neighborhood for the purpose of teaching home and farm arts and skills. Elsewhere the family has long since vacated such instruction.

CREATIVE AND RECREATIVE ACTIVITIES

"To work diligently and create something," and "to excite the admiration and approval of others" seem to be the basic needs of all persons. Under the isolated conditions of the traditional rural family these needs for achievement and recognition had to be largely supplied by the family and neighborhood. The family circle and fireside amusements and neighborhood "gatherings" were often rich means of creative expression and achieving personal recognition. Many biographies of men who gained prominence as scientists, inventors, statesmen, musicians, clergymen, and others refer to the early stimulation, encouragement, and patient tutelage they received in their homes during their childhood and youth. It is certain indeed that any suggestions, provision, and encouragement for creative effort would have to come, if at all, from the family and friends under isolated rural conditions. Unfortunately, life was a dull routine in many families, and neither children nor adults experienced a minimum of satisfying achievement and social recognition for imaginative and creative uses of time. Hard physical work seemed so necessary and rewarding that other activities were often regarded as distracting and sinful.

It is obvious that these needs for creative achievement and recognition can be met outside of the family. Teachers, clergymen, and

other varied leaders are often able to supply the suggestions, opportunities, and encouragement which are needed by persons hungry for creative expression and appropriate recognition by others. The curricular and extracurricular programs of schools are often designed to meet such needs. Churches, community centers, and an almost endless number of community agencies are now concerned with recreation and amusement. The time of children and young people is increasingly spent away from the family in association with peer groups directed by various institutions and agencies.

Limited Function of Mass Amusements. The only drawback in the mass participation in sports, amusements, entertainments, and other activities is that their basic function and the basic needs of the individual are often partially or entirely missed. It is sometimes difficult for some people to understand why much social activity and extensive amusement is not satisfying, and is often frustrating. Although the explanation is reasonably simple, the remedy is not. People do not thrive on continual spectatorship and applause for others, even though some vicarious experience is needed. Up to a certain point it seems good to witness star performers and experts of all kinds. But the self dries up if one does not have the direct experience of doing something which gives a feeling of creativity and mastery, and which receives some favorable recognition from others. Without analyzing the matter fully here, it should be fairly clear that families vary with respect to the discharge of this function; but in general it is being shifted to other institutions and agencies. And the postscript can be added that these agencies often lose sight of what the function is. Furthermore, it will be pointed out in the next chapter that commercial agencies often obstruct or interfere with the fulfillment of the function.

DETERMINATION OF VOCATION OR VOCATIONAL PREFERENCE

The traditional family often determined the vocation which sons and daughters would pursue. Under simple conditions most sons followed in the footsteps of their fathers by serving a sort of apprenticeship and doing the same work the fathers had done. Daughters became housewives in families similar to their own. Even if such a course were not feasible, parents were often able to arrange what was considered advantageous placement for their children. But such relations between parents and their children

have been so completely revolutionized that they occur rarely indeed. Robin Williams has said in this regard,

> . . . Because our occupational structure is still one of rapid change, competitive placement, and high specialization, the tendency is to defer final occupational choice until after childhood. Yet, if the young person is to enter a "good" occupation, he is likely to need an extended period of specialized training. Thus among the middle class groups, at least, he must choose his occupation as an adolescent, but without clear and institutionally stable guiding definitions and prescriptions . . .[8]

Under the mobile relations which now prevail, parents themselves are caught in specialized and bureaucratic positions over which they have little control. Each person is likely to have a history of vocational movement from one job to another and from one place to another rather than some continuous pursuit in one place as farmer, artisan, or merchant. Thus, vocations of children cannot be determined by families; nor is it often possible for families to suggest or influence vocational direction. Studies have indicated that some parents would like to be helpful in such matters, and a significant number even try to "push" their children into or toward particular vocations. However, no agency has yet been able to satisfactorily locate and guide the talents of young people into optimum vocational choices.

It now seems reasonable to say that the American middle-class family does instill aspiration and striving for status higher than that occupied by the family. It was stated earlier that all family members tend to work separately and to strive separately for individual advancement. The study of Middletown and many other studies which have been made since concludes that increased income and advancement of economic status are primary goals of American society. But this is further evidence that families are not concerned so much with particular vocations for their children as they are with advancing vocational level.

FOR INVESTIGATION AND DISCUSSION

Suggestions for Investigation and Discussion on Chapter 8 and Chapter 9 are presented at the end of Chapter 9.

BIBLIOGRAPHY

Bibliographic references for Chapter 8 and Chapter 9 are listed at the end of Chapter 9.

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[8] Williams, Robin M., Jr.: *American Society, a Sociological Interpretation.* New York, Alfred A. Knopf, 1951, p. 72.

Chapter 9

FAMILY RELATIONSHIPS (Continued)

DETERMINATION OF CONCEPTIONS OF SELF AND PERSONALITY

So much attention was given to the nature of self and its development in the first part of this book that this subject does not require expansion here. The same may be said about the determination of the basic personality pattern. Limited treatment of these matters in connection with family function is not meant to discount their importance, but merely to avoid repetition. It should be evident from what has been said that every child is likely to spend the first six years of its life primarily under family influence, and one or two periods of similar length in close association and dependence upon family members. If the child is wanted before birth, fully accepted when born, and nourished and cared for through successive periods of its development, it is likely to come to think of itself as wanted, needed, and approved. If its physical, emotional, and social needs are understood and met throughout the period of its growth and development it will become normal and mature in these respects. But if it is definitely not wanted before birth; if, because of its sex, race, appearance, or other presumed limitations, it is not fully accepted; or if its care is neglected or receives some particular slant it must get a peculiar conception of self and learn a basic pattern of behavior which is abnormal. Parents may be emotionally unstable, incompatible, quarrelsome, excitable and fearful, egocentric and jealous, overworked and fatigued, dissipated and brutish. In the treatment of their children parents may overprotect and indulge them, and unduly praise them and demonstrate sympathy for them. Contrariwise, they may be excessively critical and unjustly punish their offspring. Even those who try to follow psychological suggestions and doctrines may be permissive to the point of leaving their children insecure; or they may produce a similar result with

diametrically different treatment. Under such varying conditions some children may develop extreme dependence, self-pity, or hopelessness. Some may act upon attitudes of resentment and bitterness by patterns of aggression and attack; others may act upon feelings of inferiority and sensitiveness by various forms of withdrawal and isolation. Whatever conceptions of self and basic patterns of action emerge in the development of personalities, these are likely to result from family interaction.

MASTERY OF LANGUAGE

It was pointed out previously that children develop some of their deepest satisfactions and anxieties in connection with their earliest learning of how they must behave in society. Thus, many basic matters which affect all later behavior are learned before their meaning or social significance can be communicated. It is important indeed to realize that the meaning of much early experience is never grasped because it has never been verbalized or expressed in language forms. It is possible to enter fully into social experience only by means of words and symbols. As the child learns words, including his own name, the names of persons and objects around him, and a few verbs to express action, he becomes able to relate to others and to himself (pp. 59–63).

The traditional rural family was often isolated from others by physical space and by the necessity for continuous hard work. Social relationships were relatively simple and communication was usually direct and oral. Children learned to speak in the vernacular which was often limited in range and deviated more or less from standard construction. There was little time or need for reading, and opportunities for schooling were quite limited. Even after their introduction, public schools developed slowly; attendance was low and uncertain, terms were short, and levels of learning remained low. Even now isolated rural families are still relatively limited in their range of experience, and tend to interpret much of it in terms which were prevalent a century or more ago. The over-simplified appeals and explanations used by politicians, the simplicity and transparency of most propaganda, and the extreme popularity of blues, jazz, and hillbilly music are indications that revolutions in communication have not revolutionized insight and sophistication to any remarkable degree.

In recognition of this situation, recent studies have shown the necessity for simplifying the language used in agricultural, health,

and other informational bulletins in order that they may be understood by those for whom they are designed.[1]

Children May Learn More Than Parents. In spite of these facts, however, the impact of schools, reading material, radio broadcasting, television, and all other forms of mass communication is producing significant changes in learning and sophistication. More children are attending schools and other educational institutions outside the family earlier in life, and the formal educational process is being continued longer for more people than ever before. As a result, most children are learning less from their parents than formerly; and they are learning more about more things than some parents know. In many instances children and young people read more and are able to understand more of what they read than do their parents. To the extent that this becomes true there is something of a reversal of dependence for interpretation and understanding of meaning. Children are becoming able to read technological material and instruct their parents in many farm and domestic procedures. They are able to advise their parents on matters of management in family affairs. The extent and results of such reversal of certain dependent relations in the family, while others tend to remain on a traditional basis, are offered merely as hypotheses which cannot be developed further here.

TRAINING IN MANNERS AND MORALS

Although folklore concerning prenatal social influence upon the developing fetus may be discounted, the significance of very early learning for all postnatal life is becoming more clearly recognized. The child is learning from the moment of birth—long before he learns symbols and the social significance or meaning of what he does. He is learning from others by the very ways he is handled, fed, and cared for. John Whiting and Irving Child have made a cross-cultural study of certain aspects of child training in fifty-two societies. They base their study upon the fact that, "in all societies the helpless infant, getting his food by nursing at his mother's breast, and having digested it, freely evacuating the waste products, exploring his genitals, biting and kicking at will, must be changed into a responsible adult obeying the rules of society."[2] They find that societies

[1] Klare, George R., and Buck, Byron: *Know Your Reader*. New York, Hermitage House, 1954, pp. 24–26, 49–50.

[2] Whiting, John W. M., and Child, Irving C.: *Child Training and Personality*. New Haven, Yale University Press, 1953, p. 63.

differ as to the rules to be taught; the techniques used in forcing conformity; the age at which conformity is demanded to each adult rule; and the extent to which children are trained into a distinctive culture of their own rather than directly from infancy into adult culture. The purpose of their study was to look for relationships between customs of child training which will provide indices to adult personality traits characteristic of members of a society.

Child Training and Reactions to Illness. Whiting and Child focused their attention upon reactions to illness in adult life as an instance of differences in personality traits which seem likely to have emerged from differential experience in childhood.[3] A person may be quite aware that the disease from which he is suffering is due to microorganisms transmitted from some other person. Yet one may tend to blame others who had the disease for going about in public while sick and giving him the disease; another may blame himself for carelessly exposing himself; still others may emphasize their failure to take exercise or vitamins or something else which would have warded off the disease. Some may have violent aggressive feelings against others for bringing on their trouble. Persons also differ in their preferences for dealing with the conditions—in reliance on laxatives, pills, rest, abstinence from smoking, less sexual indulgence, eating fewer fatty foods, and so on.

These authors referred to child training practices in the American middle-class family in all their comparisons of similar training in the fifty-two different cultures. As a result of their study, they are inclined to associate differences in adult response to illness, and other behavior differences, with "variations in the experience of different individuals in childhood" probably because of "variation in emphasis and interpretation from one culture group to another and from one period to another."[4] Thus, the wide variation in American families among different segments of our society mentioned earlier in this chapter presents differences in child training almost as wide as those existing among many different cultures. Furthermore, their study was made before the pattern of permissive behavior in American child training practices became widely diffused.

Cross-Cultural Differences in Early Training. The study is particularly valuable because of its detailed comparison of nursing and weaning practices, anal training, sex training, dependence training, and the curbing of aggression in children. It is also concerned with the associated satisfactions or anxieties which are learned

[3] *Ibid.*, p. 322.
[4] *Ibid.*, p. 323.

in the training process. For instance, in the case of weaning, anxiety is dependent upon brevity of time required in the change from satisfactions of nursing to the taking of adult foods, the frequency and kind of punishment used to impose control, and the conflict with other desires which may be involved. In some societies nursing is used as a means of pacifying discomfort of any kind, and weaning is seldom begun earlier than two and one-half years of age. Until recently, middle-class American families observed a rigid schedule of nursing and began the weaning process at about six months of age. The severity of change among families varies from gradual building of satisfaction with eating like an adult to the administration of punishment for infantile feeding.[5] Similarly, anal training may wait until the child has learned to talk and understand or it may be started and reinforced by punishment by six months after birth.[6] The American family was found to be quite severe in such training, and also in sex training with respect to masturbation, heterosexual play, and modesty.

Relative Length of Complete Dependence. Further attention will be given later to the child's desire to be near and touch its mother. Nearly all pains and discomforts experienced by the child are reduced by being petted, warmed, embraced, scratched, and otherwise attended by the mother or mother substitute. But the period within which relatively complete dependence is encouraged and allowed to continue varies greatly. Abstinence is taught in one culture by putting the child in a hanging cradle where it may kick and scream until it is so tired and exhausted that it sinks into repose and resignation while the mother is away at work. It has the satisfaction of being fed when she returns.[7] Most societies do not begin training for independence before two years of age, and others delay still longer. American society differs from all others in that dependence training is continued so late—even into adolescent or early adult years. At the same time, however, American children may be required to dress themselves, help around the house, and observe good manners at a very early age. We know, of course, that dependence training in rural families[8] varies widely from that which occurs in middle- and upper-class families, Negro families[9] living

[5] *Ibid.*, p. 70.
[6] *Ibid.*, p. 77.
[7] *Ibid.*, p. 3.
[8] Hagood, Margaret Jarman: *Mothers of the South.* Chapel Hill, University of North Carolina Press, 1939, pp. 128–156.
[9] Frazier, E. Franklin: *The Negro in the United States.* New York, The Macmillan Company, 1949, pp. 321–333.

under various circumstances, and those found in other classes or ethnic groups.

Family Continues as Chief Source of Early Training. The point is that certain early training is inescapable as a family function and that it has basic significance for all later behavior and learning throughout life. Children may be influenced by experience in kindergartens, in city streets and neighborhoods, or farmyards and fields after the age of two. But, until they have learned to walk, talk, and gain some independence their initial learning of the folkways and mores goes on under family responsibility. It continues much longer, of course, because American families, especially in the middle and upper classes, continue the dependent relation for many years. August B. Hollingshead found in his study of Elmtown's youth that the behavior patterns of children are established primarily by their early experience in the family and secondarily in the neighborhood, and that similar experiences in family and neighborhood mold the children into similar social types because their learning in both areas tends to be strongly associated with class.[10]

Community Shares More Training. It is equally important to recognize that the job of teaching ways of behavior is being increasingly shared by community and neighborhood agencies. Increasing amounts of time are spent by children away from their homes in educational, religious, and "character building agencies." In many families both parents are required to be away from home much of the time because of gainful employment, or on account of civic and social engagements. In cities especially, at all class levels, perhaps, the schedule of activities outside the family is increasing. Furthermore, diverse interests and experience outside often make teaching and communication difficult when members are at home. Children of various ages are associated with their peers in schools, clubs, playgrounds, camps, teen towns, gangs, and elsewhere. With reference to many interests and activities persons are associated in cliques by sex as well as by race.[11] Thus, training tends to conform to peer group standards and expectations, and experience tends to be limited to these. Studies have been made of street corner society and gangs in parts of cities, which show how some deviation from norms are learned.

Guidance from "The Lonely Crowd." The fairly universal, uniform, and simple teachings of the traditional rural family are being supplemented or replaced by teachings which are diverse be-

[10] Hollingshead, August B.: *Elmtown's Youth; the Impact of Social Classes on Adolescents.* New York, John Wiley & Sons, 1949, p. 444.

[11] *Ibid.*, p. 446.

cause of class differences, complex because of secondary relations, and often confusing because of frustrations.[12] The codes and manners of gangs are often out of harmony with those approved in the larger society, and many scouting and recreational programs prove too tame for some adolescents. In a study of the changing American character David Riesman and associates have contributed their interpretation of what is going on.[13] They recognize a former period when social character tended to conform to rigid standards—"*tradition directed.*" Relatively homogeneous and settled folk transmitted traditional ways to their children, and maintained social control by direct means when necessary. Later, when population increased, and children moved away from direct association with their folk to new frontiers and cities, they tended to be "*inner directed.*" That is, they were not only taught what manners and morals they were expected to live by, but they were also taught to seek "fame and fortune" "through struggle" for success. They were encouraged to work toward long-time goals for which they were willing to endure privation and risk failure. Their "inner direction" came from the family originally, but their day-to-day behavior required individual judgment and adaptation. More recently, due to frequent wars, closing frontiers, bureaucratic organization, mass communication, and especially peer group association, behavior tends to be "*other directed.*" To be popular, to gain the approval of others, to do the latest thing, to go with the crowd seems important. Long-time goals seem too remote and costly when short-time goals promise some pleasure and satisfaction. How to win friends and influence people, to go out, to enjoy one's self, and even to have a hobby similar to that of others, are not goals learned at home, but, as the authors suggest, in the "lonely crowd."

PROVISION OF AFFECTION AND SECURITY

Essential Family Function. Up to this point attention has been given to many changes in family structures and the shift of many functions from the family to other institutions and agencies. We come now to the age-old function of providing affection and interpersonal security for family members. There is mounting evidence that it cannot be adequately discharged by any device or system other than the family. With the highly competitive and individualistic tendencies which have been described, the decline of neighborhood life and mutual aid, and the probable increase of loneliness and

[12] *Ibid.*, p. 412.

[13] Riesman, David, with Glazer, Nathan, and Denney, Revel: *The Lonely Crowd.* New Haven, Yale University Press, 1950.

anonymity under urban conditions, this function falls more completely upon the family than at any earlier time. Numerous agencies and services, to be discussed in Chapter 11, have been set up to supplement and support the family, but their limitations underline the strategic place of early teaching and provision of security and affection by the family.

Effects of Institutional Life on Personality. Ashley Montagu has drawn upon a number of studies, notably those of William Goldfarte and Lawson G. Lawry, to summarize what is known about the effects of institutional life upon the personality development of children. Anyone who has visited orphanages and several other institutions designed for the care of children has been impressed with the highly routinized experience to which all children are subjected. It is still a frequent practice to have children rise at a given time in the morning and go through each day on a relatively constant schedule of duties and activities. Similar food, prepared in similar fashion, may be served day after day or at regularly staggered intervals. The clothing everyone wears may actually be a uniform, but, if not, is differentiated very little. If play and recreational activities are provided, they are likely to be designated or scheduled rather than spontaneous. Under such conditions behavior tends to be passive and apathetic. Children are unreflective, and drift restlessly and aimlessly without focus and ambitions.

Language development, which has been referred to several times previously, is retarded in institutional children. Such retardation is marked as late as adolescence. It is not surprising that many normally expected inhibitions are not learned. Since care under institutional control is impersonal and mechanized, children are starved for attention and affection. Attention-seeking behavior is marked in small children, and highly emotional, unstable, and aggressive behavior may be observed. Emotional isolation results in limited effort on the part of many and in withdrawal from life's tasks by some. All of these observations add up to the fact that children under institutional care are arrested in their potential development and are quite immature. Furthermore, they are marred for life by a few years of such experience, and are able to improve only slightly when adopted into normal home and family life. The retarding effects of institutional life are evident throughout adult years.

Montagu compares institutionally reared children to those who are rejected or not wanted by their parents. Similar traits appear, but rejected children do not show the lack of ambition, or the failure to develop life purpose and to focus on goals. Neither do

rejected children show the limited span of attention, concentration of thought, and development of insight which marks the institutional child. Furthermore, rejected children respond to treatment and may largely overcome some early handicaps when situations become favorable.[14]

Quite surprising results came from some of the first intensive studies of high infant mortality rates. It was found that more than half of the infant deaths under one year of age were due to marasmus, or infantile debility. Even more surprising was the fact that babies in the poorest homes and under apparently less favorable hygienic conditions survived and developed normally, whereas those in the best homes and hospitals did not. The love expressed through constant and solicitous care by mothers under difficult circumstances was the crucial factor in promoting life and vitality. For this reason, infants are kept at hospitals for as short a time as possible. Montagu states in this connection that infants in hospitals suffer so much emotional privation that more damage results from that cause than from the physical condition which brought them under hospital care. It seems that the generalized feeling of dependency is such a fundamental need that there can be no greater privation than loss of a mother's care. A foster mother or nurse, if sufficiently devoted to a child, may successfully take the place of a mother. But, ordinarily, the mother is the one most profoundly interested in the welfare of her child.[15]

Report of Case Study. The provision of love and security for infants and children is of such far-reaching significance that it seems desirable to summarize a particularly illuminating case reported at some length by Dr. Margaret Ribble. She states that little Bob was born in the maternity hospital where she was making studies of infants' behavior. He was a full-term child and weighed six pounds, three ounces at birth. He was breast-fed during his two weeks' stay in the hospital, and there was no apparent difficulty with his body functions. His mother was a professional woman and had some reluctance about breast feeding her child. She wished to take up her work as soon as possible after the baby was born, but she accepted the suggestion of hospital nurses, and the feeding was successful.

When the mother returned to her home with her baby, she was shocked to find that her husband had suddenly deserted her. Because

[14] Ashley-Montagu, M. F.: *On Being Human*, 3rd ed. New York, Henry Schuman, Inc., 1950, pp. 64–67.

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

of her deep emotional reaction, her milk began to disagree with the baby. The infant became ill and was returned to the hospital. The mother did not go to look after the child, and at the end of a month she wrote that she had been seriously ill and asked the hospital to keep the child. It soon became apparent that she had abandoned him altogether.

In spite of careful medical attention and skillful feeding, this baby remained for two months at practically the same weight. He had to be put in a crowded ward where he received very little personal attention. Nurses had no time to take him up as a mother would, to change his position, and to make him comfortable at frequent intervals. He developed the habit of finger sucking, and became what is known as a ruminator. At the age of two months he weighed five pounds. Dr. Ribble said that the baby looked much like a seven months' fetus, and at the same time had the strange appearance of oldness. His arms and legs were wrinkled and wasted, his head large in proportion to the rest of his body, his chest round and flaring widely at the base over an enormous liver. His breathing was shallow. He was generally inactive, and his skin was cold and flabby. Although he took large quantities of milk, he did not gain weight because of little assimilation and copious discharges of mucus from his intestines. He had the pallor which has been found typical of infants who are not mothered, although careful examination did not indicate serious blood anemia. There was no evidence of organic disease, but growth and development were definitely at a standstill, and it appeared that the child was gradually slipping backward to lower and lower levels of body economy and function.

He was transferred to a hospital in which concentrated nursing care was given to babies who were not gaining weight. At this hospital the babies were held in nurses' laps for feeding and allowed at least half an hour to take the bottle. In order to provide as much mothering as possible the position of each child in his crib was changed, and nurses carried the children about the ward for a few minutes before or after each feeding. Medical treatment consisted of frequent injections of salt solution under the skin to support the weakened circulation in the surface of the body. Under such treatment little Bob began to improve slowly. A volunteer "mother" was employed to come to the hospital twice a day to give him some of the attention he so greatly needed. She held him in her lap for a short period before his 10 a.m. and 6 p.m. feedings. She stroked his head gently and spoke or sang softly to him while she carried him around. This artificial mothering was intensified with excellent

results. After five months under these conditions he weighed nine pounds. His rumination and diarrhea stopped, and he became alert.

When his life was no longer in danger, he was transferred to a supervised foster home and given more individual attention. Although his speech development was slow and he did not walk until after the second year, his general health became excellent by the end of the third year. It is still evident, however, that he has been deeply damaged emotionally. If there is any change in his routine, or when his foster mother goes away or is absent very long, he goes into a state similar to depression. He becomes inactive, eats very little, and becomes constipated and extremely pale. His emotional relationship to the foster mother is like that of a young infant which has not yet learned to respond to mothering activities other than to function better when she is there. He has little capacity to express affection, and the foster mother would probably have given up the care of the child if it had not been for explanations of the situation by nurses.[16]

"Explanation" of Love. The poetic line, " 'Tis love and love alone the world is seeking," seems to contain basic insight. Although the romantic view of love as a mystery may also be largely true, it is helpful to lift the veil as much as possible. This is done under the principle of *complementarity*, a word which has such a formidable and forbidding length that it may seem like a second veil. Let us see whether love can be "explained." The case of little Bob gives some clue, for his needs for care were deep and basic. Both his mother and foster mother needed his response also, but neither received it because of the situations which developed.

Completeness of Self in Others. Robert F. Winch, who clearly develops the complementary nature of satisfying interpersonal relations, offers a suggestive list of basic needs.[17] It is a modification of an earlier analysis by H. A. Murray, and overlaps to some extent that which Montagu made.[18] Selections from the list follow:

Abasement —To accept or invite blame, criticism, or punishment. To blame or harm the self.
Achievement—To work diligently to create something and/or to emulate others.
Approach —To draw near and enjoy interaction with another person or persons.
Autonomy —To get rid of the constraint of other persons. To avoid or escape from domination. To be unattached and independent.

[16] Ribble, Margaret: *The Rights of Infants*. New York, Columbia University Press, 1943, pp. 4–7.

[17] Winch, Robert F.: *The Modern Family*. New York, Henry Holt & Company, 1952, pp. 408–409.

[18] Ashley-Montagu, *op. cit.*, p. 53.

Deference —To admire and praise a person.
Dominance —To influence and control the behavior of others.
Hostility —To fight, injure, or kill others.
Nurturance —To give sympathy and aid to a weak, helpless, ill, or dejected person or animal.
Recognition —To excite the admiration and approval of others.
Sex —To develop an erotic relationship and engage in sexual relations.
Succorance —To be helped by a sympathetic person. To be nursed, loved, protected, indulged.

The point of all the listing is to indicate that many of the basic needs which persons have cannot be supplied by themselves alone or by any separate and individual efforts. The basic needs of all persons are such that they cannot be or become complete within themselves; but must both supply the needs which others have and be supplied by others in their efforts to achieve completeness. This seems to be the major clue to love and security, as well as the major function of the family. Examination of the infantile death rate from marasmus, the inadequacy of hospitals and other institutions, and the special case of Little Bob makes it clear that children have need to be nursed, loved, protected, and indulged by a sympathetic person. These last two words complete the circle of love which has not been mentioned up to this point. Mothers of children have needs which can be supplied by their children. This is sometimes expressed in the slogan, "they need to be needed." They need to draw their children close to them and supply the food, comfort, and assurance the child requires. They are rewarded by the smiles and other evidences of satisfaction which the child shows, as well as by the growth and development which occur under their care. They derive satisfaction even from the increasing independence and full maturity of the child, because this too is evidence of successful nurture and crowning achievement. Going round the circle once more it may be said that the dependent child who graduates from complete helplessness and dependence to full acceptance of responsibility finds his needs met by his parents at every point in his development. Frequently, in turn, he is glad to express appreciation, respect, and honor for his parents after he is independent from them.

Complementarity in Courtship and Marriage. The complementary relations are not confined to love between infants and mothers or between children and parents. Young lovers during courtship may find that numerous and various needs are supplied by each to the other. And husbands and wives frequently grow more necessary to each other in many different ways through the years. It seems reasonable to believe that such complementary relation-

ships might have developed more frequently under the rural conditions surrounding traditional families than they do now. We have noted the complementary character of economic relations under a farm home economy, and the same is true for the reproductive, religious, and recreational facets of living. In urban society, on the other hand, separateness of interests and work and personal gratification may narrow the scope and prospect of supplying needs in others, or finding others who completely meet one's own needs. It must be remembered also that persons who meet, carry on courtship, and marry in city environments are likely to come from such differing cultures or sub-cultures that their values and ways may be very different. These differences might seem interesting and attractive during courtship, but they may develop into bases of misunderstanding and conflict after marriage. For instance, persons who marry across religious lines of difference may experience no serious conflict until the rearing of children precipitates issues which were dormant before.

Possible Clue to Divorce. Divorce rates, which have been increasing for many decades, reached an all time high in 1946. Furthermore, divorces are occurring earlier after marriage—most frequently in the third year. More important, perhaps, children are becoming involved in the sense of being left with one parent rather than being brought up in a complete father-mother-child situation. The reasons lying beneath such facts are complex, of course. But one suggestion grows out of this principle of complementarity. It is known that many young couples contract marriage on the basis of a brief romance. Many seem to expect physical attraction and superficial pleasures to last and be sufficient for their needs. They seem to regard happiness as a goal or end without considering the many elements which enter into happiness. It is quite possible, therefore, that the marriages which rest on romantic love do not endure because the parties soon discover that few rather than many needs of each can be supplied by the other. Each finds the other incompatible with respect to many of the most vital relationships which are expected from uniting their lives. Each is starved for responses the other cannot supply. There can be a sort of withering away or marasmus in the relation of marriage partners similar to that of the child who wastes away physically because his basic needs are not met through relations with his mother. Any reader may test the principle still further by applying it to relations which may develop among children in a family.

One corollary, which cannot be developed here, is that when

persons enter into relationships which are designed or expected to meet their basic needs, only to find these defeated and frustrated, the result is likely to be hostility. The original need is transformed into its opposite, and persons seek to fight, injure, and destroy that which might have served their need. This may suggest the conclusion that those who do not successfully love others become sick.[19]

FAMILY SYSTEM BECOMES UNSTABLE AND FAMILIES DISORGANIZED

We now come to the end of a brief review of changes which have occurred in the relatively stable family system which prevailed in early rural America. A number of changes in family structures and functions have been described in some detail. The rapidity, recency, and fluid character of the changes in family life have been emphasized because it is believed that no stable type or system has yet emerged. This is another way of saying that changes have not occurred evenly among families; and that particular families vary significantly with respect to the structures and functions of the traditional family which are retained. There is a tendency for specialists in the family to dwell upon the middle-class urban, nuclear family with its high valuation upon individual development and happiness as the dominant type or family system which has emerged through change. At the same time, specialists would agree with Kingsley Davis that "the small family system of our society has had its structure weakened by a growing lack of integration with the rest of the social order. Consequently, marriage is becoming increasingly unstable and the core functions are being performed only inadequately. Eventually a new form of integration may appear, but it is hard to predict what form such integration will take."[20] This seems equivalent to saying that so many significant changes have occurred in the family system that it has been rendered unstable, and is still in a process of transition. Any form or forms now currently found are not likely to continue. But, insofar as basic human needs can be determined, it appears quite certain that a relatively stable system must eventually emerge to meet them.

Summary of Changes in Family. The principal changes in family structure and functions, which have been stated or implied, may now be summarized as follows: (1) Many families have been concentrated in small areas, either in separate houses or in mul-

[19] *Ibid.*, p. 100.

[20] Davis, Kingsley: *Human Society.* New York, The Macmillan Company, 1949, p. 429.

tiple dwellings. (2) Space and facilities for outdoor play and games at home have been curtailed. (3) Housing costs and restrictions, traffic hazards, and other environmental conditions unfavorable to development of children have increased. (4) Somewhat compensating provision of playgrounds, parks, and amusement centers, and programs operated by non-family agencies, have been set up. (5) Practically all economic production is now operated outside the family. (6) Individual employment with separate incomes for working members of family is characteristic of urban families. (7) Gainful employment of women in the competitive labor market is increasing along with competitive achievement of prestige and preferred status. (8) Less emphasis is placed upon saving and accumulation of family estate while increasing wants and consumption of goods necessitate buying to the limits of available credit. (9) Increasing provision of economic security by saving plans and insurance provisions are administered by the state. (10) Birth rates are lower, and the family is limited to parent-children group. (11) Family responsibility for protection and maintenance of children is increasingly shared by community health and welfare services. (12) Parents have less confidence and certainty about ends and means of child rearing with consequent guidance by "experts" and "quacks." (13) There is increased reliance upon community agencies and programs for educational development and personality direction of children. (14) Also, there is an increased reliance of youth on peer group approval of behavior and setting of standards. (15) Younger generations often know more than the older, and discount past roots and standards. (16) Youth itself is increasing in value—youthful appearance, youthful energies and activities, youthful adventures and discoveries, youthful leadership and judgment. (17) There is increasing dependence upon romantic love and promise of personal happiness as a basis for marriage, (18) which means less reliance upon the judgment and guidance of the parent generation in matters of courtship and marriage. (19) There is practically no reliance upon the judgment, guidance, and influence of parents in vocational selection and achievement. (20) There is wider separation from parent generation and other blood relatives in places of residence.

The Family System in Transition. Without further listing of the changes in the family system, it is evident that many matters are in unstable equilibrium. In the many instances of changing division of functions there is uncertainty and confusion as to just what responsibilities are to be carried by the family and what ones are to be left to other institutions and agencies. Many women are them-

selves confused because of the changing and uncertain status and role they are to have. The emancipation of children and youth is under way, but how much emancipation they want and can bear is not known. Little need be said, perhaps, about the changing role of husband and father, but the comic strip treatment of the subject suggests that he may now be treated as an object of mirth and ridicule for all to enjoy. On the basis of experience it is well known that he is often bellicose about his mixed position of responsibility without power. It should also be evident that increasing emphasis upon the achievement of individual gains and personal desires sets the stage for conflict with others unless some basis for accommodation becomes equally recognized.

The Significance of Complementarity Reviewed. In the course of this chapter the principle of love was defined in terms of complementarity. It was shown that the most basic function of the family—the nurture of children—is a matter of mutual fulfillment of basic needs by parents and offspring. It was also suggested that the same principle holds with respect to the interpersonal relations of all members of the family with each other. It cannot be fully discussed here, but there is reason for believing that the traditional family was stable largely because of the operation of this principle. If these observations are true they would furnish a major clue to the current instability of the family.

The instability of the family system and widespread disorganization among families have aroused public concern. Some of the agencies and services which have been designed to restore a more stable system and assist in the reorganization of particular families will be treated in connection with the following chapters on community organization.

FOR INVESTIGATION AND DISCUSSION

1. Compare a number of families of your acquaintance as to marked similarities and differences in ways of living.

2. Point out as many changes in family food patterns and practices as you have observed or learned about in recent years—note especially any recent changes in baby foods and feeding practices for infants and children.

3. Some reference was made to the influence of peer groups upon the standards and behavior of youth, and the possible lack of communication and understanding between youth and adult generations. *The Lonely Crowd*, *Elmtown's Youth*, and *Middletown in Transition* were mentioned as documentary sources of evidence on this point. Whether you consult these or draw upon your own observations, make any valid generalizations you can about "modern youth" and their relation to the parent generation.

4. Make a list of responsibilities and functions which have been transferred from the family to some other institution or agency; and state what the latter is in each case.

5. Review the effects of institutional life on personality which are covered on pages 165–168; and state what institutions are likely to produce such effects.

6. Give your reaction to the "explanation" of love in the text—pages 168–171.

7. What is meant by "the romantic complex" in relation to marriage? Point out how it may prove deceptive. What is an alternative?

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Chapter 10

WE ARE AT HOME IN COMMUNITIES

HELP FROM COMMUNITY IN GETTING JOB

When young people make application to enter college or to get an important job they are asked to give much information about themselves. To do this they must draw upon several sources and involve many persons besides themselves. They must call upon the community in which they live for help. They are asked to give their "permanent" address, the name of the school they attended, what courses they received, in what extracurricular activities they participated, what work experience they had, and so on. They are asked to name three or more persons, not relatives or teachers, who will express an independent judgment concerning the ability, character, personality, and future promise of the applicant. It is not uncommon to name the minister of one's church, the family doctor, and some business man as references. Besides, the school principal may be asked to send the school record made by the student, accompanied by his judgment of the applicant's character and promise. Dependence upon people in the community is not confined to supplying data for application forms and the moral support of those willing to testify in one's behalf. This chapter will show that these are relatively minor links in a complicated chain of interdependence.

THE COMMUNITY IS A SOCIAL GROUP

Regardless of how small or how large the place may be, the community in which each of us lives is a group of people who are organized to achieve certain major goals through a common way of life. Community life and experience may be so familiar and constant that we take it for granted and are no more conscious of it than we are of the air which we breathe and the ground on which we walk. Only when the air becomes so limited that breathing can hardly be sustained are we conscious of it, and of our dependence upon it. We also think of the ground when it is so rough

and uneven that our walking becomes difficult. In Chapter 11 it will be shown that we become most conscious of our community relationships when these are not working in accustomed and expected ways.

EXPERIENCE IN COMMUNITY

If we are asked about the place in which we live and are called on to tell others what it is like, we are inclined to think we know a good deal about it. We have spent a part of our lives in it. Our friendships have been formed among the people with whom we have associated. At one time or another we have been nearly all over the place where we live. We may have read the local newspaper rather faithfully. We have attended one or more churches, and we know where most of the churches are. We have gone to theaters, parks, playgrounds, and amusement centers of various kinds. We may have gone to clinics, and may also have been hospitalized one or more times. We have certainly visited friends at hospitals. We have visited most of the stores and made purchases at many of them. We may have had a job, or have known where to go to inquire about getting one. These and many other things about our community seem familiar.

WHAT WE KNOW ABOUT OUR COMMUNITY

But, if we are asked how all these familiar things are made possible, we become vague and uncertain. We may not know just how far the community extends and how many people live in it. After all, we may have paid little attention to people other than our friends and those who render us service. How people live on the "other side of town" or in some particular section may be something we have not thought about. Whether most of the people rent or own their homes and the types of houses they live in may seem unimportant to us. The list of things we don't know about the place we live in is likely to grow more extensive the longer we think about it. As a matter of fact, persons may talk about "our town" and "what a fine place we have here" until asked about some details of taxation, police protection, health services, and so on. When so confronted, the pronoun "we" is often shifted to "they"; and reference may be made to "the poor service *they* give" and "the heavy taxes *they* demand." Thus, we may at times fail to identify ourselves with others who compose the community and refer to parts as if they were separate and independent.

BETTER ACQUAINTANCE WITH COMMUNITIES

Since practically all adults are citizens of some community, they must participate in its affairs. If they do not do so intelligently and positively, they do so negatively, or by default. Communities are so organized that what occurs in one part or significantly affects the lives of some citizens has a genuine effect on all other parts and all other citizens. Thus it is that persons who do not concern themselves with community affairs or express their judgment through discussion and voting leave decisions and activities to others—often a minority—whose action controls all. This negative aspect of citizenship is particularly obvious in matters of health; for persons are no less menacing if they needlessly spread infection to others because of their ignorance, indifference, or carelessness.

What We Need To Know. What seems to be needed is a systematic or whole view of one's community. This would be helpful to all citizens; but it is particularly essential for professional persons who are expected to work for and with people in the interest of public welfare. This does not mean that all specialists in professional services must become experts in community affairs. But some systematic understanding of community relations is necessary if professional service is oriented or related to public interest.

It is the purpose of this chapter to suggest a systematic study of communities. Such a study is a large assignment and can't be completed quickly. It should be thought of as cumulative over a considerable period of time. It should prove interesting, as well as professionally useful. It should draw upon many sources and involve some cooperation with many others. Although the first chapters of this book should have laid a foundation for the study of any society or people, it now seems desirable to focus the knowledge we have acquired upon the local society in which the routines of daily life and most of our interests are centered.

A systematic acquaintance with any particular community will require attention to each of the following matters:

1. Geographical and regional location of the place.
2. Geographical and topographical characteristics, including natural resources.
3. Historical sketch covering the factors leading to early settlement and succeeding developments.
4. The size, extent, and layout of the place—utilizing maps.
5. Description of the population characteristics with respect to total size, numbers by sex, age, race, ethnic origin plus all vital statistics available or readily computed.

6. Location of each of the natural areas in the community, their characteristics, and their functional-relation to each other and to the whole.
7. Description of existing class divisions, and bases of their distinction.
8. Description of basic economic resources, technological developments, markets, and division of labor by means of which people produce their living.
9. Description of family patterns prevailing in natural areas and class divisions.
10. Description of religious organization and activities.
11. Analysis of the system of government.
12. Analysis of communication within community framework, and with other communities and areas outside.

Even after all these matters have been discussed, consideration must be given to how well the community is held together and to what factors seem most potent in this respect. Also, some observations must be made concerning the distinctive character of each community. Despite the fact that a general pattern of analysis may be applied to all communities, each will be found to have distinctive values and focus of organization.

GEOGRAPHICAL AND REGIONAL LOCATION

It does not require extensive travel to become impressed with the wide variation in geographical location of communities. Many are found along the courses of rivers and at their mouths where they flow into lakes, bays, gulfs, and seas. They are scattered over wide valleys and plains. Some are found on the sides and on top of hills; others are at various heights on plateaus and mountains. The kinds and amounts of natural resources, the direction and limits within which human development may go, and the basic conditions of wealth, climate, and so on are set by the geographical location of the community. Some writers have been so deeply impressed by geographical influences upon types of economic activity and productivity, on human comfort and energy, and upon health and disease that they have arrived at a geographic explanation or determinism for much that man does. It is not difficult to fall into easy generalizations about what man is likely to do under hot and humid conditions, on barren and rocky land, along the sea coast, and so on. These factors must be taken into account as basic conditions and limitations. But the way of life, the health, and the satisfactions which are achieved are largely matters of adaptation and transmission of established learning. It would be foolish, however, to ignore the relation of a community to land forms, water bodies, soil, climate, weather, altitude, and latitude if full understanding is desired.

Reasons for Community Location. It is well to remember that thousands of communities owe their location and existence to the extraction of raw materials from the surface and interior of the earth or from waters which meet the land. Widely scattered villages, towns, and even cities are focused upon the extraction of ores such as iron, copper, and zinc; minerals such as coal and oil; various woods to be converted into lumber; and numerous fresh- and salt-water fishes. Besides, many "healing springs," "medicinal waters," "cool and pollen-free air," and numerous other "geographic advantages" become the basis of "health resorts" and places for varied recreations. However, most communities are not found where they are because of the location of a single natural product. The "spot" on which most communities stand is advantageous to transportation and trade, and depends upon a wide area for its existence. "Breaks in trade" or "crossroads" may occur where land routes meet or cross water routes, or where routes through mountains cross into valleys. Communities spring up, continue to exist, and grow only when the supporting area furnishes raw material for loading and unloading, for manufacturing, or for trading. Few if any communities are consciously planned or planted. Each is the outgrowth of many factors.

Regional Connections among Communities. Although communities may be regarded as rather complete societies in the sense that each provides the goods and services people need, they are, nevertheless, interdependent with other communities within a region. Open-country communities are dependent upon village centers and small towns for some of their trade, services, amusements, and so on. These, in turn, are dependent upon still larger or more diversified centers. This is equivalent to saying that the larger centers are dependent upon the smaller ones for trade and utilization of services. Thus, numbers of communities are connected by transportation routes which form a sort of network or web among them; and their interdependence for matters such as labor, raw and finished goods, and services such as banking, hospitals, and libraries can be analyzed and measured in detail. Acquaintance with the regional relations of any particular community may be aided by showing its connection with other communities on a map, and describing the forms of interdependent activities which go on among them.

VALUE OF HISTORICAL SKETCH

The people who originally settle in a place and establish a community bring their ways of living with them; and they had reasons

for coming to the place and staying there. While it is true that geographic conditions impose limitations and require adaptation on the part of man, man also acts upon his environment. Thus, the French settlers who migrated in the days of Napoleon to the St. Lawrence valley in Canada established, as nearly as possible under the new circumstances, the kind of life they had known in the old country. Since they were isolated by the intervening hills from contact with rapid changes outside the valley, their descendants, even to this day, carry on much of their living in the French manner of long ago. They are still regarded as "quaint," even after recent military and commercial influences have speeded up change. Similarly, "German towns," "Swiss villages," and other ethnic concentrations give significant stamp and form to communities all over the land. Whole regions were settled predominantly by English, Scotch-Irish, French, Dutch, Italian, or Scandinavian immigrants. In spite of later mobility and extensive changes these early settlers have left their mark upon the laws and systems of local government, dominant religious beliefs and practices, moral codes, work patterns, and even such details of life as housekeeping, cooking, and cleanliness.

Frequently, of course, communities were settled by streams of migrants from a number of foreign countries or regions within America. Many communities have multiple ethnic and cultural roots which go back several generations in time; and many others have received successive waves of diverse peoples.

Quite a number of community relations and developments can become clearly understood only through historical perspective. This certainly does not mean that laymen or specialized professional personnel can take much time to probe historical foundations of present situations. But it is suggested that much published material may be available if some efforts are made to uncover it. Older citizens may be helpful in relating past events. And, what is more to the point, citizen groups often find it both interesting and profitable to explore cooperatively the general roots of the present which extend into the past.

EXTENT, SIZE, AND LAYOUT OF COMMUNITIES

Legal and Sociological Boundaries. The community may be incorporated and have a boundary line for relationships which are regulated or required by law. It is exactly surveyed and marked. But the sociological limits seldom coincide with the political and corporation boundaries. The community extends as far as the peo-

ple participate together to achieve major goals for themselves and consider themselves to be involved in the common life. It requires some investigation, therefore, to determine the line within which the principal interests of people are served. This may be done somewhat roughly by plotting on a map the area within which patronage for various services, such as water, fuel, building supplies, home furnishings, markets, banking, news, major theatres and amusements, is focalized. It is much more difficult, but more important, to determine the line within which communication among the people takes place to the end of reaching some common understanding about their major interests. This may not be difficult with respect to communities of small or moderate size which do not grow rapidly.

Rapid Expansion Quite Disturbing. It must be made clear, however, that many places are growing beyond their legal limits at such a rapid rate that relationships are quite confused and there is no common understanding about goals, services, and responsibilities. In the studies of Hampton Roads, Willow Run, and a number of other rapidly growing places, several consequences are evident, such as exceedingly large and rapid expansion of population with unbalanced sex, age, and race composition; inadequate housing, recreational, school, and other facilities; excessive demands upon all services; highly mobile, undependable, and inefficient personnel to operate most community agencies; generally higher incomes without much relation to experience, training, or competence; disturbed business, labor, family, and governmental relations; anonymity coupled with confusion of roles, insecure status, shifting loyalties, increased juvenile delinquency, and other indices of social disorganization.[1] The outer growth of many cities is producing similarly undefined and confused relationships. These will receive further attention in Chapter 11.

Variability in Size of Communities. The mention of community size[2] suggests the wide diversity in type of local world in which people live. In 1950 there were 5 places in the United States with over one million inhabitants; 13 with 500,000 to 1,000,000 people; 23 with 250,000 to 500,000; and 65 with 100,000 to 250,000 population. These 106 cities contain just about half of the urban popula-

[1] Marsh, Charles F. (ed.): *The Hampton Roads Communities in World War II.* Chapel Hill, University of North Carolina Press, 1951.

[2] Size refers to both space and population. Technically, space is measured in square miles within the recognized boundaries. And population is measured in numbers of people within the boundaries. When the population reaches the number of 2500, it is classed by census definition as a city.

tion of the nation; the other half dwell in more than 3,000 smaller cities. There are also about 13,000 smaller places in which 61,770,000 rural people live—some in the open country and others in hamlets, villages, and towns. One of the most notable changes is the increase of population at the outer fringes of cities and the marked slowing down of growth within. This trend became possible because of better highways and rapid transportation, but it seems to have developed on account of the desire for more rural and more simple relationships.[3]

Need for Base Map. Regardless of size, acquaintance with any community may well begin with securing or constructing a base map. The community pattern as it is laid out in space may be indicated. Even the seemingly formless open country community, which is made up of widely scattered family residences organized around some merchandising hamlet or village, or around some schools or churches, will show a pattern of communication and interaction. All other types exhibit a clustering or concentration of houses with roads, streets, and communication lines among them. The base map will show the physical structure or space relations within a community—the location of different types of dwellings, business concerns and industrial establishments, together with streets, transportation lines, and all lines of communication. Indication of the location of churches, schools, parks, playgrounds, theaters, clinics, hospitals, and other institutional agencies is essential. It is equally valuable for understanding community relations to locate the centers for illicit and immoral enterprises variously referred to as "joints," "honky tonks," "speak-easies," and some species of "night clubs."

POPULATION

The total number of people within a community area has been referred to as a basis for determining size. But acquaintance with the characteristics of population is essential to somewhat deeper understanding of the community. For most places, the total number of people listed at the last census can be found in census reports. But detailed information for the smaller places may be obtained directly from the people or, possibly, from school or county officials. Whether data come from census reports or from local sources, it is important to break the information down by age, sex, race, ethnic origins, occupations, and so on. Besides, vital statistics covering birth

[3] Landis, Paul H., and Hatt, Paul K.: *Population Problems.* New York, American Book Company, 1954, pp. 352–356.

and death rates, infant and maternal mortality rates, and death rates by a number of specific causes should be determined if greater insight is desired. It should be obvious that national and state census data give only limited clues to understanding highly variable local situations.

Variation in Sex and Age Ratios. Only a few significant variations can be suggested here. First variations in age distributions show that some communities have a large proportion of young children and of persons who are aging or past middle age. This situation results from the departure of older youth and young adults from their homes to places which promise more work opportunities and many other advantages. Thus, one community may have a disproportion of those who are dependent, less capable of production, and more likely to be ill in one way or another. On the other hand, communities with larger proportions of young adults who are at the peak of their physical and economic powers are likely to present fewer problems of dependency and decrepitude. Similarly, rural communities and cities with particularly heavy industries offer fewer opportunities for young women to find work, whereas the cities and towns with lighter industries, merchandising, and extensive office work attract a larger proportion of women. The resulting sex ratios—number of men per 100 women—are unbalanced, and numerous other unbalanced relationships follow from such basic population differences. Even from these two illustrations, it can be seen that marriage opportunities, marriage rates, birth rates, and other vital matters within each community are related to the basic characteristics of the population. When the earlier discussion of intergroup relations is recalled, it becomes evident that the presence and numbers of racial and ethnic groups in a community set the stage for potential and actual interaction.

NATURAL AREAS

Everyone who passes through grammar grades and high school has noted the fact that his fellow students come from rather distinct neighborhoods and sections of his home town. They may be merely identified as belonging to the "High Street crowd" or being from the "Mill houses." Differences are sometimes evident in clothing and in manners of behavior. By whatever ways they become known, there are fairly distinct areas in every community which exhibit homogeneity with respect to such matters as housing, income per family, general source of income, level and standard of living, educational attainment, and, often, political alignment and re-

ligious practices. They are sometimes homogeneous with respect to race and ethnic composition—China towns, Polish settlements, Negro quarters, and "Little Italy's." Such areas are called natural, because they have not come into being by conscious design or planning. They have emerged through unconscious competition and cooperation, and have often become traditional. They are not limited to dwelling areas alone since similar types of business concerns are found close together. In cities, banks will tend to be clustered near each other, as will be theaters, hotels, and such special types of merchandising as department stores, 5 and 10 cent stores, and "automobile row." If a community has both light and heavy industries, each will have its "natural area" or segregated place.

In Smaller Places Such as Jonesville. The analysis by which natural areas are located may be more or less precise. In smaller communities sketches may be made on the basis of what the people themselves recognize. Limited inquiry will reveal a pattern in space which is accepted or assumed in the minds of the people. The sketch shown in Figure 6 was made in connection with the study of *Democracy in Jonesville*, a small city with 6,145 population in 1940.

In Larger Cities. In a number of larger cities statistical analyses and careful mapping have uncovered a general ecological pattern which appears to characterize the social and cultural relationships in urban communities. In abstract form these relationships are represented by a series of concentric circles or adjacent sectors. The actual relationships, even if accurately represented on a map, would not, of course, occur in circular form or in any other uniform fashion. However, not only have the relationships which were first intensively studied and represented for Chicago proved significant there, but later application to other cities has been equally revealing. A free interpretation and compounding of several urban studies, shown in Figure 7, reveals ten major areas or zones.

Ecological Areas Described. Zone I is at the center of the city. Within it there are segregated areas, such as the "bright lights," where theaters and amusement places occur, with the hotels and restaurants nearby, the large department store area, a banking area, and so on. Just outside, or Zone II, may be found wholesale houses of various kinds and such manufacturing as garment making, bread baking, and other production which does not require heavy machinery. More impressive perhaps is Zone III, with a vast number of crowded and decadent houses which shelter the most impoverished families of the city. At the same time it contains cheap hotels, rooming places, and "flop houses" for the homeless and drifting

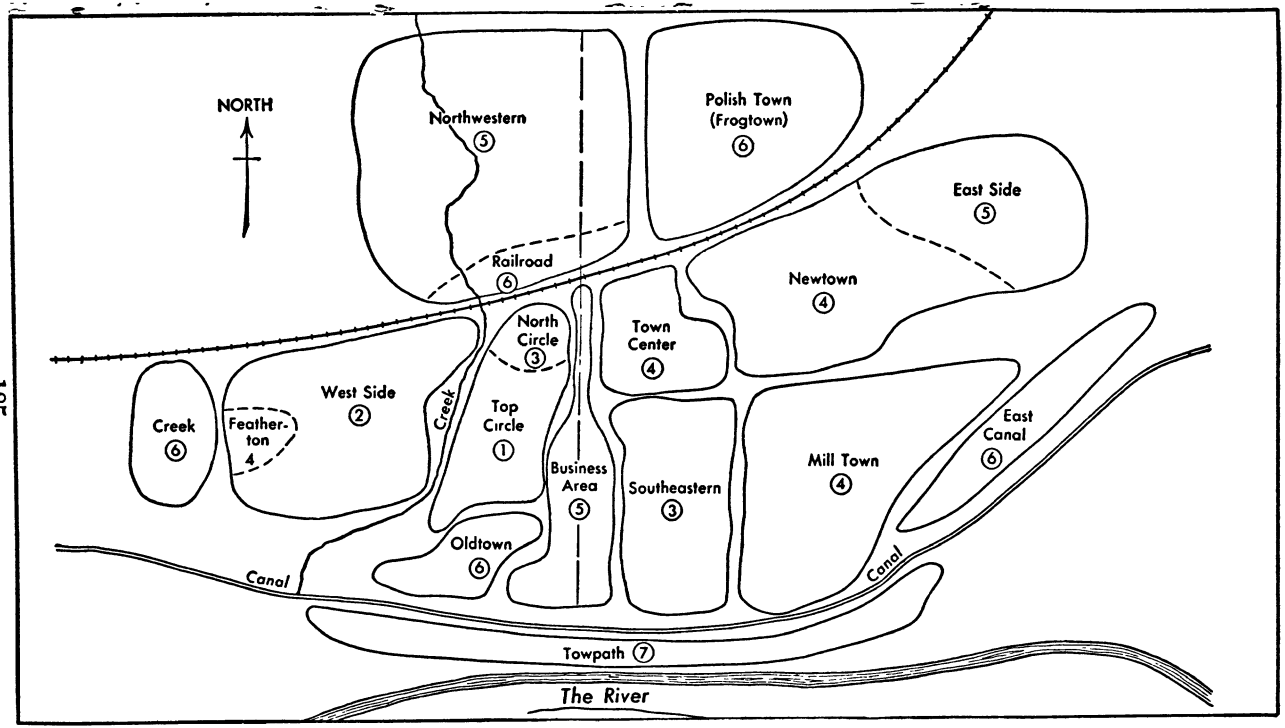


Fig. 6. Dwelling areas of Jonesville. (From W. Lloyd Warner and Associates: *Democracy in Jonesville*. New York, Harper & Brothers, 1949.)

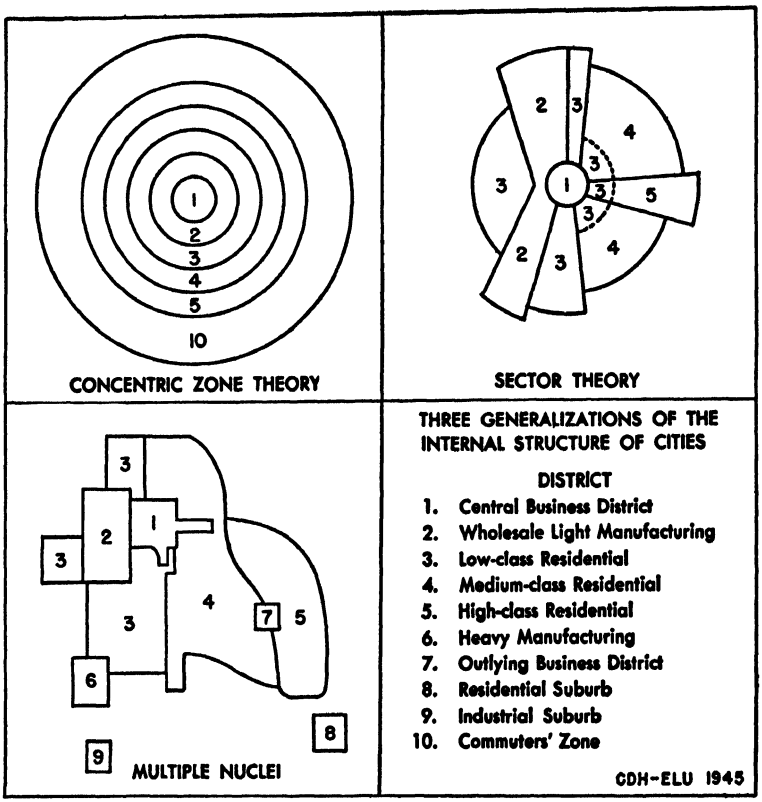


Fig. 7. Generalizations of internal structure of cities. The concentric-zone theory is a generalization for all cities. The arrangement of the sectors in the sector theory varies from city to city. The diagram for multiple nuclei represents one possible pattern among innumerable variations. (From Chauncy D. Harris and Edward L. Ullman: "The Nature of Cities." *The Annals of the American Academy of Political and Social Science, Vol. 242, p. 12, November, 1945.*)

population. In this slum area may be found many of the centers of "underworld" life—such as gambling, promiscuous dancing, prostitution, sale of narcotics, and "racketeering."

It must be understood, however, that there is segregation or separation of areas within the slum area—the Black Belt, Little Sicily, China town, the Ghetto, and a long list of ethnic and racial groupings which have their separate dwelling areas. And this is true for the homeless, criminal, and vicious elements of the population. This Zone III is called the area of transition because every aspect

of it is constantly changing; but, in spite of this, a pattern of fairly distinct and homogeneous areas can be found. In Zone IV workingmen's housing predominates, but here again it is important to look for the rather distinct areas within it. Similarly, the residential zones contain apartment houses, residences of middle-class families, and various grades of single-family dwellings on out to the large and ample estates of the wealthiest families. Beyond these are the heavy manufacturing areas, shipping yards, and the like.

Value of Area Analysis. The location of natural and ecological areas is not an end in itself, but merely a means of getting a better understanding of community structure and how the various parts are related to each other. As stated before, the detailed ways of life tend to be similar within each of the separate areas; or they tend to differ among the areas. Thus, characteristics of standards of living, family life, religious and moral behavior, political interests, and recreational activities, as well as mental and physical health and economic independence or dependency, are associated with these natural areas. Some of these will receive further attention in Chapter 11, dealing with community problems.

CLASS STRUCTURE

In Jonesville. There is often a definite correspondence between the natural areas in which people live and their social status or position in the community. It was found, for instance, that the people living in the towpath section of Jonesville (see Figure 6) were ranked lowest in the whole place. In this and Old Town people live in "abandoned stores, small industrial plants, or 'squat' in rudely constructed shacks and small insubstantial houses. Towpath is disordered and lacks any planned arrangement of houses." The East Canal section is similar, except not so old, and people tend to live in tar paper shacks and small bungalows. Polish Town, or Frogtown, is described as an area which it is often impossible to drive through because "streets are like alleys bordered by broken fences which lean over into them. . . . Old women sit out in the yards in broken-down chairs watching the chickens running over the alleys and destroying the yards."[4] People in these sections are generally ignored or referred to in derogatory terms. At the other end of the social class scale are the people living in the Top Circle and North Circle areas. These are the ones who live in the fine

[4] Warner, W. Lloyd, and Associates: *Democracy in Jonesville.* New York, Harper & Brothers, 1949, p. 36.

houses and mansions with ample grounds and sometimes lovely gardens. The "very best" people inherited wealth, reputation, and manners from their "old families," but others who earned their wealth and built or purchased their fine homes stand close to the top ranking. These are the better educated people who hold prominent positions in business, professions, and political influence. They are secure in their position and do not have to worry very much about "setting the pace" or "keeping up with the Joneses." Oddly enough, perhaps the people at the bottom levels feel reasonably secure and have "little to worry about" so long as they have jobs and can maintain themselves. They have little to lose by way of reputation and position.

Between these two extremes are three levels of "climbers" who do not wish to fall any lower in the class scale, and do everything they can to rise to a higher status. Such rise would be measured not only by residential movement, but by such things as educational advancement; occupational change; transference of membership in church, business, recreational, and other associations; change in types of activities, getting into different cliques, revision of role, and interclass marriage. A change in any one of these, whether upward or downward, is likely to result in some change in the others.[5]

Variations in Class Structure. It is not within the scope of this book to go into detail concerning the stratification of communities by class. Lloyd Warner and his associates have led others in making such studies. They have found as many as six class divisions in some communities, and fewer than this number in others. The six divisions have been called upper upper and lower upper; upper middle and lower middle; and upper lower and lower lower. They call three of these levels "above the common man," within two of them they find the "common man," and below these is found one level "below the common man." Figure 8 shows the proportions found at each level for Yankee City.

In the Jonesville study no separate distinctions were made at the upper class level, and the proportions within the levels were not the same as those shown in the profile for Yankee City—being 3 per cent upper, 11 per cent upper middle, 31 per cent lower middle, 41 per cent upper lower, and 14 per cent lower lower. This comparison suggests that the number of classes and the proportions within them vary from one community to another. Acquaintance with the class structure requires careful study but is highly reward-

[5] *Ibid.*, p. 64.

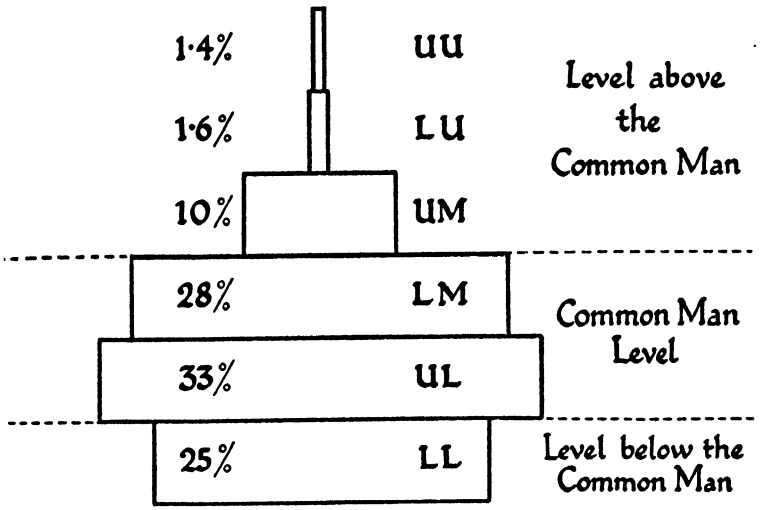


Fig. 8. The class levels of Yankee City. The exact social-class placement of a ıall number (less than 1 per cent) was unknown; they are distributed some-ıere from LM down through LL. (From W. Lloyd Warner: *American Life; 'eam and Reality*. Chicago, The University of Chicago Press, 1953.)

g in insight. It bears a significant relation to all other aspects of)mmunity life—family standards and patterns, child rearing, sexual :havior, occupation, political slants, religious practices, and many her vital matters.

ECONOMIC BASE AND DIVISION OF LABOR

One of the marvelous aspects of community life is the division of .bor by which it operates. Nearly everyone who wants a job has ıe and fits in with sometimes thousands of others to produce the ıcome needed by all. There are problems, of course—problems of nemployment at times, problems of unemployability, problems of .bor-management relations and many others. But it still remains ıite remarkable that people from all the different areas, classes, ıd groups which have been described in this chapter work to-:ther in such a way that all the economic enterprises of the com-ıunity are operated with more or less efficiency. It is most impor-ınt to see that each person fits into a system by which he is able to ırn and obtain desirable ends for himself at the same time he plays part which makes it possible for others to do the same. Each is a rt of an interdependent whole.

Competition and Cooperation. Most of the readers of this book are preparing themselves for a special type of work, and expect to find plenty of it to do. But few, perhaps, give much thought to the fact that they are getting ready to fit into a system with others to produce ends which none could achieve alone. Emphasis is frequently put upon free competition as the key process by which all these relationships are motivated and made to succeed. It is a fact that persons are "sifted," "screened," or "fitted" to the particular roles they come to occupy through competitive relations with others. But it is equally important to see that the roles for which persons compete are finally cooperative—just as players compete for positions on a team in order to get the most effective and cooperative team play. Similarly, consider the milkman and all the other handlers of food from raw production, through refinement and delivery for consumption. It is a wonderful cooperative process (at the same time it involves competitive elements) to develop through experience an organization which is not deliberately planned.[6] These basic matters must be kept in mind when the imperfections and problems of the system are briefly treated later on.

Little can be said here about the economic base of communities. What has been said already implies that there is work for all to do. In some communities the work is centered upon agricultural production; in others it is centered upon the extraction of raw materials such as oil, coal, iron, and lumber; in many, life revolves around some special form of manufacturing. Some communities are centered around multiple industries; some are concerned with commerce and centers of distribution; some are primarily known as seats of government, because so many agencies are located in one place. There are also a few large and complicated places which are based on practically all forms of human enterprise. Any significant acquaintance with a community requires a growing or accumulating knowledge of its economic base and the division of labor by which it maintains its level of life.

[6] It may be helpful to understand the term *symbiosis* which carries about the same meaning in biology and sociology. It refers to the association or living together of different or dissimilar forms of life, most frequently for mutual advantage. It is illustrated by such association as bees with flowers, whereby flowers are pollinated by the bees and the bees receive nectar from the flowers; or by a taxi-driver and the passenger he transports. It does not refer to highly intelligent and humanistic organization and cooperation, nor to a common life based on a grasp of the generalized other which was discussed earlier. It is a mechanistic sort of unifying process which often contributes to survival. It is well to explore the vast extent of symbiotic relations in human affairs by which many persons and groups use each other merely for their own ends or advantage.

FAMILY LIFE

Two chapters have already been devoted to the family system or institution. Attention has already been called to variations in the system which may be found in different natural areas of the community and among different classes and races. Emphasis has also been placed upon the extremely significant functions of the family in the socialization and development of all personalities, and the indirect dependence of society upon stable and normal families. There is room at this point only to look at the other side of the coin and see that community efforts and organization are necessary to strengthen and preserve families. At the proper place it will be pointed out that the educational, health, and welfare services of communities are largely devoted to supplementing and aiding families.

RELIGIOUS ORGANIZATIONS

Religion is concerned with man's relation to the universe, to God, and to all mankind. It begins with man's weakness and insecurity and is devoted to the search for sources of strength and basic assurance. The definition of religious goals and the activities by which they are to be reached are not uniform but vary among religious groups. Whatever they may be, however, they command intense emotional loyalty and personal devotion. It is not surprising that many religious sects have strong in-group feelings and often regard others as not only mistaken but indeed wrong. At the same time, however, many religious groups recognize God as Father of All Mankind and profess love for all men as a vast brotherhood. Under such belief, some groups are willing to respect differences in origin and faith among others and cooperate to discover a truer relation to the universe and a more ideal relationship among men.

Some Points of Difference. To get acquainted with a community, then, it is essential to recognize the various religious groups to be found in the place. An effort must be made to try to understand the beliefs, goals, forms of organization, and activities of each. If any are exclusive, intolerant, or even hostile toward others, it is likely to be due to their origin and emphasis over a period of time. Some communities will contain one or more cults which stress magical practices as means of healing physical and mental illness. There may be sects which stimulate emotional frenzy and manic expressions. These may serve to bring brief personal recognition to many who feel forgotten, or serve as a form of catharsis for pent-up hate and anxiety. More important, perhaps, are those groups which con-

serve the beautiful forms of music, pageantry, and expressions (noble motives, aspirations, and ideals of the past, and those wh by creed and action devote themselves in many ways to the a(vancement of common good. Religious groups may contribu greatly to the stability, solidarity, and creativity which may cha acterize a community. On the other hand, some may contribute t superstition, hostility, and disorganization. Communities va widely so far as the place and influence of religious groups may b concerned.

SYSTEMS OF CONTROL AND GOVERNMENT

Control Related to Freedom. One of the simplest symbols (government is the traffic light. The light serves to regulate mov(ment, thereby also setting it free. If it were not for the light perso driving or walking on the highways would be likely to pursue the individual ways as fast as they were able to do so. But each woul soon run into some interference from others who would be attemp ing to do the same thing at the same time. Some might be incline to blame or attack others for interference. It is most certain tha confusion and delay—even danger and destruction—would resul from unregulated and wholly individualized efforts to move throug the intersection of roadways. When each is attempting to be utter free, none are free to move. But when the changing signals of th traffic light are respected, some wait while large numbers are abl to move freely and rapidly. Later those who have waited gain bot time and freedom because they have obeyed regulations. In a boo as short as this forgiveness may be in order for one who reduces th vast complexities of government to the simplicity of a traffic ligh It is one way to illustrate the idea that the object of government i the formulation of rules and the exercise of power not as ends i themselves, but as means toward providing maximum freedom fo human enterprise. Many and diverse classes, groups, and agencie which form a part of the community's life would interfere with an(confuse each other, and a chaotic state of affairs would develop i rules were not formulated to govern their action, and obedienc insisted upon.

Making Community Decisions. The process of community liv ing is largely concerned with making decisions about how affairs ar to be run. In practically every election people are expected to mak up their minds about the best way to regulate certain things, suc as the sanitary handling of food, the proper disposal of garbage, o the larger matter of providing parks and playgrounds. People fro

l subdivisions of the community and from all classes are given an ɔportunity to discuss these matters which concern their general elfare, and to vote on either how they shall be done or who shall : given authority to set up means to such ends. After voting has ken place, all are expected to accept the regulations and benefit ɔm them. The whole history of government in a community is und in the decisions people have made and voted upon for ad- ıncing their common life.

Why "Political Machines"? Actually, however, many people ɔ not take an active part in decision making and are willing to ave government or the regulation of community affairs to those ho do vote and those who are elected to various offices. Some fail ı participate because of ignorance, indifference, or lack of faith in ıe system. It is not surprising, therefore, that in many communities :rtain groups seize the opportunity to muster a majority of votes ıd control many elections. Thus it is often true that regulations are ıade, money is expended, and taxes are required which are con- ary to majority interest and approval. These are likely to be :sented, and people may be disposed to condemn government and :gard regulations as unduly authoritative or oppressive. In some ɔmmunities small cliques are able to perpetuate themselves in office ır years for the purpose of obtaining graft and special privileges for ıemselves. Such dominant "political machines," as they are called, ın often insure a majority of votes in all elections by obtaining the ıpport of families connected with those who hold office, their 'iends, and a certain number of ignorant or vicious people who are 'illing to sell their votes for cash or special favors. It is particularly nportant to locate the "invisible government" which actually ex- rcises important control over community affairs. The mayor, coun- il members, and officers and members of appointed boards may ctually be "the front" for a well organized group which continues ırough the years, although the visible government may change 'om election to election.

One-Family Domination. In the study of Middletown some ears ago it was found that a prominent and wealthy family exer- ised tremendous control of all community affairs.[7] The family wned the principal industry in Middletown; they held controlling tock in most of the business concerns; relatives held prominent ositions or were members of boards in all banks. The family gave he land and buildings for the local college and profited by the rise

[7] Lynd, R. S., and Lynd, H. M.: *Middletown in Transition, a Study in Cultural onflicts.* New York, Harcourt, Brace & Co., 1937, Chapter III.

in land values on the adjoining real estate. Members of the family held prominent positions in leading churches, and exercised dominating influence in local and state political affairs. To use a slang expression, this family "had the place sewed up." In another sense, they assumed the responsibility of a feudal lord or tribal patriarch. Some other communities are also subject to the power of a particular family.

Power Structure. More recently, a study of a place fictitiously called Regional City was examined for its "power structure."[8] It was found that, rather than being exerted by a prominent wealthy family, the power resided in a clique composed of prominent men. Forty appeared to be at the center of power; eleven of this group directed large commercial enterprises; seven headed banking and investment operations; five were lawyers; one was a dentist; five were industrialists; two were labor leaders; four held high positions in government; and five were called leisure personnel because they were not actively associated with any going concern. These persons met informally at numerous business, civic, and social gatherings in the city. It is correct to say that they attended or were represented at every important meeting which was held in the city at any time. It must be understood that this group was largely concerned with policy decisions, whereas literally hundreds of others were needed to carry the policies into the operation of civic, health, and welfare services.

If Informed People May Rule. From these very limited summaries it is evident that decisions concerning public policies and the regulation of community affairs are not simple matters of well informed citizens expressing their judgment through voting and regulating their own affairs through their elected officials. This is far from saying that the people have no power and do not influence the decisions which are made. It is certain that when people are sufficiently well informed or emotionally aroused about public questions they do not fail to register their combined judgment at the polls or to insist upon the kind of regulation they approve. It is quite clear, however, that eligible voters are seldom well informed about their rather complicated community relations, and they are often indifferent about seeking information or expressing a judgment by voting.[9] Social intelligence can be rated low in most communities. Unfortunately, this creates an ideal situation for the application of special pleading and propaganda techniques by special

[8] Hunter, Floyd: *Community Power Structure.* Chapel Hill, University of North Carolina Press, 1953.

[9] Lynd and Lynd, *op. cit.*, Chapter X.

interest groups and cliques. By manipulating feelings of insecurity and anxiety which many people have, their suspicions, fears, and hate may be focalized upon relatively unimportant matters while their judgment is made dull concerning vital matters.

COMMUNICATION

This brings up the matter of communication within the community. It has been stressed before that a human society depends upon communication for its existence. Only to the extent that members of a society are aware of "what the game is" and "what the score is" are they "in on" or "on to" the total situation. These are expressions in terms of slang to indicate that if citizens are to participate intelligently and actively in community life they must be reasonably well informed about practically all of the matters outlined in this chapter and the next. Besides, they must try to keep up with the changes and turns of events which are continually taking place.

The Local Newspaper. The local newspaper is one of the chief means citizens have for the intercommunication of all groups and divisions. It carries the advertising which keeps people posted concerning sources and prices of available goods. It transmits the notices and announcements of forthcoming meetings and events. It contains statements concerning financial and other matters of business and government. Numerous informative articles on health and welfare, farming, marketing, domestic arts, child rearing, and the like appear from time to time. Religious interpretations and comments are often conveyed by competent persons, and religious activities are reported. Extremely varied news reports with respect to deaths, sports, society, politics, crime, and foreign affairs may be found in the local paper. Many contain a page devoted to interpretation and comment upon news and social issues through editorials and "letters to the editor." Newspapers are often criticized for selecting some news while withholding more important information; for "slanting" reports of events so as to form or prejudice opinion about them; for playing up sensational and human interest stories and ignoring or minimizing more significant matters. Some or all of these criticisms may be true of some newspapers, but others could be cited which take a constructive lead in the public interest. Actually, many communities have no local newspaper in any sense because it is not economically feasible.[10]

[10] Svirsky, Leon (ed.): *Your Newspaper.* New York, The Macmillan Company, 1947.

Informal Communication. In all communities there are n merous and various organizations and associations which commu cate through their meetings and through the literature they d tribute. It would require a separate book to describe the commu cation which takes place in civic clubs, parent-teacher associatio the League of Women Voters, and a long list of other organizatio The informal communication which occurs at social gatherings a "rubbing shoulders" in daily contacts is probably as important way of influencing attitudes and action as that of the more form channels. Certainly there are centers of gossip which radiate mu influential fact and fiction throughout the community.

It is important to assess both formal and informal lines by whi understanding among the people is reached. It is a rare communi indeed, which has adequate and dependable information and int pretation of its interests and problems. People are confronted with hodgepodge of news reports plus occasional and haphazard accou ing of their public services. It is small wonder that major decisio are often made by a few who are in a position to grasp somethi of a whole view of the problem, and their own relation to it.

HOLDING TOGETHER

Habitual Patterns for Living. This brief discussion of co munication raises the question of what holds the people of a co munity together in a fairly unified common life. Or, putting t question another way, to what extent are the people consciously ganized and unified in a system of living together? One answer that there is a more or less standard pattern of culture which w outlined in the first chapter of this book and applied through this chapter. This cultural pattern amounts to a system of habitu ways of doing things and behaving in line with normal expectatio It is more or less common to all communities, and much of it quires little reflective thinking, decision, or planning.

Special Occasions and Interests. It was found in Jonesville th weeks of preparatory thinking and planning were necessary to ma and organize arrangements for the observance of Memorial Day Nearly everyone was kept informed about matters which had to decided, and all had some responsibility to discharge in connecti with the affair. When the day arrived people entered into physic and spiritual union as they solemnly honored the sons of the co munity whom they now made sacred through credit for devot service and sacrifice of life for all. In other communities it mig

[11] Warner and Associates, *op. cit.*, Chapter 16.

some other symbolic event which would bind all together, such ›ageantry to represent historic hardships and achievement. Vari- festivals may serve this purpose. In Middletown it was the con- ıous interest in and support of the high school basketball team, Bearcats, which furnished the common bond for talk and ›rt. Now and then a community may be found which is highly fied and organized with respect to all major interests—people able to think together and act together to produce a most sfactory common life.

)ISTINCTIVE CHARACTER OF EACH COMMUNITY

We may now conclude with the observation that communities local societies which are much alike in many general basic terns. But they differ so much in location, size, major economic erprise, population components, history, dominant traditions, l conscious unity that each is distinctive and significantly different m all the others. In recognition of this fact, Carle Zimmerman re- s to the life organization or personality of each community. He ls attention to the historical fact that German and English laws aranteed the continued liberties and customs peculiar to certain es and towns. He also cites the spirit of the people in a Quaker nmunity in which "acts fit together in a single framework of a chological community of men against life."[12] Many modern nmunities are not sufficiently isolated and stable to develop ch unity, morale, and distinctive character, but the very degree their instability may constitute their distinctiveness.

Calls for Particular Study. So far as the purpose of this book concerned, however, the evidence that each community is sig- icantly different from others suggests that general statistical aver- s and trends may throw scant light on particular places, and ıuine acquaintance can come only from somewhat detailed local estigations.

FOR INVESTIGATION AND DISCUSSION

. Use the outline on pages 177–178 as a systematic guide for exploring your wledge about your home community. List the principal facts you know from t observation and experience in one column and the things you would need to estigate in another.

. If you have recently lived in a rapidly expanding community or have read ut one that has been having "growing pains," give the principal reasons for ansion and note some of the problems and readjustments which developed in nection with the process.

Zimmerman, Carle C.: *The Changing Community*. New York, Harper & thers, 1938, pp. 148 ff.; also see pp. 294–295, and pp. 636–641.

3. Review the variation of sex ratio which may be found in different types of communities, give major reasons for these, and state as many implications of such variations as seem warranted.

4. Make a superficial exploration of natural areas in the community with which you are most familiar. What would you need to do if you were to locate these accurately? Discuss the implication of natural areas for various health services.

5. Read the brief explanation of symbiosis given in the footnote on page 190, and point out community relations which seem to be on an unconscious symbiotic level. State whether nursing services may sometimes approach such a symbiotic relation of patient and nurse.

6. Explore the newspaper reading preferences and habits of your colleagues and note whether these have any implications for participation in community affairs, particularly local government.

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Chapter 11

COMMUNITY ORGANIZATION AND PROFESSIONAL SERVICES

AMERICAN IDEAL OF PROGRESS

The early settlers who came to America left their homelands in Europe for many different reasons, but one basic motive and belief seems to have been common among them. They thought a better way of life was possible, and they were willing to endure severe hardships in order to bring it about. They and generations which came after them spent toil and sacrifice to convert a wilderness into a rich land. People now are proud of past achievements, and derive some feelings of superiority from them. A few have become cynical and make gloomy predictions about the future, and a very active minority are insisting upon rigid conformity to the status quo. But in spite of all these the original credo and habits continue. People believe in "pursuit of happiness," "progress," and creative action—continuously moving toward a better way of life.

MANY ORGANIZATIONS FOR IMPROVEMENT

This belief is evident in nearly all phases of community life, but especially in the numerous and various organizations which are designed to improve some condition which has caught the attention or imagination of the people. Most of these efforts have to do with education, health, recreation, and welfare. For lack of space they could not be considered in the preceding chapter, and will be treated here only in regard to some of the most important interrelations among these four systems. Stress will be laid upon the independent and separate developments which have occurred in the past, and the consequent need for more coherence and coordination of community efforts today.

The goals for which communities are organized are often stated positively. Education for all the people has long been regarded as a major goal toward which united community effort is to be exerted.

Good health is a highly significant value which requires organized action for its achievement. Happiness and general welfare are rather vague, perhaps, but much desired. They are often translated in the somewhat more specific terms of orderly and well adjusted living. Still another broad goal which has recently received growing community attention is recreation.

EFFORTS TO ELIMINATE UNDESIRABLE CONDITIONS

Actually, however, people have most frequently organized their efforts on a negative piecemeal basis. Their attention has been directed to first one and then another specific matter which seemed undesirable. In view of historical developments, it would appear that people have been most concerned to correct, destroy, or avoid some definite evil or objectionable condition rather than to bring about some new and positive gain. It is doubtful, for instance, whether sanitary measures were developed in any total or positive fashion. The specific elimination of sources of impure water—this well and that spring—led eventually to the cooperative provision of one dependable pure source. The attack upon the housefly was one battle and that upon the mosquito another; fleas and mites required more sophisticated attention, as did many microbes. By now sanitation is thought of and organized as a whole. Similarly, the poor, the sick, the strangers, neglected children, and others who became sufficiently numerous and troublesome to require attention became the beneficiaries of organized effort.

TRIAL AND ERROR LEAD TO ESTABLISHING AGENCIES

It was pointed out earlier that the folkways and norms which are now established as forms of expected behavior have resulted from a process of trial and error in dealing with problems. In a similar manner the agencies which have been invented to deal with community problems have emerged at different times and different places to become more or less widely accepted later on. Local differences may still be rather pronounced. But it is well to remember that jails, workhouses, penitentiaries, kindergartens, elementary schools, secondary schools, hospitals, social settlements, and other agencies were set up for certain purposes at certain times as devices to be tried. In many instances they were set up under religious or charitable auspices, and were later supported wholly or in part by taxation and administered by government. Furthermore, the personnel charged with the operation of community agencies were

at first selected on a hit-or-miss basis. Some were ordered or assigned to their tasks, and some were available because they had nothing else to do. The process of trial and error is by no means outmoded for many new agencies; and recently specialized personnel are being tried for the control of juvenile delinquency, family disorganization, automobile accidents, dull and monotonous life, and many other matters of deep concern to people living together in communities.

The history of the development of professional personnel parallels that of the development of community agencies. Professionals also arise to deal with social problems; in fact, all professions seem to have had a history of development somewhat as follows: (1) Social problem emerges when general recognition of difficulty or frustration spreads throughout a group. (2) Problem is first treated by unspecialized persons who respond to social need. (3) Persistence or extensive character of difficulty calls out persons with somewhat related or pertinent skills who address themselves to problem. (4) Conscious procedures grow out of trial and error. (5) Apprenticeships are set up and accumulated skills transmitted. (6) Theoretical foundations are formulated from experience and from the mobilization of seemingly pertinent bodies of knowledge and sciences. (7) Education becomes prolonged in order to learn theory and skills. (8) Group consciousness, organization, and organs of communication emerge. (9) When services become directly purchasable, codes and standards are developed for defining and controlling relationships. (10) Subspecializations to deal with more particularized phases of the original problem develop as refinements of theory, experience, and technique become possible and support becomes available. Corresponding standardization occurs. (11) Subspecialization is carried to a point of completely solving the special phase of difficulty, or to a point of diminishing returns, or to a partial or complete loss of original functions.[1]

The object of this chapter shall be to briefly outline the major structures and functions now operative in communities with respect to health, welfare, recreation, and education; to point out something of their interdependence and interrelations with each other; and to analyze some of the major problems with which they are confronted.

HEALTH ORGANIZATION

A brief description of the functional development and structural forms of community health organization is presented first as a sort

[1] Hayes, Wayland J.: "The Place of Sociology in Professional Education." *Social Forces*, Vol. 26, No. 3, p. 293, March, 1948.

of type or model. Comparisons and interrelations with the other systems can then be pointed out.

Historical Perspective Needed. Like so many other matters which have been discussed in this text, present relationships and organization of health services cannot be understood without some historical perspective. Medical knowledge and practice; hospitals, sanitoria, and clinics; public health ideas and procedures; and nursing services have had separate origins and lines of development. The identity of each emerged at a different time and under differing circumstances. Thus, objectives, basic ideas, training of personnel, and public emphasis and support have varied. Since, however, the development of all health services has been in response to similar needs of people, some interrelation and interdependence among them has been inevitable. They have advanced on the basis of increasing knowledge and organization. Their objectives are steadily converging; and there are definite trends toward a unified coherent pattern.

Antecedents of Medicine. Medicine is one of the oldest arts. It had its beginning in magical beliefs and practices whereby evil spirits presumed to bring misery and suffering to man were placated or coerced. It is possible that some of the concoctions or devices which were hit upon had some beneficial results; and it is certain that faith in the powers of medicine men quieted the fears and stabilized the behavior of tribal groups. Trephining of skulls, stopping the flow of blood by pressure, ritual purification of the body, and stitching of wounds were forerunners of later discoveries and skillful practices. It would be difficult to date the origin of true medicine, but the Greek people are credited with evolvement of early systematic and scientific foundations. Their communities offered all citizens facilities for physical culture and training, as well as medical treatment in case of accidents. Athletic institutions had medical staffs. The code of ethical practice and public character of Greek medical service has influenced all subsequent development as much as did therapeutic methods and systems of thinking.

Whether based on magic, religious taboos, or empirical considerations, some of the customs found in many primitive and ancient societies had the effects of modern public health measures. Persons with contagious diseases were segregated or expelled from some tribes. The Magi in ancient Persia required that not only all dead bodies but even the clippings of hair and paring of nails should be buried so that evil spirits might not use them. Those who worshiped the sun exposed their bodies, their furnishings, and their

utensils to sterilizing rays as a part of their worship services. Wholesale fumigation was used to combat epidemic diseases. The first great water supplies, public baths, and sewers were instituted in Rome. Isolation and quarantine were set up in many seaports.

Recognition of Environmental Factors in Disease. Although many advances in medicine were made during the centuries, physicians were first employed about 1840 to systematically study the environmental conditions which might contribute to ill health. From such studies it was evident that many diseases could be prevented by situational changes, such as provision of pure water supply, sewage disposal, and the elimination of filthy living conditions. Several decades later it was found that many diseases could be cured or prevented by building up vital resistance of the body. Thus, it became necessary to educate the public with respect to dietary and hygienic living and the support of sanitary measures. The evolution of medicine has led to marvelous developments in the diagnosis and treatment of disease, and also more recently to prevention through situational change or early detection and care. Knowledge concerning the relations between physical and psychological processes is being extended. Medical service is increasingly oriented toward goals of positive health. To achieve such goals it becomes increasingly necessary for medical service to be more closely allied with others which are reviewed in this chapter.

Discoveries Essential to Advent of Public Health. Many biological and medical discoveries were essential to the advent of any public health system. Epidemiology was developed and vaccination discovered. These and many other scientific means were mobilized under the pioneers of public health, humanitarians, and social reformers, to prevent illness through controlling the sale of poisons, adulterated and putrefying foods; by requiring vaccination; and by passing sanitary legislation. So, up to 1900, diseases which were subject to control by environmental sanitation, such as cholera, plague, and typhoid, were already disappearing from organized communities, and rapid progress was being made in the control of diphtheria by bacteriological and immunological methods.[2] In the attack upon tuberculosis it was found, however, that in addition to isolating open cases of the disease and reducing the element of infection as far as possible by the pasteurization of milk, it was necessary to do something more positive. It was necessary to establish a program of hygienic living in order to build up the vital resistance of

[2] Winslow, C.-E. A.: "Public Health," *Encyclopedia of the Social Sciences*. New York, The Macmillan Company, 1933, Vol. XII, p. 648.

the body not only in those individuals infected but in the public as a whole. Public health services were broadened to include responsibility for developing positive health practices in daily living on the part of all the people through education and community organization. People not only are supplied with information and suggestions for its application but they are encouraged to appraise their community services definitely with respect to proportion of children immunized against diphtheria, number of visits by nurses on behalf of tuberculosis cases, number of visits by mothers to prenatal clinics, the proportion of milk pasteurized, amount of health instruction, and numerous other items. The effectiveness of public health services is being measured by organization and participation of people in their own community efforts.

Evolutionary View of Hospital Services. Any evolutionary view of hospital services would probably begin with the attention given to sick people in ancient temples. Some of the priests were detailed especially for medical ministrations. Wherever there have been large aggregations of people it has usually been found necessary to organize some asylum for those who are sick. The forms and amounts of specialized service available to those suffering from disease have varied from period to period. Some early Grecian centers offered such diverse services as the application of herbs and drugs, poultices, massage, and the provision of gymnasia, baths, and surgical operations. Some doctors had what amounted to private sanitoria for their patients. Special places for the sick slaves were established by large landowners on Roman estates, and these were utilized by the landlords and their families. With the spread of Christianity hospitals served as shelters for pilgrims, the poor, and the defective, as well as for those with disease. There were times when hospitals were entrusted exclusively to monks and nuns. And, for a period of time in England, physicians were opposed to the organization of hospitals. It may be surprising to learn that military hospitals are of comparatively recent origin. Toward the end of the eighteenth century hospitals remained largely undifferentiated in functions, were crowded, poorly ventilated, and insanitary, and contributed heavily to the spread of infectious diseases. In general, the process of their reform and reorganization was set in motion by the same forces which initiated sanitation in prisons, industrial plants, and slum areas, and instigated community-wide efforts toward prevention of disease.

Modern Hospital and Related Services. It is a far cry from these beginnings to modern general and specialized hospitals, and

to increasingly available clinics and convalescent homes. The work of a hospital is measured not only by the number of patients it accommodates but also by the service rendered to ambulatory patients in the community. These far outnumber the resident patients. Furthermore, the high cost of hospital facilities and services and the pressure of numbers to be served have made it economically and otherwise desirable for patients to be discharged in as short a time as possible. The shorter stay in hospitals, combined with the crowded apartment and other urban living arrangements, has forced communities to set up convalescent homes. In these, rest, diversion, proper diet, and adjustment guidance can be economically provided. Furthermore, general hospital and convalescent services are becoming increasingly available to people in smaller places and rural areas. The organization of diverse services under a coherent system may not be far removed in time.

Nursing Becomes Essential to Coherent Health Service. Modern nursing services have also emerged after a long series of changes. These are not outlined here because Part II of this book is concerned with detailed social relationships of nurses, and students of nursing generally receive special courses in the history of their profession. Suffice it here to paraphrase one of its greatest leaders, and say that nursing is being increasingly developed as a science and practiced as an art, with devotion and intelligence, rather than as a sentimental outlet for emotion or penance for sin. It should be obvious indeed that nursing is essential to the effectiveness of each of the other services which have been reviewed, and it provides a major channel for their coherent organization and community understanding. In the words of Margaret A. Tracy,

> The nurse is the interpreter of the findings of medical science. She acts as a "bridge between the sources of knowledge (the physician or the health officer) and the people." Her intimate association with the patient and his family establishes a relationship which affords many opportunities for teaching.[3]

Chief Reasons for Revolutionary Gains in Health. The marvelous results achieved through the several health services in recent years have been statistically presented on preceding pages. These show the extensive control over communicable diseases which has resulted in greatly extended expectancy of life. To these facts can be added the equally significant advancement of a more valid understanding of conditions essential to health among the people and more widespread practices of hygienic living. But the point to be

[3] Tracy, Margaret A.: *Nursing, an Art and a Science.* St. Louis, C. V. Mosby Company, 1949, p. 31.

stressed here is that most of this progress has been due to a constant search for the cause of disease and for effective means of cure or prevention. To this factor has been added the pursuit of knowledge concerning the processes of organization by which communities achieve effective protection and a more healthful way of life. Furthermore, considerable attention has been given to clarification of priorities in community action as indicated by need and adequacy of knowledge.[4] Indeed, it appears reasonably certain that any future advances must rest upon these processes, not only in health organization but also in the other types of organized effort to be outlined in this chapter. It is also important to recognize the fact that while these health services maintain their concern for the cure of disease and rehabilitation of the patient, the goals of preventing disease, disability, and attendant economic insecurity and the promotion of positive health are becoming dominant.

Chronic Diseases Illustrate Future Challenges. With these things in mind, many problems of community health organization press for attention. There is room for considering only one of these, but it is related to many of the others. It stands out in previous statistical summaries, it involves the basic objectives, and it challenges further advance—this is the matter of chronic diseases. The control which has been gained over acute diseases and the fact that more people live to more advanced ages tend to accentuate this situation—that one out of every six persons in the population has some chronic disease; that three out of four hospital beds are required for patients of this classification; that 60 per cent of all disability and 66 per cent of all deaths result from chronic diseases; and that the enormous loss of a billion days of productive work annually has been charged to this source. It is sometimes erroneously believed that the aged are the only ones afflicted; but more than half of the persons with chronic disease are under forty-five years of age, and one-sixth of them are under twenty-five. It is a fact, of course, that two thirds of those who are invalids are in the older age bracket, that is, are over 45.[5]

It should be obvious from these facts that thousands of families must provide care and support for members who vary by degrees of dependence to total dependence. Persons with chronic disease often reduce the productivity of others because of the care they

[4] Buell, Bradley, and Associates: *Community Planning for Human Services.* New York, Columbia University Press, 1952, pp. 136–138.

[5] Yahraes, Herbert: "Something Can Be Done about Chronic Illness," *Public Affairs Pamphlet No. 176.* New York, Public Affairs Committee, Inc., 1951.

require. To the extent that families are unable to provide necessary care and support for their members responsibility shifts to the community. In view of the recency and growing volume of the problem, it is not surprising to find communities without adequate organization and facilities to deal with the changes which have come upon them.

SOME CHRONIC DISEASES MAY BE PREVENTED. It should also be evident that the problems of chronic disease can never be wholly prevented or solved. However, knowledge is now available which make it possible to prevent rheumatic heart disease, diabetes, syphilitic heart trouble, many occupational diseases, and some accidents. Besides, there are other forms of illness which can be cured or sufficiently controlled so that patients may lead productive and satisfying lives. The potentialities of control are largely dependent upon education and early detection. There must be wider diffusion of information about what is known concerning chronic illness as a preliminary to cooperative effort. People must learn what they can do to prevent avoidable diseases. And, since cure or secondary prevention depends largely upon early detection, people must provide and use opportunities for periodic examinations. Multiple screening of the whole population by means of x-ray for evidence of tuberculosis, heart disease, and lung cancer; blood tests for syphilis, diabetes, and anemia; urinalysis for kidney conditions; and checks on hearing and sight, has been undertaken in some communities. Whether this or some other procedure is applicable in various communities, any early detection is of little significance unless follow-up education and organization are also effected.

WELFARE ORGANIZATION

To use the term welfare organization may be unfortunate because it stands for such a wide variety of interests and activities. *Public welfare* and *social work* are rather vague and broad terms, but they are related and, so far as the community is concerned, may be thought of together. In 1926 Alice S. Cheyney said that

> Social Work seems to comprise a group of allied activities called by a common name and considered to be but various phases of a single undertaking because they are all engaged in spontaneous efforts to extend benefits in response to evidence of need; because they all show a major interest in improving the social relationships of their beneficiaries and because they all avail themselves of scientific knowledge and employ scientific methods.[6]

[6] Cheyney, Alice S.: *Nature and Scope of Social Work*. New York, American Association of Social Workers, 1926, p. 24.

E. C. Lindeman defined public welfare as public social work—

> . . . governmental services rendered on behalf of certain individuals or groups within the public: namely, those who lack the means of subsistence; those who need protection because of their immaturity or incapacity; those who need to be guarded against various diseases and infections; those who are without adequate family or parental guidance; and those whose behavior constitutes a threat to the general welfare.[7]

These two definitions emerged from the search for a better way of life through attacks upon the separate problems which have been forced upon public attention from time to time. It would be impossible to get a clear understanding of the varied, complex, and often overlapping or contradictory welfare agencies to be found in many communities without some knowledge of their historical development. Despite modern developments and, perhaps, dominant trends, there are very lively survivals of former conceptions, theories, objectives, and practices now flourishing in most places.

Some Forerunners of Welfare Organization. It is beyond the scope of this book to do more than suggest a few illustrations of historical significance. Centuries before the advent of what is now termed social work and public welfare, communities had to deal with the poor and relief of the poor. In Deuteronomy it is stated that "the poor shall never cease out of the land" and a Psalmist writes, "blessed is he that considereth the poor." Some attitudes and practices with respect to the poor had to be developed in all civilizations. The point is, however, that the poor have generally been regarded and treated as if they were all alike—sometimes pitied as unfortunate, sometimes blamed as being a menace—but always categorically. The status of the poor was often attributed to weakness of character, shiftlessness, and irresponsibility, rather than to external circumstance. By rationalization the poor were regarded as objects of supernatural curse, or as a weaker breed and abnormal type by heredity. Criminals, drunkards, prostitutes, and even dependent children were classified under appropriate designations of inherent weakness. It is not surprising that physical force was tried as a means of dealing with such people. A work test was among the devices forced on the destitute before they were given enough food and shelter for subsistence. Public whipping and many other punishments were applied to paupers, debtors, criminals, and various other types of offenders. Confinement, custodial care, and bondage were imposed for "people's own good." Prompted by charitable

[7] Lindeman, E. C.: "Public Welfare," *Encyclopedia of the Social Sciences.* New York, The Macmillan Company, 1933, Vol. XII, p. 687.

ideas that each has a duty toward "his fallen brother" and should be "his brother's keeper" if he wishes to "obtain a reward," sectarian, fraternal, and other groups distributed direct relief to the poor—in their homes or through such institutions as orphanages, almshouses, and hospitals. It is in this connection that some clue may be found for the existence of innumerable specialized agencies and similar agencies under many different auspices—churches, fraternal bodies, civic groups, and independent agencies. They have continued to emerge since the recent wars and great depression, in organizations for dealing with poliomyelitis, heart disease, cancer control, mental illness, delinquency, and so on.

Case Work—New Rationale and Method. More recently, under the influence of scientific applications to other types of problems, case work has been developed as a dominant method of dealing with people who are experiencing various forms of difficulty. Considerable progress has been made in getting away from arbitrary classification of people and the imposition of uniform measures upon them. Ideally, each case of dependency, delinquency, or other form of social deviation is investigated individually on the assumption that the person is maladjusted and many factors have contributed to the particular instance of this condition. After an analysis of the factors and determination of the probable cause of difficulty, a plan of treatment is undertaken with a view to achieving more satisfactory personal and social adjustment. This is followed through with appropriate recording of facts, procedures, and results. Usually, however, social work records are designed for the practical use of particular agencies and have limited value as accurate sources to be used in theoretical studies. The method is now applied in family case work, child welfare work, medical social work, psychiatric social work, probation and parole, visiting teacher service, and industrial relations.

In spite of this scientific development there is still some tendency to deal with people categorically or to base diagnosis and treatment on some one theory of behavior.

DISCOVERIES IN ST. PAUL INDICATE MAJOR NEED IN WELFARE ORGANIZATIONS

Bradley Buell and his associates, with the cooperation of 108 public and private agencies, made a study of the interrelated community services dealing with dependency, ill-health, maladjustment, and recreation in St. Paul in November, 1948. In a single month these agencies were serving 40 per cent, or 41,000 families in this

city. Of these 7,000 (7 per cent) were dependent; nearly 11,000 had problems of maladjustment; over 15,000 were troubled with some form of illness; and 19,000 were being served by some recreational agency. Although each agency serving the people was independent, or could be classed as one of the parts of three separate systems in the community, the problem situations were not so nicely separated. Seventy per cent of the dependent families also had problems of ill health or maladjustment; 58 per cent with problems of maladjustment had problems in other fields; and 38 per cent afflicted with illness had other difficulties as well. The study uncovered the startling fact that 6,600 families (about 6 per cent), "were suffering from such a compounding of serious problems that they were absorbing well over half of the combined services of the community's dependency, health and adjustment agencies."[8]

Equally shocking is the fact that the 60 various agencies devoting such a large proportion of their time and energy to a small group of multiproblem families were unaware of the total situation with which each was related. The public welfare department did not know the full complexity of the health and maladjustment problems under its care. Furthermore, after all this effort is expended, "No one yet knows the extent to which the present volume of service results in the rehabilitation of capacity for self support."[9] The authors go on to review the need for a generally accepted pattern for achieving such an end—procedures for continuous identification of families who give evidence of serious disorganization and systematic recording of data about them; integrated diagnosis of whole family situation; analysis in terms of rehabilitative potentialities; assured continuity of treatment; periodic review and evaluation of total program.[10] They finally suggest,

> We believe, however, that there is now sufficient knowledge about the causes and characteristics of maladjustment, the functions of a community-wide attack upon it, and the structure through which these functions may be organized to warrant experimentation to develop principles and procedures for achieving community-wide prevention and control.[11]

Such an approach would be more fundamental and far reaching than anything now being done. But it should be said that the submission of budgets by agencies to community chests for coordinate financing, the establishment of community councils to promote

[8] Buell and Associates, *op. cit.*, p. 9.
[9] *Ibid.*, p. 87.
[10] *Ibid.*, p. 88.
[11] *Ibid.*, p. 334.

coordination of services, and the more recent development of coordinating councils for projecting programs on the basis of community-wide study of conditions and needs are movements in the direction of more systematic and scientific operation of community services.

RECREATIONAL ORGANIZATION

Unlike health organizations, recreational organization does not rest on centuries of experience and searching for a better way, nor does it have historical roots comparable to the organization of welfare services. It is true that such folk arts as story telling, singing, dancing, and dramatics, as well as creative expression through crafts and thousands of games, have characterized community and tribal life at all times. It is also true that great accomplishments resulting from Grecian emphasis upon intellectual and physical development have influenced the arts in all later periods. Roman pageantry, grand amusements, and spectacles for the masses have no doubt influenced later times. Then, too, the bearing of such doctrinal extremes as hedonism and puritanism might be traced. Until recently, leisurely recreational interests and activities have been among the prerogatives of wealth and high social position; and amusements for the masses were designed to pacify and distract otherwise miserable people. But present-day recreational organization is not directly rooted in these historical mass amusements. It is largely a product of the industrial revolution, the release of men from endless toil by machine production, and the growth of modern towns and cities.

Recency of Many Recreational Demands. The increasing use of high-powered and often automatic machines has steadily reduced the amount of time required for productive work—now 40 hours per week for many thousands of people, who find a great many hours of undefined and unstructured leisure time now available to them. With the aid of machines, work is often "light" so far as muscular energy is concerned; however, at the same time, the work associated with machine production often requires that accurate performance of routine acts be maintained at a rather high and regular rate of speed. These demands for accurate performance at high speed, combined with a certain monotony of routine, call for the expenditure of nervous energy day after day. Whether jobs are "light" or "heavy," workers experience marked fatigue in connection with the tempo and functional specialization of machine production. This seeming contradiction between increased leisure on

the one hand and increased strain and fatigue on the other is further complicated by the high concentration of workers in living quarters without adequate space and facilities for either rest or recreation. Another ingredient compounds the problem still further—the coming together of many people from diverse localities and cultural experience, separated from their primary group ties, often produces an impersonal, conflicting, and emotionally insecure social world in which to live. It should also be emphasized that, whether a place is an industrial or commercial town or city, a "boomtown" or "resort," or a suburb, a considerable proportion of the population is mobile rather than "permanent." These factors of highly concentrated, mobile "strangers" engaged in mass production under somewhat insecure and fatiguing conditions with greater amounts of leisure time than people have ever known before presents a combination of relations which is of relatively recent development. It must be understood, of course, that these factors do not occur with full or equal weight in all places, and communities vary widely in their recreational needs and the "set-ups" which have been developed to meet them. Considering the rapid development of factors which created a sort of vacuum in the opportunities and usages of leisure time, it is not surprising that a system of commercial entertainment and amusement has grown into big-business proportions. A long catalogue would be required to list the profitable enterprises which have been invented to satisfy recreational demands—professional baseball and football, prize fighting, racing, swimming, billiard and pool rooms, cabarets, night clubs, roadhouses, and dance halls are a few which may come to mind, along with the motion picture and various other types of theaters. More recently radio and television entertainment is provided on a mass basis.

Recreation Gives Rise to Problems of Regulation. Communities vary not only in the type of commercial recreations available, but also in their control over them. Gambling is associated with many legitimate amusements, and many attractive places foster vice and immoral conduct. Some places are even based upon prostitution, gambling, and illicit sale of liquors and drugs. Legislative and police efforts are frequently organized to prohibit or limit such places and forms of entertainment and amusement, especially in regard to the participation of minors. More recently, in response to impressions and studies concerning the harmful effects of highly emotionalized radio and television programs and comic books, some efforts have been made toward local and general control of these. It would be ironic indeed if communities should increase their efforts

to improve mental health and at the same time foster commercial agencies which generate feelings of insecurity, fear, and often extreme terror in children,[12] and provide a rather steady diet of violence and sensationalism for adults. This reference to some negative aspects of commercial recreation is not intended to discount the code of self-regulation which some agencies have developed or the tremendous volume of wholesome amusements which are operated for profit.

Recreation for All. Many of the noncommercial recreational provisions were made originally for the "underprivileged" or those in need of moral security or "character building." Playgrounds under some supervision and guidance were set aside in crowded and disorganized areas to furnish outlets for positive and approved activities. Settlement houses became centers for friendly intercourse and creative activities within areas otherwise hostile and dull. Christian associations set up libraries, gymnasia, swimming pools, bathing facilities and comfortable rooms, and fostered various classes, sports, games, and crafts for young people who found city life something of a maze. Although most of the early agencies and means of recreation have continued to exist, few remain confined to particular areas and the service of special classes. Provision of recreational facilities and opportunities is now regarded as a community-wide function. The catalogue of available services and activities is almost unlimited, and these are organized under religious, educational, governmental and independent auspices. One can think of parks, playgrounds, golf links, tennis courts, bridle trails, field houses, beaches, and swimming pools, with all the outdoor activities which these imply, as well as the libraries, museums, theaters, studios, and schools for creative endeavor. A new profession or several

[12] Publications in 1933 indicated that motion picture attendance influenced the emotional development, formation of criminal attitudes, and actual behavior patterns of children and youth. Evidence of similar results from reading comic books and viewing mystery-murder pictures on television has been found. Excessive fears with consequent sleeping and eating disturbances in young children, ideas of "easy money" and luxurious living based on crime, and the mastery of techniques for forcing locks, cutting burglar alarm wires, gaining entrance to houses, and many other results are set out. See Blumer, Herbert, and Hauser, Philip: *Movies and Conduct*, New York, The Macmillan Company, 1933; Charters, W. W.: *Motion Pictures and Youth*, New York, The Macmillan Company, 1933; Waugh, Coulton: *The Comics*, New York, The Macmillan Company, 1947; Wertham, Fredric: *Seduction of the Innocent*, New York, Rinehart & Co., 1954. See also the rather extensive *Hearings before the Subcommittee to Investigate Juvenile Delinquency* of the *Committee on the Judiciary*, United States Senate, Eighty-third Congress.

new kinds of expert service have emerged along with the growth of recreational organization. These in turn serve to further promote recreational opportunities and expenditures.

Communities Vary Widely in Recreational Organization. Provision for recreational opportunity and the standards of organization and leadership vary greatly by communities. Little community-wide attention has been given to recreation in some places, whereas others have probably carried expenditure to the point of diminishing returns. Again quoting Bradley Buell, "little has been done to clarify the basic functions indispensable to a complete community-wide program" and, as yet, no "criteria by which to judge the quality of performance in the recreation field or to allocate labor and responsibility among the community agencies" have been developed.[13] There may be general agreement that large-scale facilities should be available for public use; that activity interests should be organized; and that friendship groups should also be promoted among young and old. There may also be increasing agreement that communities would be better served if the organization of recreational activities were consolidated in a single unit to be located in a separate structure, in the park department, or in the schools.

Therapeutic Values of Recreation Uncertain. Recreation exists for its own sake, but therapeutic values have also been claimed for its use in connection with delinquency, mental illness, and so on. Until more evidence is available from experimentation with recreational methods in camps for diabetic and cardiac patients, for emotionally disturbed children, and in treatment groups affiliated with psychiatric clinics, wider application is on uncertain ground. Similarly, generalizations concerning the utilization of recreational methods to promote educational achievement cannot yet be clearly made.

EDUCATIONAL ORGANIZATION

Cabinet Post Combines Health, Education, and Welfare. The fact is rather striking that our national government has recently been reorganized to include an additional member in the President's cabinet. The Department of Health, Education, and Welfare was created in 1953 in accordance with the Reorganization Act of 1949, and these combined services are given a status comparable to Departments of State, Defense, Treasury, Commerce, Agriculture,

[13] Buell and Associates, *op. cit.*, p. 378.

and others. This development is significant not only because it is a recognition of the relative importance of these services, but also because it is an acknowledgment of their essential unity. It may seem strange that it occurred so late in history and that it has taken place first at the national level. It brings in sharp contrast the separateness of health, education, and welfare organization in communities across the land.

Educational Functions Widely Diffused. It has been noted in this chapter that educational functions are increasingly emphasized throughout practically all health services. The slogans of total health and positive health can be approximately achieved only to the degree that hygienic and healthful patterns of living are learned by larger proportions of the people. The achievement of public health and mental health goals rests particularly on the process and organization of education. Recently the new specialization of "health educator" has emerged to provide a three-way liaison for teachers, students, and parents with respect to health, and a two-way link between separate organizations in the community. It is an interesting commentary that such a specialist is in some places attached to schools, and in others to health departments. Similarly, much case work and group work under welfare organization is essentially educational. The fact that adult education is most frequently dependent upon chance organization, and is usually classified as recreation, is further evidence of the segmentary and fragmentary relations among educational services.

Education Broader than Schooling. Educational organization is frequently thought of in terms of schools, and these may be highly divorced from other community affairs.[14] There is a growing tendency, however, to use school buildings and other facilities for community-wide activities. Parents and teachers are directly organized in numbers of ways, and indirectly involved through such specialists as visiting teachers, school nurses, counsellors, and so on. Nursery schools, kindergartens, and educational clubs for mothers have been added to many community systems. School curricula are becoming loaded with courses designed to serve almost any general awareness of educational need: various forms of specialized vocational education, civic education, religious education, safety education, sex education, education for marriage and family, and other courses concerned with learning particular skills. In addition, the

[14] Waller, Willard: *The Sociology of Teaching*. New York, John Wiley & Sons, 1932, Part III.

extracurricular organizations connected with schools emphasize many activities as ends in themselves but, more often, attribute various educational values and results to such activities.

Average Educational Level Rising. Masses of children receive the elementary education which is afforded by the particular community in which they live. Much larger proportions than ever before go on to high school. It is also the ambition of many more parents to send their children to college, and, because of their greater earnings and the aids from GI provisions and other sources, a larger proportion of the population is attending college. The average level of education attained by citizens in each community should be expected to rise. It is frequently assumed that this will bring about a better way of life for all the people.

Historically and Currently Schools Lack Integration. The scope of this text does not allow an excursion into the history of education or the controversies which are now in progress concerning the goals and results of educational efforts. It is in line with previous observations in this chapter to call attention to the historical separation of functions for elementary and secondary schools and differential functions of colleges and universities. Education for masses and education for upper classes were not originally in one system, nor was education for professional responsibilities narrowly specialized. Historically, systems existing in different societies to serve distinct purposes were introduced into America as public schools and were made available to all people. They were not reorganized and fitted together but simply added together.

Investigation and Experimentation Needed. Since nearly all other additions which have been made in recent times have also been added to one level or another, it is not surprising that resulting organization is rather confusing with respect to aims and purposes, as well as results. Neither should it be surprising that the hundreds and thousands who "drop out" of the educational process at various levels of development constitute quite a mass of persons who are uninformed and incompetent to deal with many personal and family problems and the even more complicated public issues. The average educational attainment by communities varies quite widely but is often quite low.

On the basis of this brief summary there seems to be great need for experimentation to determine proper methods and content for adult education and the coherent organization of community-wide educational services. Until something of the sort is done it will be

difficult to judge the potential contributions of education to a better way of life.

TOWARD POSITIVE COMMUNITY ORGANIZATION

Health Organization Points the Way. Community organization has now been seen from two views—dynamic and static. This chapter has emphasized the continuous efforts which have been made to achieve better adjustments or better ways of living on the part of communities for families and individuals. At the same time some attention has been paid to the varied and confusing mosaic of agencies which have been developed as means of reaching desirable ends. Their development has been due partly to the independent and spontaneous origin of the numerous and varied agencies; but it is also due to the bewildering conflict of ideas about causes of undesirable conditions, and what values or ends might be more satisfactory. At any rate, when means or agencies come into existence there is a tendency for them to expand and become rather permanently established. In a very real sense they become ends in themselves, and their perpetuation becomes a prime objective of their existence. Thus, from a static point of view, community organization consists of the system of existing agencies which at any given time are operating partially to maintain themselves and partially to promote the essential and desirable ends of community living.

It was observed that health organization and agencies have probably been more dynamic and achieved more significant results than other systems. To some extent this might be due to the kinds of problems confronting health services, the clearness of ends to be achieved, and the continuous pressure to discover means to achieve them. But the substantial results of health organization have been primarily due to the experimental and clinical search for basic knowledge of causal relationships in health and disease. Procedures based upon magical and theoretical formulations have diminished; and treatment and prevention programs have become almost revolutionary because of deepening insight and socialized understanding. What has been called positive health, or optimum development of physical and mental well-being, has become a possible goal for the future.

Lag in Welfare Organization. It has been suggested in this chapter that the advancement of health organization will continue on the basis of knowledge tested by experimental and clinical experience. It has also been suggested that welfare, educational, and rec-

reational ends may be more satisfactorily achieved in a similar fashion. Thirty years ago Franklin H. Giddings commented upon the "program" of an organization which was set up to make young men physically "fit"; "develop" them intellectually; "deepen" them spiritually; and train them for "service." Yet there were no physical examinations or goals of physical fitness, no evaluations of fitness achieved in connection with the organization. No particular evidences of intellectual development or depth of spiritual interest were considered. And no tangible definition of "service" was attempted nor evidences of training for service obtained or recorded.[15] Although the agency and its program continue to this day, and many similar ones have been set up in the meantime, goals are no clearer nor are results less vague. It can be said parenthetically that public enthusiasm, faith, and support for the particular agency has dwindled; it has died in many communities and merely "hangs on" in others. Nevertheless, some organizations now currently supported with enthusiasm are equally vague concerning their objectives and evidences of accomplishment. The point is that organization may develop and continue without any very clear or definite ends, and constitute a sort of trial-and-error groping for more desirable conditions. But there can be no experimentation or clinical observation until and unless persons know what they are attempting to do, how they propose to go about it, and what evidences of achievement may be looked for. Let it be said at once that many valuable activities do go on as ends in themselves, and hit-or-miss, trial-and-error procedure has been known to "pay off." Although "muddling through" may be happily negotiated, the argument here is that mature organization demands more scientific fortification.

PUBLIC SUPPORT AND PARTICIPATION CRUCIAL

It should be evident that public support and general participation by people in a community is essential to community organization. After all it is the people for whom agencies exist, and unless they enter into programs and programs enter into them the programs fail. Furthermore, people lose faith in programs which are extraneous and either do not support them at all or merely give them token support as symbols of hope. The relationships between the people, and the experts or professional personnel who serve them through the operation of organized agencies and services, call for a more extensive analysis than can be given here. Doctors, nurses,

[15] Giddings, Franklin H.: *The Scientific Study of Human Society.* Chapel Hill, University of North Carolina Press, 1924, pp. 39–41.

case workers, group workers, and many other specialists are leaders to whom people look for wise and dependable guidance. At the same time people tend to be conservative and continue in established ways. If experts are multiplied greatly in numbers and increasingly narrowed in specialization, if their theoretical and policy disagreements become pronounced, and if they come to insist upon vested interests in techniques and jargon, mounting public confusion and frustration may result. Specialization often results in divergent interests and technical vocabularies among workers, and often creates greater barriers to dealing with communities, families, and other groups as units. Many professional persons are isolated with respect to the social relationships they are expected to serve. Leadership requires a delicate balance between initiation of ideas and making decisions for people. Community organization is a street along which citizens must learn together with the experts where they are headed and help make decisions about policies for the journey if they are to maintain faith and support. Expert opinion and public opinion must be reconciled.

Economy and Efficiency Required. In order to do these things there must be more coherent organization, coordination, and consolidation of local services. Numbers of agencies may need to be cut down in many places; or, if they are retained, functions may have to be changed. The public has a legitimate claim upon economy and efficiency of organization, and unless experts can find a way to achieve these, as well as other ends, public support is likely to decline. However, experts must be interested in coordination for reasons of maximum achievement as well as economy. The need for further coherence and integration of all social services has been supported by considerable evidence in this chapter. This may be another way of saying that better ways of coordination may have to be discovered through future experimentation. Many teamwork and community coordination efforts are already under way.

TWO TYPES OF COMPETENCE FOR PROFESSIONAL SERVICE PERSONNEL

Professional persons and specialists of many kinds will need to work together and to encourage community-wide participation if the best ways of living are to be discovered and established in the future. Toward this end they will need competence of two kinds rather than one. Each professional person may be expected to develop competence in the special service he is to render; and at the same time he will need to develop some comprehension and tech-

nique for dealing with intergroup relations and community-wide organization.

FOR INVESTIGATION AND DISCUSSION

1. Whether your home community is a city or town, list all the organizations or agencies you can discover in it which are devoted to some kind of improvement or betterment of conditions. Some will be under the direction or sponsorship of local, state, or federal government; local churches or denominations; civic groups; national organizations; and various associations of women, parents, businessmen, farmers, doctors, laborers, and others. If your home is a city, you may find a printed directory which lists most of the agencies engaged in various types of betterment.

2. Go back over your list and classify the organizations and services in terms of their principal objectives, such as those for infants and preschool children, crippled children, orphans and neglected children, maladjusted and delinquent children, youth and young adults, unmarried mothers, domestic relations and family services; and also by principal activities as educational, recreational, counseling, case work, and the like.

3. Considerable stress is being placed upon the evaluation of organized efforts, including the performance of groups, particular programs, and the work of agencies. Report any instances of such evaluation you may know about through participation, observation, or reading. What similarities and differences appear to exist when you compare evaluation procedures with scientific interpretations which grow out of investigation and experimentation?

4. Cite instances of social efforts which were first organized for the purpose of improving conditions among the poor and underprivileged, and later developed into services for the whole community.

5. Cite instances of advantages and opportunities which were formerly available only to people of wealth and high status which have, through community organization, been made accessible to practically all people regardless of status.

6. Can you think of any educational needs of adults which do not seem to be provided by any schools or other organized agencies of the community? If so, give reasons for regarding the matter as a social problem or as of little consequence.

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PART TWO

Sociology Applied to Nursing

Introduction to Part Two

Part One of this book deals with the basic sociological concepts and includes sociological orientation.

Part Two of this book is limited to an approach, distinctly sociological, which will aid the nurse in applying the basic concepts of sociology in her contacts with people, both as a citizen and as a nurse. Emphasis will be placed upon the phenomena which are the subject matter of sociology and fall within the pattern of nursing which always involves interacting human beings. There will be coworkers in many categories, all members of groups, all types of personalities, all with culturally determined patterns of behavior. There will be persons enjoying optimum health status and patients with illness, disease, and disability. They will have definite personalities, and will have group affiliations and cultural determinants. The basic sociological concepts have an important contribution to make in any situation in which the nurse finds herself. These basic concepts are no more than tools, and unless the nurse can competently utilize them her proficiency in the technical skills is less effective. If these tools are to become an integral part of the nurse, as they should, guidance must be provided for the student nurse in all of her learning experiences.

Comprehensive nursing embodies the totality of the situation. The term *situation* will be used to mean all factors significant to the relationship of the aspects of nursing under consideration. The nurse, as the observer, will need to analyze the facts objectively and, with knowledge of the basic concepts, determine the course of action most profitable under the circumstances. It is quite important for the nurse to remember that she has been influenced by culture, etc., and that her definition of situations and her behavior in them must be understood if she is to have the ability to detach herself from aspects of the situation. Facts should be viewed without prejudice, emotion, or preconceived ideas. Objectivity on the part of the nurse is absolutely essential for the well-being of all persons involved. The nurse is considered a mature individual capable of functioning effectively in a democratic society. She is envisioned as one who has great respect for humanity, based upon well established appreciation for democratic values.

Chapter 12

CHANGING ORGANIZATION AND FUNCTION OF HEALTH SERVICES

EMERGENCE OF PRESENT-DAY HEALTH SERVICES FROM A DISORGANIZED PATTERN OF CARE FOR THE SICK

Health services in present-day society cannot be understood without some comprehension of the events bearing upon them that have occurred over the years. Contemporary events and practices have meaning, the full significance of which becomes apparent only after insight into the past is attained. A brief review of their development during the early years will best provide the background essential for understanding health services as we find them today. An earlier chapter substantiates the fact that cultural changes develop over a long period of time and that patterns which appear at present have emerged through slow or rapid acceptance of inventions.

Excellent books are available which give in detail the history of any aspect of development one wishes to investigate. In contrast to such a detailed account, the material presented here will give only a glimpse into the swiftly moving events that have brought about the present environment. Many facets of vital developments will be omitted purposely because they are more adequately covered in histories of medicine and nursing. The purpose here is to identify and briefly describe only those aspects of the vast heritage which will furnish the information necessary for some understanding and appreciation of existing health services. The complexity of reality today contrasts sharply with the relatively simple life of the past. Change has been gradual, occurring slowly in some instances, more rapidly in others. The pattern of health services which has emerged contrasts sharply with that of the past.

THE FAMILY PRIMARILY SELF-SUFFICIENT IN MOST ILLNESS SITUATIONS

Tradition and superstition related to maintenance of health, well-being, and illness exerted powerful influences in family behavior in the early days. Many families relied heavily upon information handed down from older persons. They placed an unusual degree of confidence in books which gave details for treatment of many ailments, including remedies for animals as well as for man. Cures for cancer, consumption, and rheumatism were included.

In earlier days the sick person was cared for in his home, the mother delivered her baby at home, and patients with communicable diseases were treated at home. In most illness situations the family, enlarged by relatives, gave the care needed. If additional assistance was necessary, willing neighbors were always available to lend a hand and usually gave freely in innumerable ways when illness beset their friends. It is not difficult to recall when members of the family would go to the home of a friend to "sit up" during the night with a sick person. Frequently assistance was given with the farm or family duties, allowing the immediate family members to devote more time to care of the patient. In these early years few nurses cared for the patient in the home.

Often the family had to contend with many complications which hampered the effectiveness of the doctor's diagnosis and treatment. These complications were not only physical but cultural as well.

CHANGES IN MEDICAL CARE AND MEDICAL PRACTICE

The Family Doctor. Fifty odd years ago medical attention was focused on curing disease. The family doctor was not a specialist in a particular field of medical science. Actually he knew little of medical science as it exists today. The cure of the patient was the doctor's honor. He brought babies into the world, cared for them through whooping cough, measles, diphtheria, etc. Few persons outside the family constellation shared in or assisted with his accomplishments.

Facilities available to him were limited. Pneumonia was treated without benefit of antibiotic therapy, oxygen, and other modern resources. The doctor attended the patient through long days of high fever, waiting anxiously for the crisis. There were few mechanical devices to aid in diagnosis and treatment. X-ray was not readily available to show him where a bone was broken, or to indicate the adequacy of the alignment after the doctor had "set" the fracture and placed the part in a splint.

ROLE OF FAMILY COUNSELOR. In the early days families approached the doctor for advice and counsel on many problems, some not even remotely connected with medicine. As a counselor the doctor knew intimately each individual as well as the entire family. He had keen insight into family strengths and weaknesses and was aware of the relationship between the manifest physical symptoms and existent personal problems. He gave full consideration to the latter in his treatment of the patient and in his advice to the family.

PERSONALIZED MEDICAL CARE. Years ago every one had a family doctor. Although the need for his services was infrequent, he did see a great deal of the family. Regardless of the situation in which he functioned, his service was truly personalized. This unique relationship made families dependent upon him for a wide variety of needs. The doctor's personal attention and genuine interest provided each family with a deep sense of security. His own understanding of the role he played gave him an enviable feeling of worth and accomplishment. This early doctor-family relationship is seldom encountered today.

CONTRASTS IN COST OF MEDICAL SERVICES

The cost of medical care some fifty years ago was consistent with prices prevalent at the time. Early record books reveal that the fee paid the doctor for the delivery of a baby was five dollars. All the necessary articles for the new baby were purchased for less than two dollars. Yet today it is not uncommon to pay a doctor three hundred dollars as a delivery fee. Furthermore, the wife may be told late in her prenatal period that the doctor expects her to pay his fee at the time of delivery. Gone indeed are the days when one might pay for medical attention with produce or during the season of the year when money was more plentiful and routine expenses were less. Today the cost of medical services and hospital care may produce severe financial burdens for many families, although many types of hospital insurance are available at varying rates and with a wide range of benefits.

THE ADVENT OF THE SPECIALIST

Specialization in Medical Practice. Times truly have changed. Recently a mother was asked, "Who is your family doctor?" In reply she said, "Do you mean my obstetrician, my gynecologist, or my pediatrician?" The present seems to be an era of the specialist, and the services are all too frequently rendered in an impersonal

manner. This is especially true in metropolitan areas where most doctors have large practices. In many instances visits to the specialist are infrequent unless there is a specific indication of illness. All too often now the individual is viewed as a collection of organs, mutually dependent on each other and each with a specific function. If an organ becomes defective the appropriate doctor, as a specialist, must be consulted. Regular visits to one's physician in order to prevent disease rather than to cure disease is an exception worth mentioning here, for this practice is receiving increasing emphasis now. This is especially true for those who visit their physicians for yearly physical examinations and for families who regularly utilize the services of a pediatrician in order to keep their children well and to receive guidance on normal growth and development.

Access to Clinics and Hospitals. Today doctors tend to be classified, and only certain doctors are permitted to care for patients of a certain kind. Some doctors must turn the care of their patients over to a specialist if hospitalization is necessary. In part, this is the result of ethical practices and the high degree of competence developed with specialization. This practice, however, has its weaknesses, for it further widens the gap between the doctor and the family and patient. The patient often finds himself being treated by a physician whom he has never seen before. Such a relationship frequently limits the patient's confidence both in the doctor to whom he is referred and in the doctor he had previously consulted.

Permission to practice in certain clinics and hospitals is not equally available to all doctors. Classification does not stop with specialization, but sometimes includes other bases of discrimination, such as race and sex. Patients may even be classified so that those of certain races may not have the same facilities as others.

EARLY HOSPITALS

Hospitals were few and far between in the early days. These establishments lacked much of the modern mechanical equipment so readily available today. Complicated, accurate diagnostic procedures were unknown. Early hospitals were poor examples of cleanliness. Skilled nursing care, as we know it today, was not available. Disease conditions which rarely prove fatal today ranked high in causes of death in those early years. Many disease conditions formerly requiring long periods of hospitalization are almost completely preventable today. The privilege of practicing in the hospital was available to any general practitioner in the early days.

Attitude toward Hospitalization. When the family doctor ordered his patient to the hospital it was immediately evident that all elements of care in the home had failed to produce improvement and the hospital was the last resort. The attitude of the patient in those early days confirmed such a belief, for the feeling was that he would certainly die from his malady if his condition became critical enough to require hospitalization.

Personnel Involved in Care of the Patient. In the past, the doctor and the nurse were usually the only individuals involved in the care of the patient in the hospital. Other persons were responsible for supplementary services but seldom had direct contact with the patient, and only to a limited extent with his family. The number of personnel on the hospital ward was limited and might consist of a head nurse and students if the hospital maintained a nursing school. A maid and an occasional orderly might be available in some hospitals. Relationships were simple and responsibilities clearly defined.

MODERN HOSPITALS

Changing Role of the Hospital. Consistent with existing ideas of the times, the hospital of earlier years fulfilled its role by concentrating on curing disease. To bring hospital services in line with changed concepts of function the modern hospital today assumes a dual role in the community. The prevention of disease is recognized as a function of the hospital equally as important to society as curing disease. The hospital's attempt to fulfill this dual role has been responsible for the addition of services formerly not available, and, to provide such services, hospitals have had to secure additional equipment and personnel. Policies necessary for the assumption of these new responsibilities have had to be formulated. Active participation in community health programs and close cooperation with existing facilities not only have increased the responsibilities of the hospital but have provided more comprehensive care and thus have improved the general health status of individuals and of the community as a whole.

Changes in Hospital Environment. Improvement in technical facilities and skills gives the hospitalized patient today many advantages over those who required care for the same diseases earlier. Increased scientific knowledge in the fields of nutrition and physical therapy provide much more in the way of supportive therapy than in the past. Technical skill has been utilized to a high degree in an

effort to make the physical environment more convenient, more practical, more comfortable, and more conservative of human resources.

Length of Hospital Stay. Periods of hospitalization have been almost unbelievably shortened. Early ambulation, although slowly accepted at first, is now an essential element in minimizing complications and hastening recovery. Acute stages of illness have been markedly shortened by the new miracle drugs and advanced medical and surgical techniques. Long periods of convalescence, formerly an essential part of the service offered by the hospital, now take place in the home or elsewhere because of early dismissal. This radical change in care has presented new and different problems for the physician, the nurse, the family, and the community.

Change in Attitude about Hospitalization. Much more respect for the hospital has developed over the years. Patients and their families are more inclined to look favorably upon the services offered for relief of suffering and incapacity. Many seek early hospitalization for minor defects as a means of avoiding more serious illness later. Many enter the hospital with optimism and feel confident of recovery. Advancement of scientific methods and wide publicity about the wonders of modern surgical procedures and antibiotic therapy have done much to alleviate earlier superstition and fear.

It is not the intent here to leave the impression that no fear exists when hospitalization becomes necessary. Both the patient and his family are gravely concerned, but much of the reluctance to seek hospital care has disappeared.

Increasing Complexity of Relationships of Hospital Personnel. Today an increasing number of hospital personnel interact continuously in providing care for patients. The variety of personnel available on the ward for nursing care will probably include a supervisor, head nurse, junior head nurse, staff nurses, graduate practical nurses, attendants and/or an orderly, and a maid. Each member of the group contributes directly in varying degrees to the nursing care of patients. Student nurses give nursing care in many hospitals, but increasingly the emphasis is being placed upon guided learning experiences for them instead of upon the quantity of nursing service which they are expected to provide.

Unfortunately, manipulation of the human environment has not kept pace with the marked advances in medical science and with the improved facilities in the physical environment of the hospital. Effective manipulation of the physical environment has not been accompanied by a corresponding improvement in organization and

utilization of personnel. Many factors have perpetuated this lag, and accompanying problems still persist in the human environment of the hospital. In fact the increased numbers of persons with their multiplicity of functions have served to increase the complexity of relationships and have added considerably to the intricacy of hospital administration.

Team Concept of Care. Frequently recovery of the patient is credited to "team work" which involves the contributions of many who supply the essential elements of care or who may have contributed in places outside the immediate hospital environment, such as the public health nurse in the home, the doctor in industry, or the sanitarian in the community. The family is considered a part of the team. Thought is given to the over-all picture, what went on prior to the immediate situation, what will happen after recovery. Many elements formerly not recognized as important are given careful consideration. Cooperation is a basic essential for effective team care with each participant being given recognition for his contribution. Maximum utilization of each individual team member's potential is possible and results in coordinated effort directed toward the common goal of more effective care for the patient.

Hospital Facilities More Readily Available to All. Prepaid hospital care plans are becoming more popular and a broader coverage of a larger percentage of the population seems certain. No doubt such expansion will continue until a major part of the population is provided for. Hospitalization insurance and prepayment plans which provide hospital services for individuals formerly not financially able to utilize facilities except in dire emergency have resulted in the hospitalization of increasing numbers of persons. Results are evident especially in the decrease of more serious medical and surgical conditions. Further effort is necessary to insure adequate medical and nursing care for all who require it. The criterion for receiving medical and nursing care is not so much the individual's ability to pay for such services as his need for the services. It would appear from the increased availability of hospital facilities that more care, not less, will be demanded in the future.

HEALTH SERVICES AND THE CONSUMER

The Consumer. Today the public is much better educated and much better informed, resulting in an earlier and more thorough recognition of health and social needs. The public now realizes that what affects one may well have an indirect or even a direct effect on others even though they themselves may not be the victims of

poor housing, low income, high disease incidence, and the like. Increased interest and better understanding on the part of the general public lend support to improvement of the less desirable aspects of the environment.

Demand for Adequate Health Services. There is a growing demand for the provision of adequate health services for all in rural and urban communities. Rapid strides have been made in medical science and accompanying advances have been realized in other areas providing ancillary services for health promotion, disease prevention, and care of the sick. Many of these advances have developed because of the rapidly changing needs of our people. Interest and participation of lay people increase. This seems sound since the public is the largest consumer of medical and nursing services. These people have much knowledge and information that is extremely helpful in the formulation, planning, and execution of improved health services. The strength of an interested, well informed public should not be minimized. Today everyone is interested in working so that all people may receive better medical and nursing care in quantities sufficient to meet their needs and of a quality consistent with acceptable standards of care.

Public Relations. More and more hospitals are beginning to recognize the importance of an active public relations program and some have employed specialists to interpret the hospital and its functions to the community. Careful thought and planning with newspaper reporters result in publicity that is informative, educational, and helpful to all. In many cities, a code has been developed between hospitals and newspaper publishers defining the type of information to be released, the responsible person to provide the material, and the like. This code has done much to improve relations between hospitals and newspapers.

The bulletins, annual reports, monthly papers, etc., prepared and distributed by the majority of hospitals also serve as means of describing the services of the institutions in their communities. The bulletins and annual reports usually contain simplified pictures of hospital expenditures and attempt to give the public the facts and reasons behind "high hospital costs."

Volunteers who contribute their time and efforts to hospitals are excellent public relations persons since they are consumers of health services who are actually participating first-hand in the activities of the hospital. If they are happy and enthusiastic, they communicate these feelings to others in the community so that their influence is widespread.

BROADENING CONCEPT OF HEALTH

A broadening concept of health care concerns itself not with the patient alone but considers the family and encompasses the neighborhood and the community. Increasing emphasis is being placed on positive health for individuals and families and the direction of effort toward health promotion has simultaneously resulted in an impressive accomplishment in disease prevention. Constructive progress is being shown in an improved health status for the nation.

Consistent with present trends, consideration cannot be limited to the symptoms manifested by disease, but must give cognizance to the social and mental-emotional components involved in a particular disease condition. Curing disease is not enough. Today the job is not complete until the individual is returned to useful, happy living, able to assume his role in society and fully prepared to resume an occupation.

It is fair to say that good health is being considered the right of every individual. More and more people are beginning to recognize the importance of preventive medicine. The importance of confirmation of sound health equals or exceeds that of actual healing. Early diagnosis becomes possible and, as a result of it, the accompanying benefits, such as lowered cost of care, earlier and more complete recovery, and increased life span, are within the realization of many.

Changes in population characteristics during the past fifty years confront present-day society with a completely different situation. There is an ever-growing number of aging persons who are faced with the predominance of long-term illness. Increasing concern with issues like housing, education, and government which are related to the general health and welfare of the population is becoming evident.

Communities are becoming more actively interested in identifying long-term health needs. With that goal in mind it then becomes possible to assure more adequate utilization of available facilities and the future expansion and extension of services can be planned with maximum efficiency and minimum cost. The interpretation of needs, so often necessary for securing increased funds, becomes easier and more effective if sound plans provide a basis for action.

NURSES' TRAINING GIVES WAY TO EDUCATION FOR NURSING

It is not wholly fair to contrast nursing today with either the beliefs or practices existent in the past. The early days, when anyone

who wanted to be a nurse could enter "training," were simply the beginning. Few requirements had to be met. Educational prerequisites were very limited, although a number of schools required high school education.

Only a few years ago the young nurse, fortified with a smattering of theoretical preparation and classroom practice, might be placed alone on a large ward at night and given the complete responsibility for the critically ill patients. Little thought was given to the emotional needs of the patients. Contrast this situation with that of the young nurse of today. She is much more adequately prepared to cope with the mental-emotional aspects of nursing care. Although the quality of the care given by the young nurse of the past seemed adequate under the circumstances, it can be assumed that it did not measure up to that provided by the young nurse today, who has the advantage of a much wider background of theoretical information and who has learned, under close guidance, to perfect her skills.

Nursing Education. The present leaders in nursing seem rather generally agreed that nursing education must prepare a well rounded, thoroughly integrated individual if she is to give the quality of professional nursing care that patients and families should receive. Today much more thought is given to the selection of students. Various tests are utilized in determining the qualifications deemed so necessary for the prospective student if she is to succeed in nursing. Extreme care is exercised by those who have the responsibility of determining personality traits and other characteristics that seem to be increasingly more important if effective, satisfying relationships are to emerge from a complex environment. Intellectual equipment is still vitally necessary for the desired attainment but family background, experiences of early life, and resultant attitudes receive increasing attention in the selection of the person who is to become a student nurse.

Nursing has made tremendous strides in the improvement of educational standards. Many studies are currently being made in an attempt to evaluate the present system of nursing education and should eventually provide some concrete suggestions for improving the product—a nurse adequately prepared to meet the requirements of nursing today and tomorrow.

Constant revision has broadened curricula, and further improvement in both breadth and depth seems certain. Much of what is being taught to young students today was not part of nurse training twenty years ago. Modern theoretical preparation teaches the student to consider each patient as a person—an individual, who is

different in every respect from all other patients. Nursing care, then, must be constantly adjusted to fit each individual and a special pattern must be developed to fit a certain family group with a specific religious belief, definite cultural patterns, mores, and customs. All these factors are inherent in the patient's total care and treatment. Today emphasis is placed on the importance of the nurse's remembering that each patient is a member of a family group, that he has friends with varying degrees of influence, and that his affiliations in various groups are essential in providing some of the fundamental satisfactions required by all individuals.

Nursing Service. Years ago student nurses supplied the bulk of the nursing service—nursing care for patients in the hospital. Although this is still true in many situations, concerted effort is gradually limiting this practice. To provide significant and essential learning experiences for the student nurse increasing emphasis is being placed upon the use of the clinical facilities in the hospital environment and within the community. This practice tends to limit the amount of direct service that can be assured through the use of student nurses. Today the graduate staff nurse is an integral part of the nursing service, although twenty years ago such a person was practically unknown in the hospital.

CHANGE IN CONCEPT OF NURSING

One of the nurse's basic functions which has remained consistent through the years is care of the sick. Today there is increasing evidence that this narrow interpretation of function should be broadened to include concern for and work with well persons. Some of the variation in function and the change in emphasis and the comprehensiveness of nursing as conceived today will be elaborated in later chapters.

The early nurse had limited theoretical preparation and the major part of her learning was acquired at the bedside. Just as a baby grows to be an adult, so nursing grows from training or apprenticeship status through education to professional status. Consideration for the physical comfort of patients was paramount and even today has excluded other aspects of nursing which are equally, if not more, important. The pattern of this early nursing paralleled the theory and practice of early medical care in the hospital which can be illustrated by former use of such expressions as "this gallbladder" or "that thyroid," in contrast to the broad ramifications unavoidably included when "the individual, Mrs. Jones, with gallbladder disease," is considered. Emphasis is shifting from disease-

centered physical care to comprehensive nursing with all its implications. Much remains to be accomplished. The goal is in sight, but it will not be reached without additional years of toil and effort contributed to by all. Now the educational experiences planned for nurses must prepare them to assume an increasingly wider variety of positions in administration, industry, education, public health, psychiatry, long-term illness, and rehabilitation.

For some years nursing has been attempting to change from "craft" status to professional status, but inclusion of the "total care" concept in present-day nursing has not been as rapid or as complete as many would like to think. No one can deny that even today many nurses lack sufficient understanding of human beings as individuals. Quality of nursing care is proportionate to the extent of this understanding and the degree to which the basic fundamentals of this concept are included in the practice of nursing. Fortunately today the young student has an advantage that results from the emphasis placed upon the sociological implications inherent in illness as well as in the maintenance of health.

In the early days few nurses had the time or the inclination to do more than care for the sick. Today, one of the elementary necessities for the professional nurse is a working knowledge of the facilities available in the community. Some of these will provide services directly related to comprehensive care for the patient and/or his family while others will furnish services essential for healthy, happy living. The latter is becoming increasingly essential as interest broadens to include aspects other than physical care and the cure of disease. If the nurse is acquainted with persons, such as press representatives, government officials, and similar individuals in a community, who can promote interest for improvement of facilities and provide for better care, she can render a more valuable service. Intelligent interpretation often gives just the boost necessary to initiate much needed programs for human betterment. Continuous growth and evolutionary development have brought nursing to its present place in society.

Status and Role of the Nurse. As mentioned previously, sick persons were first cared for in their own homes under the pattern of mutual aid. When the family could not meet the situation adequately, neighbors came in to give assistance. Whoever became ill, whether a child or an adult member of the family, each was looked after by those who were "up and around." Nursing as a separate function probably started when soldiers or travelers became ill away from their homes or when the volume of illness became too great for

family care. When nursing first started it was for the purpose of administering to the needs of the sick and wounded. Nurses gave baths to the patients, dressed and cared for their wounds, and did whatever was necessary to make them comfortable and to provide a clean environment.

Today, society's need for such services is even greater. Nursing is becoming increasingly essential to health and human welfare. The nurse continues to play the dominant part in providing nursing care. In present-day society nurses are found wherever people are found. Nurses are widely distributed throughout our most fundamental social institutions: the homes, the schools, and the hospitals. They are found in cities, in rural areas, in factories, in transportation, and in the military services. Not only do we find the nurse in more places than formerly, but the variety and number of duties she is expected to perform multiply with each passing year. What then is the status and the role of the nurse in society?

Not only was Florence Nightingale the prophet of nursing in her time, but the ideas which she suggested long ago are just now being grasped and utilized. The quotation below indicates that she realized that nursing of the sick could not be separated intelligently from the proper maintenance of health and well-being. Florence Nightingale, in her *Notes on Nursing: What It Is, and What It Is Not*, clearly defined the role of the nurse:

> The very elements of what constitutes good nursing are as little understood for the well as for the sick. The same laws of health or of nursing, for they are in reality the same, obtain among the well as among the sick.[1]

STATUS. The meaning of status and role has been discussed in earlier chapters. Status is social standing or prestige, and is the inevitable result of relationships between individuals and groups. It is influenced by individual-to-individual, individual-to-group, and group-to-group relationships. Status is the standing accorded the nurse by other persons. Status of a group likewise results from the standing given a group by other groups. Since status and role are so interrelated, no effort will be made to differentiate distinctly between them in all instances.

ROLE. Role is usually defined by the group or the culture. When the individual, in this instance the nurse, performs certain functions or exhibits expected patterns of behavior she plays a role. Function and role will be used interchangeably. How well the nurse performs various roles determines her status in her group. In the

[1] Nightingale, Florence: *Notes on Nursing: What It Is, and What It Is Not.* New York, D. Appleton-Century Co., 1914, p. 9.

opposite way, the nurse's incompetence or failure to perform will also affect her status in nursing groups. Roles differ and change constantly. With interacting units, for example, the nursing group and the medical group functioning in relation to each other, each group plays a role. Each member within each of these two groups plays a role. Participation in different groups calls for a change in behavior in order that the individual's behavior will conform to that which the group expects. Identity of a specific role presupposes that certain minimum requirements have been satisfied. To illustrate, the title of registered nurse indicates that a nursing program has been satisfactorily completed and a state board examination has been passed with an acceptable score. Attainment indicates the kind and degree of responsibility that one is qualified to assume. Thus, certain evident requirements are necessary for certain roles. For example, management and leadership skills are essential for supervisory functions. If the nurse possesses the necessary essentials or skills she may play certain roles without adjustment. If the essentials or skills are lacking, then a greater degree of adjustment will be required. In some instances it may be possible to copy or imitate the pattern of behavior required for playing a certain role. The nurse may be lacking in the supervisory skills but she may pattern her behavior after a well qualified person in giving instruction, reprimanding co-workers, etc.

The nurse's status may be vague in some respects but fairly well defined in others. Generally the nurse will occupy a different status in different situations. Work relationships are arranged in the form of stratification. Horizontal division of nurses is fairly definite and identifiable in a particular work environment. Identity is by like kinds in a single category: supervisors, head nurses, or staff nurses. In each category a certain degree of status is accorded an individual so identified irrespective of the qualities possessed by the individual. This means, then, that some of the symbols such as leadership, ability, and accomplishment by which status may be judged are not considered in determining status accorded by title, degree, etc. Persons in the head nurse category will have marked dissimilarity in preparation and experience. One person may have a degree, another may not, but in both instances the title "head nurse" gives each a status in the group of nurses. Certain functions or roles, such as those concerned with ward administration, teaching of personnel, receiving visitors, giving information, etc., can be expected from nurses with titles of head nurse, supervisor, and the like.

Differentiation in status becomes evident with the acquisition of

a certain role by the nurse. Location in an organizational pattern can be recognized when status is clearly indicated by title. Other means by which status may be recognized are duties performed and kind of uniform, its color, and its insignia. Vertical division of nurses in a work environment frequently establishes status in terms of varying degrees of superiority and inferiority. The response to any one member of this group by other members indicates group acceptance and so establishes an individual's status within the group. The horizontal distribution typifies in-group relationships which are friendly, intimate, and informal. This type of relationship suggests common interests, attitudes, and beliefs. The vertical division of nurses tends to be established on an out-group relationship basis and makes for competition. The head nurse may be included in such a group but may feel toward it a sense of separation which results in a vague concept of status.

Variations in the Community. Nurses are like other human beings. The nurse in the community has the responsibility both of a citizen and of a professional person. The nurse as a citizen has the same obligations as any other, and the same things should be expected of her. No one can deny the fact that today the nurse is recognized as an essential member of society.

PROFESSIONAL STATUS. Status is the position that the nurse or nurse's group holds in public esteem. Nursing is moving in the direction of professional status. The qualifications as set forth by Flexner will have to be met before true professional status is realized by the majority of nurses. The thesis that nursing is a profession seems justified to a degree because it includes a fundamental body of scientific knowledge as well as many of the other components ordinarily considered essential for professional status. According to Dr. Abraham Flexner's interpretation of the professions:

> (1) they involve essentially intellectual operations accompanied by large individual responsibility; (2) they are learned in nature, and their members are constantly resorting to the laboratory and seminar for a fresh supply of facts; (3) they are not merely academic and theoretical, however, but are definitely practical in their aims; (4) they possess a technique capable of communication through a highly specialized educational discipline; (5) they are self-organized, with activities, duties, and responsibilities which completely engage their participants and develop group consciousness; and finally (6) they are likely to be more responsive to public interest than are unorganized and isolated individuals, and they tend to become increasingly concerned with the achievement of social ends.[2]

[2] "Is Social Work a Profession?" in Proceedings of the National Conference of Charities and Correction, 1915, pp. 578–581.

Detailed analysis of the qualifications prerequisite for this assumption would serve no purpose here, since the decision as to whether or not nursing possesses many of these elements is still controversial.

If professional status is to be achieved the nurse must assume a role of leadership in the community and perform many functions besides those directly related to keeping people well and caring for the sick. The nurse must actively participate in civic affairs as she performs her role as a citizen in a democracy. This performance will provide the nurse with innumerable opportunities to interpret the functions of existing health services and promote the establishment of additional services as needs are indicated. In her role of health teacher the nurse must contribute to promoting health and welfare for all members of society. As she assists in the attainment of this goal her efforts must be conducive to the prevention of disease and of other undesirable conditions.

The increasing emphasis on general as well as professional education for the nurse should better prepare her for the role which our dynamic society of today seems to demand—assumption of increasing responsibilities in a constantly broadening range of activities. Nurses, not unlike other women, have been slow to recognize and accept their civic responsibilities to society. There will be increasing realization of the importance of the nurse's role in the contributions made by health departments, hospitals, and other cooperating facilities toward the improved health status of the people, not only in our own society but throughout the world. The nursing profession is undergoing some very important changes, and the demand for nurses prepared to meet the needs of our present day society is greater now than ever before.

Economic Status. One way of determining economic status in our society is by the amount of one's income. In many instances economic status alone insures prestige. It is no longer considered unethical for the nurse to be vitally interested in the financial remuneration she receives for her work. In earlier years it was considered incompatible with the ideals of nursing and ethically not acceptable behavior for the nurse to be interested in how much money a job paid. Nurses' salaries have been low and in many instances still remain far below the level of that received by other persons whose work requires less or shorter preparation. The monetary incentive is becoming increasingly important to nurses as they choose the field of their endeavor.

Social Status. Social status is merely a position in society influenced by such factors as income, race, religion, and nationality.

As the economic position and degree of responsibility of nurses are improved and increased, they will take their places alongside all other professions in general esteem.

Variations in the Work Environment. The person, in health or in sickness, is the focal point of the nurse's efforts. Only rarely can nursing service be provided in a situation unrelated to the person as a member of a family, living in a neighborhood in a community. Comprehensive nursing gives adequate consideration to all facets of this totality.

RELATED TO ADMINISTRATION. Today the hospitals and health agencies employ more nurses than any other category of workers. This means that nurses constitute the majority group in any personnel set-up. The status and role of the nurse vary in the different types of organizational patterns. These facts will influence the approach and determine the content of the discussion of status and role. Effort will be made to select illustrations that will be applicable to situations wherever the nurse is found.

The type of organization defines the functions and determines the roles of the units constituting the whole. The organization designates a place to individuals comprising the whole. Organization directs and coordinates the efforts of the members toward their goals. Interacting units in the group (whole) have relative positions, and responsibility is distributed among them. This gives each unit (group or individual) status. Roles emerge as each unit strives to accomplish the responsibility delegated to it. In every organization where nurses are employed, be it hospital, health department, factory, or elsewhere, there are differences in procedures, techniques, policies, and practices. In spite of these, however, there is a similarity of structure and an identity in the function and expected behavior of nurses.

In some hospitals and health agencies, nurses participate actively in the over-all administration through consultation, committee work, and a close personal working relationship. Nurses assist in compiling statistical data relative to costs and efficiency and desirable practices. They also keep various records of admissions, discharges, treatments, and daily patient progress essential in objective evaluation of nursing service.

The hierarchal status of individual nurses varies considerably from one organization to another. The status and role of a nurse in a particular hospital or agency depend to some extent upon the nature of administration, that is, whether it is democratic or authoritarian. Determinants of such status may be based on tenure, aca-

demic attainment, additional preparation and study in a special field, cooperativeness and enthusiasm, or personal qualifications such as leadership ability.

NURSES' GROUP. This group may be defined as those nurses who have completed requirements qualifying them as graduate registered nurses. As yet this group has not achieved solidarity in the sense of group unity. It must be recognized that as long as there is a predominance of three-year programs of nursing education, an adjustment relative to professional status is indicated. Because nurses are so widely variable in their preparation and comprehension, it may be questioned if they have developed group relations at all. Substantiating this doubt, the nurses' group is not recognized as a larger unity by each of the functioning members. Unity is dependent on both common purpose and structure. Without further education the majority of graduate nurses will not be college graduates. The nurses' group, however, will include both the college graduate (professional) and the diploma graduate nurse. Circumstances such as these have existed for a long time, so the phenomena are not new. In reality, nurses comprising this group operate on such a highly individualized basis, each using the group for her own particular purpose, that group solidarity does not emerge. The different types of basic educational preparation with status affected by them only add to the difficulty of achieving group solidarity and organization. Morale, individual and group, so essential in the maintenance of status, is present in varying degrees. Morale improves as group faith and consciousness of kind are strengthened by common sacrifices and other experiences. Such experiences must contain enough examples of what the group regards as successes to maintain hope and idealism.

For some years now the nurses' group has been faced with a new status problem. Increasingly evidence substantiates the fact that two kinds of nurses are needed if adequate service is to be provided. The two groups are composed of the graduate nurse of programs of three, four, or more years, and the graduate practical nurse. Many graduate nurses view the trained practical nurse as a threat to their status. The practical nurse is definitely here to stay and for a variety of reasons has presented a real challenge to the nurses' group. Current investigations into the functions of these two groups will undoubtedly do much to clarify the status of each.

The nurses' group plays a predominant role in shaping the health practices of all members of society. The services offered by this group should not in any way be influenced by discriminatory

practices and financial resources. As a member of the team, working in close conjunction with other groups, the nurse contributes to the health for all, irrespective of race, religion, social status, etc. Such factors become important only as they influence adjustments and adaptations necessary for individualizing care. New concepts of health promotion and disease prevention and accompanying advances in medical care constantly change the role played by the group. In each instance, however, the basic factor, service to human beings based on individual needs, remains constant. Nurses must continue to grow personally and professionally, simultaneously accepting greater citizenship responsibilities. The effectiveness with which this growth is attained will be dependent upon the individual's ability to accept the changing concepts.

RELATED TO PHYSICIANS. All too frequently physicians seem desirous of continuing the subordinate status of the nurse. Such a relationship withholds prestige rightfully due the nurse. More desirably the nurse should be conceived as a co-worker and this kind of relationship would assure increased prestige and afford a degree of recognition long overdue for the nurse. The doctor will always be dominant in any situation but without the nurse his success and accomplishment would be markedly limited. The nurse must have her own status, one which cannot be attained by playing a subservient role to the physician. Today good medical care is provided by a team, and the nurse is a very important member of the team.

Prestige, a close companion of status, may result from many factors: performance, cooperation, efficiency. Each nurse needs to feel that she is a participant in a common endeavor toward a specific goal. Nurses no longer have to stand at attention when the physician appears, or follow the old adage of speaking only when spoken to. Many of the militaristic patterns have been eliminated from acceptable behavior. Slowly, the nurse is emerging as a co-worker of the physician.

Changes in medical supervision and care have meant accompanying changes in the role of the nurse. Many of the responsibilities formerly assumed by the physician are now considered those of the nurse. Further scientific advances increase the functions of the nurse, broadening her role. The nurse, from necessity, has shifted some of her former functions to other workers on the health team. Many of the things which the physicians formerly did are now carried out by others. This readjustment will become increasingly necessary as the role of the nurse becomes more specifically defined.

RELATED TO CO-WORKERS. The provision of good nursing service is not solely the role of the nurse. Accomplishment results from close working relationships among all persons in the various departments of an organization, whether it is a hospital or other agency. The practical nurse, the aide, the clerk, and the volunteer all work together in providing service. The nurse must recognize the status and role of each person with whom she cooperates in providing necessary health services. There will be more co-workers in some situations than in others. Numbers, however, do not alter the basic principles of good human relations. The basic facet of the nurse's role is to accord the degree of status rightfully due each individual as he participates in providing vital services, however repetitive or menial such tasks may seem. These very tasks are important contributions to total care. Throughout the performance of a wide variety of roles, the nurse endeavors to cultivate an interest in what happens to her co-workers as people and does not limit her interest solely to what happens in the work environment.

RELATED TO THE PATIENT. The over-all service to the patient is the hospital's responsibility, but the nursing personnel is responsible for the direct care. The individuals who work most directly and who have the most frequent contacts with the sick are the nurses. In performing her role, the individual nurse has contact with the person at work, in the home, in the hospital, and elsewhere in the community. It is the nurse who spends the largest amount of time in the care of the patient. True, today, she may spend fewer hours at the bedside, but the time formerly spent there is utilized in performing other functions necessary for and related to the needs of the patient. Nurses have more intimate and more frequent contacts not only with the patient and his family but with all other groups who contribute essential components to the total care of patients.

The patient is the core around which all activity is formulated and executed. To the patient the nurse who is responsible for his care at the moment represents the entire profession in skill, sentiment, attitude, and behavior. The nurse's role is one of close cooperation with the physician, the attendant, the social case worker, the health officer, the secretary, the housekeeper, and laboratory and research personnel. These are only a few of the varied contributors to comprehensive care. The nurse plays an important role in developing the patient's confidence in his physician. She is responsible for seeing that the physician's orders are carried out.

In much of her work the nurse is in close contact with the patient, —constituting the nurse-patient relationship. In this relationship

the nurse may fulfill varying roles but most frequently they are the roles of mother, counselor, and friend. The nurse's status varies from patient to patient. In some instances she is highly respected, almost worshiped, whereas in other situations she may be regarded as a servant. The nurse attempts to allay the fears of the patient and to reassure him when necessary. The provision of emotional support is as essential as good physical care. Physical recovery is a part of the goal in any nurse-patient relationship, but equal consideration must be given to social recovery. The intimate contact of the nurse with the patient provides innumerable opportunities for her to assume the role of a motivating force not only for the patient but for his family as well. The far-reaching effect of such motivation cannot be minimized.

Consistent with present-day concepts, many new facets of the nurse's role have emerged. Her role no longer begins with the sick patient in the hospital. Instead, her role originates with keeping well people healthy, goes on to aid in curing disease and illness, assists in rehabilitation, and continues until each patient is returned to healthful living. Increasing emphasis is placed on the role of the nurse in rehabilitation.

A thorough understanding of human behavior influences the nurse's ability to relate her functions to others and influences the success of her accomplishments. While many of the intricate details of the role of the nurse remain undefined she continues to contribute to the improvement and advancement of health services. The nurse's role will always be that of rendering a personal service specifically adapted to the varying needs of every patient and his family in the neighborhood setting of a community.

SUMMARY

Health services of today are the result of continuing progress aided by scientific achievement, improved facilities, changing concepts, and public demand. It is easier to understand the "why" for existing practices and improved health services when there is some concept of how they came into being. The family played a major role in early health service, then the family doctor with his multiplicity of functions joined with the family in assuming responsibility. The trend of medical services shifted to increased specialization, and a decrease in interest in the individual coincided with the focus on the disease condition. Costs of health services increased steadily. Currently an attempt is being made by the medical group to put more emphasis on the individual without detracting from the

importance of disease. Preventive practices are being accepted as desirable. Hospitals with improved services and facilities are becoming an integral part of the over-all community health service as they assume broader responsibilities consistent with the broadening concept of health.

Nursing also has experienced many changes, and consideration of the "whole" individual is one of the major goals of nursing education and nursing service. Nursing education is beginning to use techniques, skills, and research to improve educational experiences for students. Nursing service is utilizing a variety of workers, both professional and non-professional, and depending only to a limited extent upon the services of students.

The broadened concept of nursing has been responsible for change in function, utilization of non-nurse personnel, and curriculum revision. Professional status remains a point for debate and clarification, but it does provide a goal for future attainment. Clear definition of role for the nurse within the work environment will make relationships with physician and co-workers more satisfying and profitable. This clarification should give the patient a better idea of what to expect of the nurse, both in health and in illness. Organization of roles will clarify the individual nurse's level of participation.

FOR INVESTIGATION AND DISCUSSION

1. Contrast the care of patients in hospitals with that in homes twenty years ago.

2. Can you identify practices in health services which have been handed down from the past and continue to influence attitudes and behavior?

3. Does nursing have a cultural heritage?

4. What do you understand nursing to be in a democratic society?

5. Make up your own definition of nursing and compare it with those given by nursing leaders.

6. What are some of the reasons motivating the increased interest of nurses in human behavior?

7. In what respects does the social world of nursing differ from that of other people?

8. What are the functions of your hospital?

9. What important factors have increased the complexity of the nurse's relationships?

10. List the number and types of personnel responsible for patient care on a particular ward. Are there evidences of in-group and out-group relationships?

11. Study the monthly or annual hospital reports for 1934, 1944, and 1954, and contrast:
    (a) daily patient average.
    (b) average hospital stay.
    (c) per cent of patients with some form of hospital insurance.
    (d) average daily cost per patient.
    (e) average cost per hospital admission.

12. What are some of the changes which have affected the status of the nurse?

13. How can the graduate nurse secure and maintain status in the organization where she works?

14. What roles have you played today?

15. Find out how the medical staff is set up in your hospital, i.e., who can use hospital and clinic facilities for patients. Are there any restrictions on medical staff appointments?

16. Visit the public relations department and find out how it functions.
    (a) Examine a newspaper for items pertaining to hospitalization, cost of medical care, etc. Are these articles critical?
    (b) Interview a volunteer and find out how she feels about her service and why she decided to come to the hospital.

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Chapter 13

STRUCTURE OF NURSING SITUATIONS

BASIC UNDERSTANDINGS

Regardless of the situation involved each nurse will need certain basic understandings if she is to function adequately and provide comprehensive nursing. She must have a background of information which will assure the understandings necessary for effective performance, recognizing that there are many variables when consideration is given to individual differences and diversity of needs. However, even with this range of difference in mind, there is a pattern of similarity which exists in any area in which the nurse may find herself. The development of a pattern will give insight into the kinds of situations a nurse may expect to meet, the frequency with which they may occur, and the degree of importance assigned to them within the professional group in which the nurse functions. The nurse's ability to analyze each situation, identifying the strengths and weaknesses, cultivating awareness of subtle and powerful influences, etc., will prove valuable as she develops plans for teaching, determines the components of comprehensive care, and functions effectively in the practice of nursing.

Physical Aspects. Physical aspects of each environment, home or hospital, will not be discussed in detail. The type of bed used in one hospital ward as against that used in another is not important; all hospitals will provide a bed of some sort. Other articles necessary for physical care may be illustrated in the same way. The technical skills necessary for care will not be discussed. Procedures will vary from place to place, but certain skills are necessary in all places if the nurse is to function adequately. The social aspects are the center of focus for discussion. To get a pattern in mind, a frame of reference, the nurse must visualize the community in which she is immediately concerned.

Social Institutions in the Community. In the community one finds the social institutions basic to human welfare in varying num-

bers. Some communities will have many, whereas others will have only a few. The structure of the community will include families, schools, churches, some form of local government, and various business enterprises. All of these will be determined by the very structure of the community itself. Within a limited space the population will be able to satisfy its needs through the use of the available facilities. Various relationships will result from the utilization of the institutions. For many persons the community is not large, since a limited area may provide for employment, home, recreation, and religious needs. The groups included in this area form the social world for the persons and, in the variety of relationships that result as each satisfies his needs, each individual plays the variety of roles necessary in living.

Population Characteristics. Each community is distinguished on the basis of boundary lines, and the size of the population is determined for the area. If the immediate area is a city it is helpful to know the number of people and their ages. If statistics reveal that 65 per cent of the population is forty years old or older, the nurse will know immediately that there will not be many pregnant women or new babies. On the other hand, if the available figures reveal that 50 per cent of the persons are in the twenty to thirty year age group, this clue will give some concept of the child-bearing age in a majority of the population of the area. The latter will give the nurse some idea of how many pregnant women she might expect in a given period of time. Age distribution will also give clues to the kinds of disease and the like which may occur. Knowledge of other facts related to population, as rate of increase, color, or sex, also proves valuable. Statistical information provides insight into various aspects of the community, but it must be remembered that such information is quantitative only.

The nurse should have some idea about the nationality groups living in the community. Will there be some who cannot speak her language? What kind of communication will be necessary in teaching? Certain nationality groups will present different cultural patterns, and the nurse may encounter ideas, beliefs, and attitudes quite different from her own.

Differences in Urban and Rural Communities. Marked differences exist when the urban community is contrasted with the rural community. The pattern of rural life varies in many respects from that found in urban areas. The nurse will expect fewer facilities such as hospitals, clinics, etc. Neighborhood patterns and social relations differ. Rural areas are usually smaller in size and the struc-

ture of local institutions is less complex. The utilities and modern conveniences found in the city are not always available to the rural dweller. Retail stores and other essential services may be limited. The nurse should be familiar with all these factors, since the effectiveness of her teaching is influenced so markedly by its adaptability in the home. Failure to consider the differences between the urban and rural areas limits the nurse's ability to perform the services which will assist the families in maintaining desirable health standards and preventing disease.

Religion. Analysis of the religious preference of the majority of persons composing the population of an area will indicate patterns of family life since attitudes vary considerably in persons with different religious beliefs. For example, some religious doctrines advocate large families, others will not be concerned particularly with numbers of children. Since religion so often plays such an important part in the family's life, it is extremely helpful if the nurse understands the essential differences in the predominant religious beliefs of a given community.

Family Size. A family is structured by the size of its group. The term "family" is usually applied to those persons who have intimate face-to-face relationships and live in a single dwelling unit. This term also encompasses those unmarried children living away from the home of their parents. The size of the family is primarily determined by the number of children.

Statistics will show the nurse that families will vary in the number of children, but an average-sized family for a given area will give her an idea of what to expect. Comparing local figures with the national average for the United States will highlight any unique features for the immediate locality. The nurse who must necessarily have an inquisitive mind may ask, "Why do parents limit the size of their family?" The answer to such a question has many aspects, some of which will be discussed in the next chapter. There has been a steady decline in the size of families over the years. A number of factors have contributed to this decline but one of the more important influences has been the economic situation resulting in the tendency of many families to have only as many children as they can afford.

In addition to the family group, the nurse must give consideration in some instances to an enlarged group which lives together in a single dwelling unit, the household group. This larger group comprises an economic and social unit and has a marked influence upon the pattern of living, the beliefs, and the behavior of the members

of the family. This extra-family group may consist of a grandmother, grandfather, and maternal or paternal aunt or uncle. The total number of this group can be referred to as size of family.

Income, Occupation, and Economic Status. Nurses are frequently poorly informed about income of families and cost of essentials for comfortable living. Resort to current statistical tables for the determination of the average family income will provide the nurse with criteria on which to judge financial resources. It is frequently necessary for her to consider family expenditures, since any planning the nurse does with the family must be within the realm of financial possibility to be practical. If a patient comes into the hospital and the nurse finds the family income is a thousand dollars less than the average, she will immediately become aware of the kinds of facilities she should expect the patient to have available at home. No doubt there would be limited space for living, food of little variety, only necessary articles of clothing, and a limited amount of money for recreation and health services.

The employment opportunities available in the area will give the nurse some idea of what kind of work the wage earner does for a living. In some areas most of the families will live on a farm and be dependent upon it for a livelihood, while in other regions all the men will work in some type of industry. In many areas the women will also be gainfully employed in a variety of establishments.

Families today are seldom self-sufficient as were the families of the past and must increasingly depend upon earned income to provide for their necessities. The economic resources of the family frequently determine the kind of house they live in and this influence even affects the kind of furnishings in the home. Limited financial resources may force the family to utilize one article of furniture in a number of ways. Each article within the home may have to serve several purposes. Ingenuity and improvision must be employed to provide comfortable family living under such circumstances. Income also influences the state of repair of the furnishings.

The old concept of the husband as the person who provides the income for the family is obsolete in many present-day family groups. In a large number of families this function is shared by the wife, who is engaged in paid employment outside the home. Modern economy makes it necessary for the wife to work. Additional income is required to provide for the needs of the family, and married women workers use the major share of their earnings for family needs. This factor alone has broad ramifications for the well-being of the family group.

Regularity of employment is another factor which must be considered by the nurse. In those families who must depend upon seasonal employment or who earn their income in occupations affected by weather, demand, etc., it is extremely difficult to provide for needs during the time when income is low or non-existent. Limited and irregular income in the lower class families and the resultant uncertain food supply has a great effect upon nutritional status of family members. It is also difficult to provide other essential needs.

The nurse must have some concept of what constitutes an acceptable minimum standard of living for such criteria will be necessary as she provides guidance to families. The financial resources of the family—the income, earned or otherwise—must be sufficient to assure the necessities of life. Statistical data revealing the distribution of income provide factual information most helpful to the nurse.

The most revealing single item in determining the socio-economic status of a particular family will be the occupation. Occupation separates people into distinct socio-economic groups, and the nurse learns to expect a pattern of circumstances which, although not identical in each instance, still retains a similarity.

Housing. FACILITIES AND ACCOMMODATIONS. Housing facilities are extremely variable. Many types may be found in one area. Some communities will provide single-family dwellings, others multiple-unit dwellings like apartment houses, whereas still others will provide only tenements. Some economic groups may occupy particular types of housing facilities in certain parts of a city. If the nurse is familiar with such facts she will know that Mrs. Jones from East Third street comes from a tenement area, or Mrs. Brown from Hopple street comes from an area made up of middle economic group families. Water, electricity, gas, etc. may be furnished in some communities by the local government, however these essential services may be the responsibility of the individual householder in other localities. In each instance a different kind of problem presents itself.

It will not be possible for every family to secure a structure of the size and type best suited to its needs. It is often difficult to find a house in a geographical area of preference. A family may prefer a single dwelling unit located in a surburban area near a large metropolitan center. If such a facility is not available it may be necessary for the family to live in an apartment which does not have desired features like a yard, garage, ground floor level, and the like. The housing shortage and the trend toward multiple dwelling units

limit the number and variety of accommodations. High rents frequently limit selectivity for many families.

Large families with many children are frequently forced to accept substandard housing units and live under very crowded conditions. It is not uncommon to encounter a family of eight living in two rooms and sharing toilet facilities with many other families in the same dwelling. Illustrations of some of the problems confronting a family with a new baby are the need for additional room, a home with modern conveniences such as bathroom, etc., or living accommodations located on a ground floor level. All will agree that a decent place to live is a prerequisite for good family life. Improved housing facilities are desirable for many families in any area.

AGENCIES. Services from agencies interested in housing facilities are available to those families with special problems. Some interests of agencies are the improvement of existing housing conditions, redevelopment of deteriorated areas, legislation relative to zoning and housing codes, and educational services directed toward planning, interpreting rights and responsibilities, improvement of housekeeping, and instruction in urban living for those from rural areas. Other agencies aim toward securing better housing conditions in the community and enforcing housing regulations of the Building Code. Official housing agencies inspect dwelling units periodically to prevent and eliminate unsafe, unsanitary conditions and fire hazards and issue orders to tenants and owners for their correction.

Federal public housing agencies supply housing accommodations for moderate- and low-income families. Eligibility for such services is usually dependent upon family income and need for housing, with preference being given to those families living in substandard housing. In some instances United States citizenship is required for admission to government housing.

The number of rooms provided for the family in the housing unit will probably be based upon the number of members in the family and not be determined by the amount of family income. Larger families need more space but may not be in a position to pay more for rent than a smaller-sized family.

FACTOR OF SEGREGATION. Housing facilities are not equally available to all in some areas. The Negro family will not be permitted to live in some locations and in many instances must accept poor and inadequate facilities even though money to pay for better accommodations is available. It is not uncommon for the nurse to be told, "We don't want to live here but we cannot find a better place," or "We would like to have more rooms but a larger place

is not possible on our income," or "They will not rent to Negroes in that area." Housing projects built with assistance from the Federal government have done much to provide more adequate facilities and are available on the basis of need, eliminating the possibility of discrimination on the basis of race, religion, etc.

Marriage Establishes the Family. The nurse recognizes marriage as a social institution. In an earlier chapter the full meaning of a social institution has been explained. Application of the criteria as set down in this explanation will show the nurse that marriage meets the requirements necessary for classification as a social institution. Marriage creates a social group and new roles must be accepted by each participant, the man playing the role of husband and the woman playing the role of wife. When two individuals are united in marriage a pattern of social relations emerges. Marriage has as one of its main functions the propagation of children. With marriage and the assumption of marital obligations by the husband and wife the basic structure for a new family has been laid. Marriage stability correlates with the success with which the wife and husband share equally their experiences. The kind of marriage existent in the situation is important to the nurse because it sets the stage for the relationships that ensue as the nurse works with the family.

Health Requirements for Marriage. Many of the states are concerned about the physical fitness of individuals for marriage and have passed compulsory regulations which must be complied with before a marriage license can be obtained. In most states each individual is required to have a blood test to determine the existence of venereal disease in an infectious stage. If disease is found, treatment must be secured and the local health department has the responsibility for measures necessary to prevent the spread of venereal diseases. A waiting period of a designated number of days, varying with individual states, is required after application has been made for a license. This period of time provides opportunity for reporting on the various laboratory tests. These tests are used to initiate preventive measures and have done much to decrease the spread of venereal disease.

Common-Law Marriage. One of the variations in marriage form which is worth noting here since it has significance for nursing is common-law marriage. Legal recognition of this status varies from one state to another. There has been no ceremony but this type of union must meet certain requirements such as mutual consent, open admission of the individuals involved that they are living as husband

and wife, and assumption of the duties and obligations of marriage. Common-law marriage is frequently a means of evading the socially acceptable practice of legal marriage, and often the individuals entering such a relationship are not legally free to be married in the customary manner. The usual practice in our society is to recognize only those marriages in which a ceremony was performed and the marriage certificate properly recorded.

Common-law marriage presents many problems for the nurse. Family stability, satisfying social relationships, and home atmosphere conducive to normal growth and development of children are often threatened. Frequently the nurse's own attitudes about a family patterned by such a relationship must be submerged if she is to work effectively with the family members.

FAMILY LIFE

All societies everywhere have a common denominator, a basic primary group, the family. There are variations in form and functioning of the family group. The nurse must be cognizant of the variations and differences inherent in geographical regions, in life in a rural area and life in an urban area, in large and small communities, in various economic and social classes, in different religious, race, and nationality groups. All these factors will have varying degrees of influence on individual families and types of family life.

The growth of this basic unit, the family, from husband and wife to father, mother, and children, is the process upon which attention will be focused in the next chapter. There are many aspects of family life which the nurse must be aware of and consider in providing nursing services for the family.

ESTABLISHING A HOME

Each family will have some kind of shelter within which to make its home. This structure in which the family lives and functions is a vital consideration since it has such a tremendous impact upon the processes which go on from day to day within its walls. The equipment contained within the structure will vary from one family to another, but in general it will include those articles necessary to satisfy the needs of family living. While the choice of such articles will be influenced by many factors, the nurse can identify cultural influences which have determined the choice and use of various articles. Furnishings are examples of material culture. The articles used for preparing and consuming food, for sleeping, for cleanliness, for relaxation, etc., are defined by cultural heritage. The variety

and quality of the furnishings will be influenced by other factors also, some within the control of the family and others beyond its control.

CLASS DIFFERENTIATION IN FAMILIES

Class Structure. The nurse will recognize distinct class differentiation in families. There will be those in the upper class, the middle, and the lower classes. Each of these socio-economic levels will have a way of life—culture—that will differ in many respects from the pattern of life existing in other classes. The extent of the contrast varies from slight differences to marked degrees of dissimilarity.

One example of difference can be shown by the variety of health services available. The upper-class group can secure the best available services because of economic status. Families in the middle-class group usually receive their medical supervision from the private physician, pay their own hospital bills with increasing assistance from some kind of pre-payment hospitalization plan, and are not eligible for free care in clinics and tax-supported hospitals. Those families which fall in the lower-class group can receive high quality medical care in hospitals and clinics financed by the local government. If not eligible for free care, they can secure it on a part pay basis at a nominal cost calculated upon ability to pay with consideration given to variables of income, size of family, etc. The statement so frequently quoted that the rich and the poor receive the best medical supervision does seem to have some justification in fact when the situation is analyzed.

FAMILY DISINTEGRATION

Some acceptable method or methods for terminating marriage will be found in almost all cultures. The fact that such provision is made gives recognition to the fact that in some instances the permanence anticipated at the time of marriage is no longer possible because of the incompatibility of husband and wife.

From a preventive point of view, family counseling as the positive approach to those problems which might lead to dissolution of marriage has much to offer. The prepared family case worker has a good understanding of the dynamics of human behavior and, after thorough analysis of the situation, can assist the husband and wife in working through their difficulties, thus achieving improvement in relationships.

The ways available in our society for the dissolution of marriage are annulment, desertion, divorce, and separation. The social

acceptability of these methods varies, and what proves acceptable in one group may not be sanctioned by another. Underlying the methods used will be a variety of reasons for marital dissolution and these are usually based upon such factors as religious beliefs, economic factors, color and race, and family attitudes and education, to name only a few. The use of any method usually results in extremely traumatic emotional experiences for one or both parties involved, as well as for children and family.

Annulment. This method of dissolution of marriage is used occasionally. The factors justifying such measures are varied and reason for annulment may not be identical for civil authorities and church sanction. Dissolving a marriage by annulment requires an admission that the marriage in question was not a valid one and hence did not exist. Remarriage is possible, often with church approval.

Desertion. Desertion is frequently considered to be the poor man's divorce. In this relationship there ceases to be cohabitation between the husband and wife. The individual leaving usually does so without the knowledge of the other person and gives no clues to his whereabouts. This may mean the loss of financial support for the wife if the husband is the deserter.

Divorce. Divorce is one of the common methods used to dissolve marriage. Attitudes relating to divorce show a great degree of variability. This variance is evident within groups, neighborhoods, and territorial areas within the United States. Divorce is a legal dissolution of the marriage relationship. All of the states except South Carolina permit divorce, but the grounds for divorce vary considerably. There is usually some sort of property settlement, alimony in certain instances, and the granting of the custody of children to one of the parents. Public opinion about divorce has changed through the years and there is now less reluctance to accept the divorced person. The Roman Catholic church does not sanction divorce with the privilege of remarriage except in special instances.

The estimated marriage and divorce rates for the United States for the years 1867 to 1950 are shown in Figure 9.

Separation. Separation is the other method most frequently used for dissolution of marriage. In separation the husband and wife cease to live together by mutual agreement. Some provisions may be made for the wife's support and for the custody of children. Separation is legal in some states and is frequently used where there is not sufficient evidence to warrant a divorce and where incompatibility has reached a point where living together is no longer

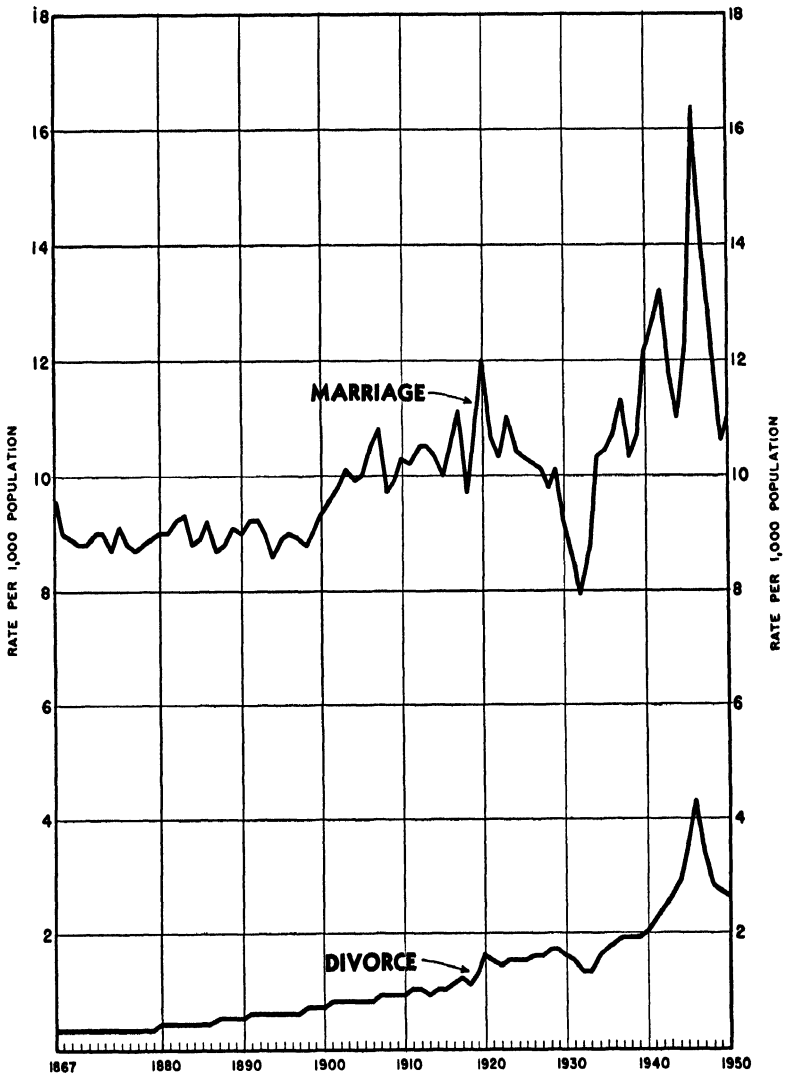


Fig. 9. Estimated marriage and divorce rates: United States, 1867–1950. (From Federal Security Agency, Public Health Service, National Office of Vital Statistics: Summary of Marriage and Divorce Statistics: United States, 1950." *Vital Statistics Special Reports*, Vol. 37, No. 3, Oct. 29, 1952.)

possible. The Roman Catholic church does approve of legal separation. In this relationship the husband and wife live apart and do not remarry.

FAMILY RELATIONSHIPS

The kind of home atmosphere modifies the behavior of each of the family members. Perhaps the two most dominant types are autocratic and democratic environments.

Democracy in the Family. In a family with a democratic pattern of relationships each person composing the group has equal importance as an individual. Each family member learns to make decisions in terms of the standards and values determined by the group as a whole. Each individual contributes to the formulation of group decisions and must willingly share in the responsibility of carrying out the plans, ultimately cooperating in the evaluation of the outcome of the group endeavor. A deep feeling of mutual respect exists in the democratic family pattern.

Control does not emanate from any one individual but remains in the hands of each individual composing the group. Each member in the family is permitted to express an opinion about his own needs and to participate according to his age and ability in the final decision of the group. In democratic living individual differences must be respected, in fact, their expression must be encouraged, for there will inevitably be differences in beliefs and opinions.

Provision is made for free discussion of issues confronting the family. Resolution of family tensions and conflicts allows for learning, and growth inevitably results. Freedom of discussion and action is permitted, but along with this goes a responsibility of abiding by the consequences, good or bad.

Democratic family living, with members working constructively together, individual with individual, and individual with group, is one of the surest ways of developing socially effective individuals. Democracy in the family is a way of life.

Autocracy in the Family. In contrast to democratic family structure there is the autocratic family structural pattern. In most instances the father is in command of the family group. He has power over the other members in the family. He usually makes the decisions, determines what others can and cannot do and when things are to be done, and prescribes and carries out punishment. The father exercises control over the family group, individually and as a whole.

Effects on Planning. Both kinds of family structural relation-

ships are important to the nurse. She may be encouraging the expectant mother to seek early medical supervision and find that no decision can be reached without the husband. Mrs. Jones will say, "I realize the benefit of early medical supervision but my husband will decide what is to be done." This illustrates the autocratic family structural pattern. On the other hand, the nurse may be confronted with this statement in the democratic family pattern, "We have talked over my pregnancy and my husband and the children want me to have the best possible care during my pregnancy. Is there a clinic where I can secure medical supervision?"

Any activity of the nurse must be planned and carried out within the framework of the family, whether it is democratic or autocratic in nature. Failure to recognize the importance of these two types of family organization will result in thwarting situations for the nurse and limit considerably the effectiveness of her nursing.

The foregoing information about the family provides the nurse with knowledge necessary to cope with the situation with which she is confronted. She can individualize her approach and give skillful and understanding guidance in her contacts in any nursing situation.

OTHER ASSETS OF THE FAMILY GROUP

Educational Attainment. A look at the records will reveal to the nurse that today a greater number of people are receiving more education than ever before. This applies to persons of different ages, in all social groups, in all residential areas, and of every economic status. This means that the nurse will have a better educated group to work with and a group better prepared to assume responsibility for its own activities. The median number of school years completed by persons in the age group twenty to twenty-nine years in 1947 was about twelve years. This means then that most of the persons in this age group had completed high school. However, not all knowledge comes from formal schooling. The very process of living provides a kind of education, and "good common sense" cannot be discredited. Both common sense and formal education are vital and meaningful. Effective nursing begins with the individual where he is, and knowledge of his educational background will help the nurse locate this starting point.

Intelligence. The factor of intelligence must not be overlooked by the nurse, and educational attainment is not a reliable criterion upon which to judge this important matter. Intelligence is ordinarily interpreted to be a combination of factors accumulated as a result of past and present experiences and manifested by individual

ability to adjust to existing and future conditions and ability to meet and solve problems. Intelligence denotes an adaptability to satisfy needs with a minimum expenditure of time, effort, and energy. The degree of intelligence tends to correlate with chronological age. Intelligence tests furnish a practical gauge of the ability of the individual to function acceptably in society.

Skill of the Homemaker. The abilities of mothers to function effectively as homemakers vary widely. This function goes beyond the activities necessary for family living such as laundry, cleanliness and care of the house, meal preparation, and other miscellaneous activities. The quality and efficiency of household equipment determines to a great degree the amount of time necessary to perform routine daily activities. The mother with a constructive attitude toward family life will want to spend some time each day with her husband, will be interested in the morale of the family group, and will be concerned with things like health, recreation, education, etc., as well as with the needs of family living. The social atmosphere of the home is just as important as cleanliness.

If called upon to help with a plan for accomplishment of household duties where the tasks are many and the physical condition of the mother presents some limitations, the nurse may need to evaluate the number, the kinds, and occurrence of the various activities, giving some consideration to the methods of doing the household tasks.

Health Information. Informative reading material is becoming increasingly available to the American family. Most of the popular magazines regularly include articles about health and related subjects, such as new drugs or advanced surgical techniques. While visiting in the home nurses are often asked to evaluate current articles which have been read by parents or children. It is essential for her to know what is being written, how much of this material is based on fact, what sources have unquestionable authority to write on a subject, and the correlation between new concepts in care and treatment and current medical practice. In this way she can refer families to the most reliable sources of information.

Health Status. The nurse must understand the stress of social problems and the effect of such problems on the health status of a family. Comprehension of the impact of social problems will better prepare her to give effective and thorough nursing care.

She should visualize health in terms of personalities (people) and families and not merely in terms of absence of disease or illness. An individual may have no physical complaints and no symptoms to indicate anything organically wrong yet he may show definite signs

of being mentally or socially sick. The attitude of the family toward health is significant to the nurse. Each family has placed a value on health, and if this value is high the members of the family group have taken advantage of all means available to protect themselves against certain preventable diseases and illnesses.

In conjunction with preventive measures the family will provide for other contributory aspects of health by giving consideration to recreation, nutrition, mental and spiritual development, and pleasure and enjoyment in daily living. The basis for health is in the people themselves, but it is influenced, sometimes drastically, by other elements in the family environment, such as housing, income, and consequent economic security, education, and life together as a family. The intrafamily relationships of all the family members determine ease of adjustment, emotional happiness, and joy of living. Living produces many strains, stresses, and disappointments. Sometimes these appear to be overwhelming, but if the individual and the family have attained good mental and spiritual health, an adjustment can be made and life continues without serious disruption or consequences. Emotional and social well-being are essential if optimum physical functioning is to be realized.

The nurse should find the definition of health as adopted by the World Health Organization useful:

> Health is a state of complete physical, mental and social well being and not merely absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.[1]

SUMMARY

An informational background is necessary for each nurse if she is to understand the community in which she lives and works. The various aspects mentioned in this chapter will vary in degree of importance in different nursing situations. The circumstances in which the nurse functions are many and varied. She will soon develop the ability to identify the factors in each nursing situation which are especially significant. Having done this she can make her nursing plan to utilize all the strengths available both in the family and in the community. The nurse will have a greater appreciation of a given community if she considers carefully the elements

[1] "World Health Organization Charter." *Journal of American Medical Association*, Vol. 131, pp. 1431–1434, Aug. 24, 1946.

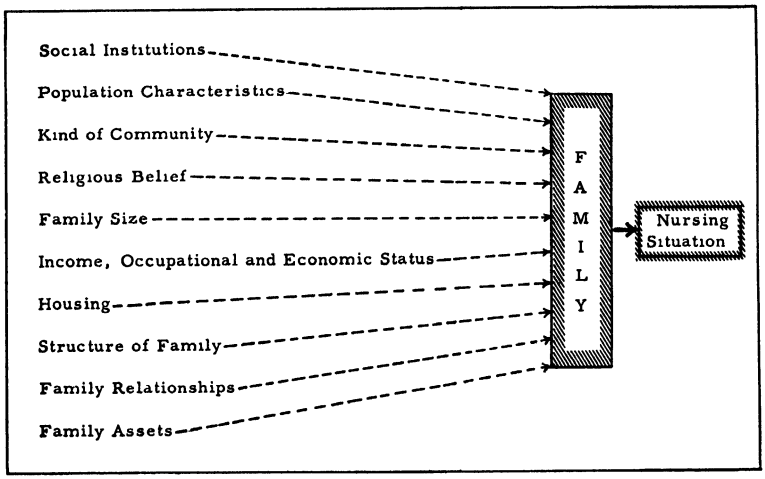


Fig. 10. Essential elements of a nursing situation.

which have combined to make it. Her understanding and acceptance of the people with whom she works will be more tolerant if she has some concept of where they live, how they live, where they work, how much money they have available, the kinds of problems encountered in daily living and the availability of facilities to promote general well-being and satisfaction of their needs.

Each nursing situation should be structured. If the situation is simple, only the usual factors will be given consideration. In contrast, if the situation is complex, presenting many problems and deviations, it may be necessary to consider additional factors. Each nursing situation is unique, and awareness of this fact markedly influences the behavior of the nurse and the quality of her service.

Figure 10 should be analyzed and reviewed to give the nurse a basis for effective participation as a member of the health team. Some such structure for each nursing situation will give the nurse an opportunity to cooperate fully in comprehensive nursing. She can formulate her teaching plans, determine effectiveness of practice, and more fully appreciate her contribution.

FOR INVESTIGATION AND DISCUSSION

1. What is the nature of the people living in today's world?

2. Identify the chief characteristics of a specific nursing situation and indicate how these factors may influence the nurse's relationship with the individual and the family.

3. Select a specific nursing situation and enumerate the different types of social relations which take place.

4. How does your concept of nursing influence your behavior?

5. What attitudes and habits do you recognize as strengths and weaknesses as you perform your role in nursing?

6. How can you utilize sociological concepts to improve your understanding of or increase your effectiveness in nursing situations?

7. Why must nurses give consideration to religious beliefs and practices?

8. How general is the shift in emphasis from disease to patient-individual?

9. Describe your home community in relation to social institutions, population, housing, health services, education of families, and religion. In what ways does this provide you with a better understanding of the people in the community?

10. Visit a housing project and find out the requirements for rental, number of families accommodated, feelings of renters about the project. Do such facilities contribute to improved family living?

11. Examine a current newspaper in your community for numbers of marriage license applications, numbers of divorce suits filed, articles about marriage, separations, and annulments, and compare these with national statistics.

12. What are the marriage and divorce laws in your state?

13. See how many articles about health and disease you can find in current periodicals and evaluate their effectiveness in relation to factual information which can be used by individuals and families.

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Chapter 14

NURSING SITUATIONS RELATING TO MATERNAL AND NEWBORN HEALTH

Knowledge of the physiological changes during the prepartum and postpartum periods, of the birth process itself, of new drugs and new procedures, of growth and development, and the like, will not be sufficient to meet the present-day concept of comprehensive nursing for the mother and newborn during this period. Many of the plus factors involved in the concept fall within the field of sociological understanding. What aspects of this discipline does the nurse need to know and use?

CYCLE OF NURSE'S CONTACTS DURING THIS PERIOD

In the field of maternal and newborn health the nurse has many opportunities for contact with individuals anticipating or beginning a normal physiological process, that of childbearing. The contrast between this normal process and that of a disease process is marked. During the entire period the nurse usually has a healthy person to work with, and this very fact alone provides circumstances conducive to mutually profitable relationships. The public health nurse will visit the wife in the home, where the wife is very secure and the nurse is the outsider, the visitor. The public health nurse's visits may be frequent or infrequent, depending upon the individual situation, agency policies, etc.

When the date for delivery has arrived and hospital admission becomes necessary, other nurses come into the picture. There will be the nurse in the labor room, the nurse in the delivery room, and other nurses on the ward. After delivery the nurse in the nursery will take the baby to the mother for breast feeding. There is considerable variation in the number of days required for hospital care, but in a week or so the mother is ready to take her new baby home. During the first few days at home the public health nurse will again visit. If the official health department offers a combination service

which includes bedside care, there will be no need for participation by another agency. However, if this is not the case, the Visiting Nurse Association may send a public health nurse to the home to care for the mother and baby until the time when the mother is physically able to assume the responsibility of care for herself and the infant.

In all, at least six or more nurses may be involved in the total care, and in each instance the nurse will participate in a different situation.

FAMILY RELATIONSHIPS

The nurse must have some knowledge of the cultural influences which determine family behavior patterns if she is to understand the total family situation. Things that have occurred in the past definitely influence the current situation and will have considerable effect upon the future. A variety of cultural factors will be operating in every family group. Individuals are what their culture teaches them to be. No two family groups are alike, and the nurse cannot consider them identical. Each family is unique. The culturally defined role of the mother is not played in the same way by any two mothers.

In one family the father may be fifty years old and the mother just twenty-five. Both are having their first experience of parenthood. The father brings to the relationship a pattern acquired from additional years of living and experiences that he has encountered in his longer life span. The mother is not only young in years but lacking in the maturity that comes from additional years of living. Certainly their attitudes, beliefs, and interests tend to be quite different. In another family the father and mother may be near the same age, such as nineteen and eighteen years, respectively.

In some instances both parents have been married previously, with each bringing to a new relationship the experiences of a previous marriage, perhaps unsuccessful and unhappy. Some parents may each bring together in a new family constellation children from a previous marriage. Unlimited variations in the family constellation emerge from a variety of circumstances, each altering the relationships for the existing members of the family.

For years perhaps a family had been centered around one child, a girl. The parents had always wanted a boy and finally after twelve years the mother had a baby boy. The advent of the new baby altered the family constellation immeasurably. The relationship in this family is quite different from that of a large family with a new

baby every year or so. The combination of these determinants varies family relationships to the extent that the family never passes on identical culture to each of the children. Likewise, the culture of a family will differ with each pregnancy. With an awareness and understanding of the cultural background of the family, the nurse will have an appreciation that will do much to enhance her working relationships and the effectiveness of her services to the family.

In an earlier chapter mention was made of the material aspects of culture. But these material aspects did not include an even more significant aspect, namely, the non-material aspect of culture. The institution of the family, universal in occurrence, serves as a mode for the transmission of a pattern of living, and this is a non-material aspect of culture.

Each family has certain attitudes—different ways of looking at things. The point of view of the family and its members is an important influence in planning nursing services. The nurse learns early in her experience that her way of life, her attitudes and beliefs are not necessarily the best or the worst, the right or the wrong way. Effective nursing can be provided if the nurse understands and is willing to accept the values and standards defined by the family. Values and standards will result in behavior in many instances quite different from that of the nurse, but both will have meaning and significance for the family members individually or as a group. Observations made by the nurse in one family or in relation to a certain type of behavior do not provide sufficient evidence for generalizations about all families or about all types of behavior in a like category.

THE WOMAN WHO IS TO BECOME A MOTHER

Textbooks on obstetrics deal with the physiology of reproduction, including in the discussion conception, intra-uterine development, and the various changes that take place in the systems of the body. The purpose of this part of this book is to describe some of the changes over and above the physical changes taking place during the antepartum period and to show how the discipline of sociology, when applied in nursing, provides for the inclusion of aspects equally as important to the pregnant woman and her family. Maternity nursing calls for many aspects of skill and understanding, but knowledge of human relationships is paramount.

The women entering into the experience of pregnancy will differ greatly: some will be pregnant for the first time, and everything about the adventure will be strange and new; some will be very

young, others will be older; some will already have many children, with the advantages that have resulted from previous pregnancies. But all have one thing in common, a pregnancy. Consistent with present-day concepts stress should be placed on childbearing as a natural, normal function of the human organism.

The pregnant woman may have her first contact with the nurse in the home or in the clinic if she is receiving her medical supervision from such a resource. The initial contact is an opportunity for the nurse to set the stage for successive nurse–expectant mother contacts and the atmosphere of this first contact will do much to help the expectant mother develop confidence in the nurse.

The nurse will take all the elements inherent in the situation and consider these as she plans with the expectant mother for better prenatal care. In many instances the nurse will be working with individuals and families who have already acquired considerable information about pregnancy and medical practices from current channels of communication such as the radio, television, or newspaper and magazine articles. One of the most frequently used sources of authentic information in pamphlet form is *Prenatal Care*,[1] distributed by the Children's Bureau.

This first contact will also give the nurse an opportunity to partially evaluate the situation and determine where the expectant mother is in her thinking and planning. How much does she know about her condition? If she is well informed the nurse will want to build on this knowledge and understanding, thus enhancing their relationship by according status to the expectant mother in recognition of her accomplishments. Nursing supervision will continue through the months but will be of little value unless it is based on a sound foundation of understanding and associated factual information. The nurse will want a degree of familiarity with the history of the patient, along with some knowledge about the family background and the personality of the family members, particularly of the mother-to-be. Information about the husband's income, his occupation, resources of the home, and the type of neighborhood may help define the situation in which the nurse will function.

The nurse may ask herself, "What cultural patterns exist to affect this pregnancy?" Interest will be centered around ways of eating and the kinds of food habitually consumed, since nutrition is one of the fundamental aspects of good prenatal care. The growth of the

[1] "Prenatal Care," *Children's Bureau Publication No. 4.* Federal Security Agency, Social Security Administration. Washington, D.C., U. S. Government Printing Office, 1949.

fetus and the general health of the mother will depend upon nutrition. Another question might be, "What standards are maintained in personal care?"

Family Customs. Folkways have determined the customary practices of the family and, since the pregnant woman is a part of this intimate group, they will also influence her activities. Some of the family customs have been transmitted to the group from preceding family groups of which the husband and wife were formerly members, and have now become a part of the life of each member of the family.

Over the long months of the prenatal period the husband and wife have plenty of time to give careful consideration to the choice of a name for the coming baby. Usually they choose a name for both a boy and a girl. Family custom has sentimental value and may result in the first son being named for his father, thus becoming a "Junior" in the family, with a name identical to that of his father or a name that has been passed down through many generations. One family custom handed down the pattern of naming the first born son with names beginning in "J" and "M." A name is frequently chosen on the basis of the meaning attached to it; for example, for boys: Francis—indomitable, Quintin—fifth-born, Boris—high spirited, and Amos—responsible; for girls: Pearl—healthy, Rose—love, and Cleo—famous.

Family Attitudes. There will be a range of attitudes regarding the pregnancy, both divergent and similar. It will be important for the nurse to ascertain the attitudes of the husband and wife toward the existing pregnancy, as the attitude of each will determine behavior of the individual toward the situation. It is quite likely that certain feelings and emotions will accompany the existing attitudes. One woman may say, "We've always wanted a baby but thought we'd never have one. My husband and I are both so happy about my pregnancy." Another may feel quite differently and say, "I am mad about being pregnant. We did not want a baby now, and my pregnancy will interfere with all our plans." Another example is that of the nurse who found a young mother four months pregnant with another child just nine months old. This mother was extremely resentful of the second pregnancy and showed signs of disinterest in her personal hygiene, in friends, and in household responsibilities. She was critical of her husband and the baby, even tending to blame her husband for the predicament in which she found herself. These statements and illustrations, as well as many similar ones, should give the nurse a concept of the attitudes of both the husband and

the wife regarding the pregnancy. It will be much more difficult for the nurse to work with some families than with others.

In each pregnancy the nurse will need to understand the wife as a person who is a member of a family, who lives in a circumscribed environment of a neighborhood within a larger area, the community. All these factors will have a profound influence upon the health and upon the behavior of the woman who is pregnant. The totality of each individual's environment will offer some strengths and some weaknesses, as the pregnant woman and her family prepare to meet the requirements of the maternity experience. Individualization is stressed in all of the nurse's experiences with the pregnant woman, and as a result of this consideration she is aware that each prospective mother is different and has diverse needs.

The nurse regards each pregnant woman as an individual with her own total personality. It must be remembered that each nurse is a personality and has many needs of her own. It will be necessary for the nurse to derive a degree of satisfaction of her own needs as she provides nursing services during the maternity experience.

Relationships. By now it must be quite evident that the quality of relationships plays a vital role in good prenatal care. The nurse has some definite responsibilities to other members of the team providing care. Medical supervision is the prime essential in prenatal care, and the private physician is most frequently the one who gives medical supervision during pregnancy. For those who cannot afford the care of a private physician, other sources of medical supervision such as the prenatal clinics can be utilized. At each opportunity the nurse should promote and strengthen sound physician–expectant mother relationships.

The nurse should be aware of concomitant sociological factors, such as group acceptance of pregnancy. Approval in the group will have great influence on the attitudes of both the husband and wife.

Fears of Pregnancy. Fear of the unknown is one of the major problems that occurs in the maternity experience. Fears are not limited to the expectant mother, but may be held by the husband and the family as well. Frequently what the expectant mother says is contradicted by her behavior. As the nurse learns to accept and understand behavior she finds that all behavior has meaning. She will learn to recognize behavior that portrays fear.

In her contacts the nurse should provide the expectant mother with opportunity for free expression of her feelings and attempt to discover their meaning for her. Feelings will often be the basis of action and may provide considerable insight into the expectant

mother's problems. The nurse can give assurance and increase the feeling of security by providing detailed explanations and careful orientation for the expectant mother, so that she will know in advance what to expect. This eliminates many fears and creates self-confidence. It is the role of the nurse to help the expectant mother and her family work through the maternity experience in a constructive way. Good nursing during the prenatal period leaves the expectant mother and her family free to work out their problems in their own way at their own level and at their own speed, with the nurse offering skilled guidance only when the situation requires it. Such a relationship is considered to be most profitable.

The husband also may have some very grave fears. He may be quite concerned about the health of his wife, and may worry about their social status when it becomes necessary for him to change their activities or modify their group associations. At times concern over whether or not the new baby will be normal is foremost in his thoughts. He may express anxiety over his wife's figure, fearing she will lose her shapeliness. He may feel a bit embarrassed about going places with his wife after the enlargement of her abdomen becomes noticeable.

Skill in communication is essential for the nurse. She must give information, not as a specialist, but in words and concepts that help the expectant mother and her husband feel adequate and informed and increase their courage. The information should put them at ease and really help them learn what they need to know. As their knowledge increases, the nurse can detect a strengthening in the relationship because the expectant mother and her husband are acquiring a new status.

It is quite probable that in most instances prospective parents are confronted with conflicts. Each individual will meet frustrations in primary group living. The lack of freedom of action and the thought of sharing affection often underlies some recognized problem in relationships between husband and wife. Each may have inner resentment about sharing love with a child. This is especially true for a newly married couple and a first pregnancy. The coming child appears as a threat to many old adjustments.

The entire prenatal period is one of emotional readjustment for both prospective parents, although the prospective mother has the greater adjustment to make toward the pregnancy. Much emotional preparation is necessary, especially in the first pregnancy. The expectant mother should receive much emotional support from her husband in terms of love and consideration. It is worth while for

the nurse to encourage the prospective father's participation in the planning for the coming baby. As the period of pregnancy moves closer to termination, the husband can be quite helpful with many of the heavier household duties. Both parents can share in the explanation to any older children in the family and cooperatively prepare them for the acceptance of the new baby.

ADMISSION TO THE MATERNITY WARD

Maternal and Newborn Mortality. Before discussing this phase of maternal and newborn health, it might be well to look at some figures which show the following: how many of the babies born in a year are delivered in the hospital, how many are delivered in the home; how many mothers survive and return home, and how many newborn babies die in the first week of life. Maternal mortality will indicate the kind of care provided for the women during childbearing. If the rate is low, there must be good medical care with prenatal supervision and hospital delivery (Fig. 11). It also indicates that there is public health nurse supervision during the prehospital and post-hospital period, as well as other facilities for the provision of special services such as financial assistance and clinic facilities.

Infant mortality rates show that more babies die during the first month of life, with the number of deaths diminishing in each successive month during the first year. It will be helpful to determine how many infants are born in a given year, where the births take place, and how many are born prematurely.

Much has already been said about the changing role of the hospital in our society today. The pendulum has swung almost completely from home delivery and care to hospital delivery and care. The hospital as an institution performs an important role in the daily lives of many as an increasing number of the population take advantage of the services offered. It should not be necessary to enumerate all the reasons why hospital delivery is encouraged.

The number of expectant mothers hospitalized for delivery is increasing, but the period of hospitalization is becoming shorter. For the nurse this means more must be accomplished prior to admission, and the value of the contacts during hospitalization must be enhanced.

The physical surroundings in the labor and delivery room may not be weird and strange to the expectant mother, nor will the experience be as threatening, if she has previously made a tour of the area and has had an explanation of the procedure followed from

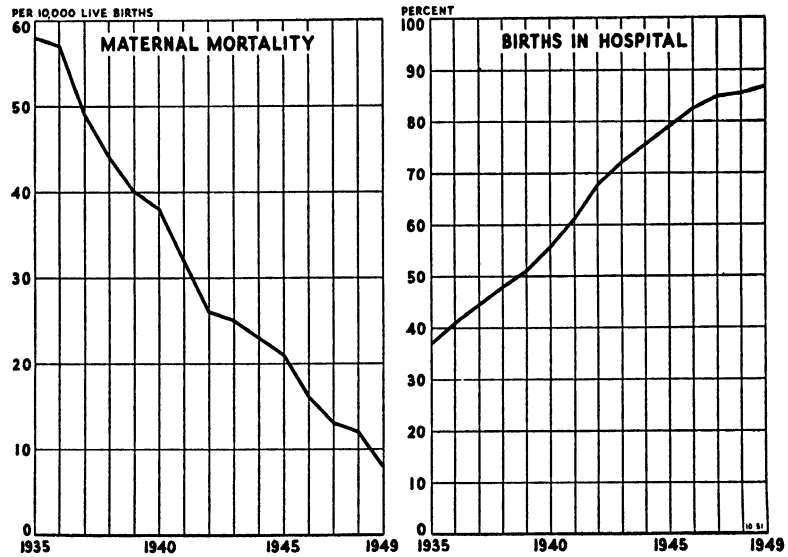


Fig. 11. Maternal mortality rates from 1935 to 1949, and percentage of births in hospital during same period, showing decrease in maternal mortality with increase in hospital delivery. (From Metropolitan Life Insurance Company, *Statistical Bulletin*, vol. 32, No. 7, July, 1951.)

admission through delivery. At that time she will have met the staff, so she will now have some concept of the human environment of the department. It is quite probable that she will have forgotten some of the information but she will still have a rough idea of what is to happen next, who will be with her, and what her role is to be in this experience. The mechanics of the routine admission procedure will not be discussed in this book.

The attitude of the nurse is more important than any specific method of procedure and is basic to the relationship to follow. It is desirable for her to avoid stereotyping the expectant mother by such a statement as, "Just another primipara." This may be true in every sense of the word, but in each individual situation the nurse is dealing with a unique personality and with a variety of characteristics that make each mother in a similar situation quite different, i.e., each expectant mother is an individual person. The nurse should have a real liking for people and a deep sense of the worth of every person, irrespective of her place in the hierarchy of the social structure. In this situation the nurse's concept of the well

person about to begin the normal physiological process of birth is important. Some nurses have the ability to make each pregnant woman in labor feel that she is paramount in the situation. The nurse should impress the expectant mother with the idea that each labor is different, and that an individual's needs are varied. If the husband can be close by he will add a great deal to the confidence and security of his wife and continue to share the maternity experience. If this is not possible, the nurse should let the wife know that her husband is just outside. Furthermore, the nurse should keep the husband informed of the progress of labor, and particularly of the condition of his wife.

This kind of nursing care will take time. As the nurse becomes more skilled in directing the contributions made by other personnel she will be free to devote her understanding and knowledge to mutually satisfying interpersonal relationships with the expectant mother in labor. This in no way minimizes the importance of skill in performing nursing procedures but gives emphasis to other important aspects of total nursing.

POSTNATAL PERIOD

After delivery the mother will be returned to a ward or a room. The physical set-up of the obstetrical unit will determine the accommodations provided. If the mother is fully conscious and aware of her surroundings, the nurse should introduce her to those persons who share the room or to her nearest neighbors on the ward. The new father's presence in the room lends security and support.

The relationship between mother and baby is a social one. The baby is completely dependent upon some human in the environment for satisfaction of his needs. The previously mentioned biological needs are necessary to maintain life. While satisfying the baby's needs for sustenance, bodily care, and protection the mother can give love and affection. Feeding, patting, holding the baby, talking to him, diapering, etc. are patterns of behavior from which the newborn gains a feeling of emotional security and dependence. Some mothers have to be convinced that such social acts will not "spoil" the baby. The self-demand schedule now advocated so widely lessens the possibility of restricting the satisfactions granted the baby in response to his demands. This parent-child relationship becomes a threefold one when the father is present and participating in the atmosphere of love and protection provided in the family setting.

The number of visitors permitted is usually limited. The nurse on

the ward can make profitable use of visiting hours by becoming acquainted with other members of the immediate family. She can detect evidence of interest as certain attitudes are expressed, particularly by the father, and can, through carefully directed conversation, fill in important facts which have direct bearing on the welfare of the mother and baby.

Early ambulation as part of the care in the hospital helps prepare the mother to assume the limited duties which she finds necessary on her arrival at home. Accepting responsibility for aspects of her own care adds considerably to her status and gives her a feeling of importance and independence.

During the postpartum period, continued teaching is one of the chief responsibilities of the nurse. She has many explanations to make to hasten the adjustment of the mother to her new baby. The physical needs of the new baby are fairly easy for the mother to understand. If this is a first baby, the mother will need more guidance than a mother who has had the experience previously.

Demonstrations by the nurse on the ward will contribute to adequate safe care for both the mother and baby after their return home. Individual guidance will be necessary to help the mother apply the teaching and adapt it to her individual home situation. Successful maternity nursing is not accomplished during the brief stay in the hospital but must embody long-term planning which makes provision for the adjustment of the individual to her new role as mother.

Hospital dismissal returns the mother with her new baby to her family group. Going home, of course, is quite an event. If the mother is unable to assume full responsibility for the care of her baby, for herself, and for her household duties during the early days after return to her home, the hospital nurse through referral should make the public health nurse aware of the circumstances. This tool, referral, is becoming increasingly important in the provision of comprehensive nursing and serves as liaison between the hospital and other community resources providing nursing in the community. Adequacy of the information given on the referral will aid the public health nurse in the home as she continues to give the guidance necessary to adapt the teaching done in the hospital to the home situation. The referral will serve as a guide so the nurse in the home can build on what has already been taught and thus avoid duplication of teaching, which tends to confuse the mother. The nurse will emphasize certain aspects of care and explain how they contribute to comfort and safety for both mother and baby.

The father deserves mention again for he is very much a part of this new triangle relationship and must be made to feel the importance and responsibility of the new status that he has acquired, namely, fatherhood. His sharing in the care of the baby is one way to build a strong, lasting family group. The early days at home are critical ones for the husband who has become a father for the first time. Each act by the nurse should tend to incorporate the father actively into this new relationship, and the mother should be encouraged not to exclude him from his rightful role of father. This is the time to make the father feel he has responsibilities for the care and welfare of the baby equal in importance to those of the mother. He, too, must give love and affection to the new baby as well as share in those activities necessary for maintenance of life. The father gives stability to this triangle relationship.

Rooming-In. The revival of the old method of keeping the baby with the mother when carried out in the hospital environment provides an opportunity early in the postnatal period for mother and baby to become acquainted. It also gives the father opportunity to be included earlier in this intimate family group, and he becomes better acquainted with his new baby. This practice fosters early development of primary relations and lessens the mother's fears when she is finally dismissed from the hospital. From a sociological point of view, there is much to be said in favor of the practice of keeping the baby with the mother.

In this early intimate relationship the mother can begin to learn the needs of the baby, to understand the means he uses to make his wants known, and the meaning of the random movements he makes. The father, too, can participate in these early learning experiences. If the mother has experienced the practice of rooming-in, by the time she leaves the hospital she is familiar with the fundamentals of the care needed by the baby and under the nurse's guidance has developed increasing confidence in her ability to care for the baby upon arrival at home.

THE NEWBORN

With the birth of the first child a family comes into being. Roles change, and new roles emerge. In all classes in our society the molding of the child's personality begins in this first month of life. The baby is not born with a ready-made personality. The way in which the baby's emotional needs are met from the start will determine the kind of personality he will have as an adult. There is a correlation between the parents' understanding of the baby's needs and the

development of his personality which will emerge gradually through his initial experiences with the human contacts and continue throughout the years of his life. The mother will feed the baby when he is hungry, but the important thing is how she behaves as she provides satisfaction of this purely biological urge. She will respond to his cry, change his diaper if he is wet, and use each physical contact to show the baby love and affection and increase his feeling of security and belonging. The mother and father should learn early to accept and enjoy the baby as he is.

Breast feeding, if possible, is most desirable since it provides close physical contact and has many mutual benefits for both mother and baby. It gives to the baby at the earliest and most critical time of life a sense of belonging and security. Group and cultural influences frequently determine the mother's acceptance of this method of feeding her baby. Economic status may make it essential as it is a cheaper way if the financial resources of the family are limited. Class differences are frequently evident. Mothers in the lower-class groups seem to accept the pattern of breast feeding more readily. In the middle-class groups the frequency of breast feedings hampers the activities of the mother, who finds it more confining to be on hand at feeding time. If it is necessary for the mother to return to a job, she may need to bottle feed her baby from necessity and not from choice.

The popular practice of "demand feeding" so frequently referred to by mothers today is simply feeding the baby whenever he indicates he is hungry. To follow this method of feeding prohibits the adherence to a strict schedule of a designated number of hours between feedings. This practice can be followed advantageously for either breast or bottle feeding.

THE MIDWIFE

Good medical care is still limited for some groups of the population in some areas of the United States. Effort is being made to improve these conditions, but because of a variety of factors involved it will be many years before all groups in our society are provided with identical facilities for medical care and hospitalization. The midwife fulfills an important function for many persons as she attempts to provide improved care by attendance at birth. The lack of facilities is usually the determining factor in the incidence of use of a midwife. Many of these persons are trained nurse-midwives and are licensed to practice as such. In some states laws may govern the practice and supervision of midwives.

Color and economic status are two other aspects influencing use. Facilities for the Negro are limited, and the fee for the midwife is cheaper.

THE INCOMPLETE FAMILY

The Unmarried Mother. The nurse should recognize that the number of women who fall into this category is large and there does not seem to be much indication of a decline in frequency (Fig. 12).

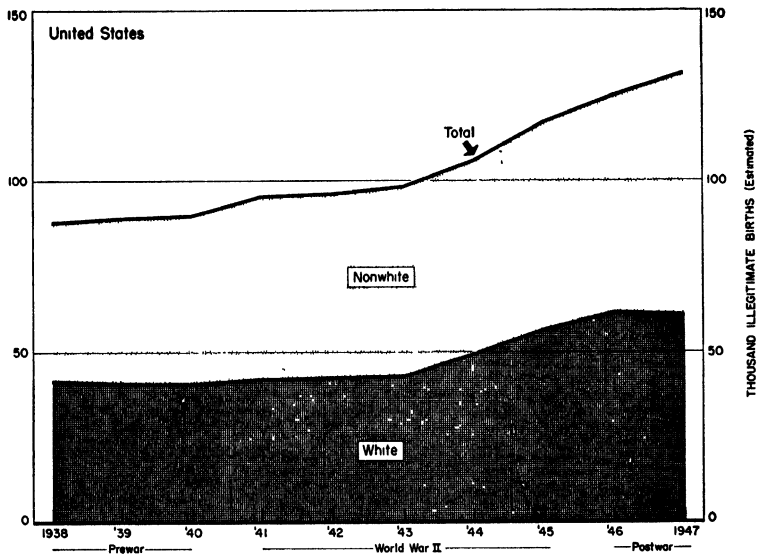


Fig. 12. Illegitimate births in the United States from 1938 to 1947; showing increase estimated at 50 per cent during period. (From Federal Security Agency, Public Health Service, National Office of Vital Statistics: "Illegitimate Births, 1938–47." *Vital Statistics Special Reports*, Vol. 33, No. 5, Feb. 15, 1950.)

There is a wide variation in the percentage of illegitimate births, the incidence being higher in the southern states, in the non-white population, and in the lower economic groups of society.

The nurse needs to be aware of many factors that are quite different with the unmarried mother. If the young woman remains in the home of her parents she may have tremendous difficulties to face, but if she must live elsewhere the problems are often more numerous. Her parents may give her the security and understanding she needs during the period of pregnancy, or the reverse may be true.

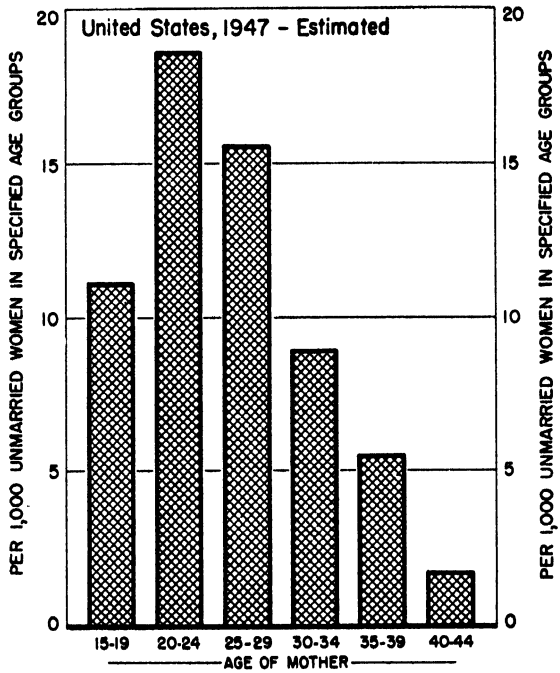


Fig. 13. Rates of illegitimate births in the United States during 1947, correlated with age of mother, showing highest rate among 20–24-year-old women. (From Federal Security Agency, Public Health Service, National Office of Vital Statistics: "Illegitimate Births, 1938–47." *Vital Statistics Special Reports*, Vol. 33, No. 5, Feb. 15, 1950.)

She may have very deep feelings of guilt which evoke changes in her behavior, whether they be only temporary or more lasting. The unmarried mother may resent her pregnancy and the frequency and extent of this resentment may be so great that she seeks to terminate the pregnancy by abortion. She may hope the baby will be born dead and refuse medical supervision in an effort to hinder successful growth and delivery of the baby. Some mothers are opposed to providing the necessary clothing and equipment for the baby prior to delivery. The handling of the problems of the unmarried mother often determines how successfully she can return to a productive, satisfying life after her baby is born.

Unmarried mothers are frequently very young and below the minimum age required for marriage (Fig. 13). The youth of these

mothers indicates the amount of formal education they have been able to complete, many having an eighth grade education or less. From this the nurse can estimate the maturity of the individual she will have to work with and can surmise the quality of care a person with such limited education can give.

The earning capacity of these mothers corresponds to their educational attainment. Many of them will not have worked, and those who have will have been employed for the most part at unskilled labor near the bottom of the occupational scale where work is irregular and salaries low. Unmarried mothers are confronted with the additional economic burdens of babies when financial security so important to satisfying living is uncertain.

The predicament in which the unmarried mother finds herself is probably in most instances not an accident but the result of her whole life situation, and the nurse will find that many of these mothers have a very unsatisfactory family background. The nurse in this relationship should be non-judgmental and understanding, meeting the needs of each individual as best she can with all the resources available.

The unmarried mother must face a very real problem, the attitude of the community in which she lives. Her group status may or may not be affected. In some groups pregnancy without marriage is accepted, discriminatory practices are absent, and no stigma whatever is placed upon the individual. Moral disapproval is a common trait of many communities, especially in the rural areas. Many will frown upon the unmarried mother. The father of the unborn child is absent in the situation of the unmarried mother, thus denying her the emotional support and security resulting from the husband-wife relationship.

The nurse needs to recall methods of family disintegration and to have some insight into the serious complications that may arise in relation to the maternity experience. The approach to the expectant mother who has been deserted by her husband will be quite different from that to the expectant mother with a secure family relationship. One expectant mother said, "When my husband found out I was pregnant he left me. I had been so happy. I really wanted a baby. Now I don't care what happens." The expectant mother finds herself very much alone in the maternity experience if dissolution of her marriage becomes necessary. Without her husband she will be denied the satisfaction of many of her basic needs during pregnancy and thereafter.

COMMUNITY RESOURCES

Social agencies are usually identified by the kind of social service they provide, such as a casework agency, health agency, and so on. There are those agencies with programs designed to meet the needs of individuals, whereas others pattern their programs to serve families. Both the agencies serving the individual and those serving the family as a unit will be functioning in the maternal and newborn health period. Those agencies with programs which emphasize the building of family life will have helpful services also. Although many social agencies plan and provide their services based on need and without regard to income, popular opinion is that they exist primarily to serve those persons who are financially dependent.

The nurse must be familiar with the various types of services available within the immediate community and those on the state and national level whose primary concern is with and whose programs are directed toward improvement of maternal and child welfare. Community needs vary, but serve adequately as a guide for planning and providing necessary services. Services provided should be available to all individuals in the community, whether young or old, rich or poor, sick or well. Such services should be operated on the basic philosophy of the true worth and dignity of the individual.

Specialized Institutions That Aid Families in the Maternal and Newborn Period. The full meaning of institutions in the social life of people has been given in an earlier chapter. Many of the problems identified by the nurse cannot be solved by her alone, and she must seek the interest and cooperation of allied professional personnel for assistance or guidance in planning and executing plans necessary for solution of problems. Comprehensive nursing will depend upon the ability of the nurse to use the various resources available in a community. Dissemination of information about community resources to families and referral for special services are only two of the ways in which the nurse can assist in improving maternal and newborn health.

NATIONAL INSTITUTIONS

Children's Bureau. The Children's Bureau, one of the many governmental agencies offering services to state and local organizations, concentrates on the development of services in the individual states. The functions of the Bureau are primarily those concerned with child welfare and include the maternal and child care program and the crippled children's program. Through the Bureau, Federal

funds are available to the states for services to children, and these funds are used in the establishment, expansion, and strengthening of various programs affecting children's welfare. The administration of provisions of certain legislation dealing with children is under the jurisdiction of the Bureau. The Bureau through its many pamphlets and publications also provides expert advice and information about specific problems in the field of child care.

Aid to Dependent Children of Social Security Act. At its inception this Act was intended to provide financial assistance for children in need. This is a means whereby the Federal government shares in the financial support of children eligible for Aid to Dependent Children. Children may be deprived of support from their parents because of death, because of absence from home in cases of desertion, or when either parent is mentally or physically incapable of earning a livelihood. These funds are matched by and dispensed at the state level, which allows for a wide variation in the procedure followed throughout the country. Primarily this program is aimed at aiding children in broken homes, and the amount of financial assistance granted varies considerably from state to state, but in general the number of children receiving aid continues to increase.

This program is important to nurses in their work in maternal and child health care because of the frequent need for financial assistance. The nurse should be familiar enough with the requirements for eligibility so that she can recommend it to a mother when the need presents itself. Many mothers with new babies and no means of support will find it necessary to secure financial aid as it is almost impossible for any mother to carry the dual role of providing both financial support and care for small children. Aid to Dependent Children is one of the chief resources when financial support is not available through the family.

STATE INSTITUTIONS

Division of Child Hygiene, State Department of Health. Each State Health Department is usually divided into several bureaus and divisions, each one charged with a specific responsibility as it contributes to the over-all health program. One of the divisions is the Child Hygiene Division. The functions of this Division are as follows: to assist and develop maternal and child health services, nutrition programs, and hearing and vision programs, and to provide consultant services to maternity and pediatric hospital services.

The Division of Nursing is also concerned with maternal and child care but usually on a consultant basis by offering the services of

specialists in pediatrics and obstetrics to supplement those of district consultants in providing and intensifying special programs. The nurse specialists are available for "on the job" guidance regarding nursing practices, procedures, activities, and techniques.

LOCAL INSTITUTIONS

County Health Department. The general purpose of a county health department, an official agency supported by tax funds, is to provide health services for the residents of a county. Desirable services utilized in the maternal and child health period are medical inspection and health supervision. In some instances physicians are employed to give supervision and care in the home, but most of the areas provide the services of the physician in clinics: prenatal, postnatal, newborn, and infant. Pediatricians are in charge of child welfare clinics, and obstetricians are responsible for the prenatal and postnatal clinics. Public health nurses are employed by the agency and provide supervision for the expectant mother, the mother, the newborn, and the infant in the clinic and through home visits. In many areas the official health department places emphasis on well child conferences conducted in a clinic set-up where both the physician and nurse have important contributions to make. Effort is usually made to provide services in various locations of the county, making the health department services for maternal and child health conveniently available to all.

Hospitals. Obstetrical wards are departments within the hospital offering a specialized service. There are very few general hospitals which do not provide this kind of service, and some hospitals are strictly maternity hospitals. Unfortunately, there are still discriminatory practices which limit the availability of services to certain groups within society. Frequently the Negro physician has no place to take women for delivery, since a number of hospitals do not permit colored physicians on their medical staffs. The same situation exists for the Negro mother-to-be. Frequently she must seek hospitalization many miles from home because of discriminatory admission policies of some hospitals. In those areas where facilities for both colored and white persons are provided in the same hospital there may or may not be segregation of services and frequently the kinds of services offered are not identical.

Maternity Homes. Maternity home services may be denominational or nondenominational, provided for married or unmarried mothers or for both, for white or Negro or for both. The purpose of such facilities is to provide refuge and obstetrical care during the

prenatal and postnatal periods and at the time of delivery. Care is provided for babies for varying periods of time after birth. Casework services are usually available for guidance, particularly to the unmarried mother as she works out complicated emotional problems: her relationship to the father, her attitude toward the baby, her fear of rejection by her social group, and her opinion of herself. Effort is made to assist her in formulating a plan for her baby that will insure happiness and security for both mother and baby. Vocational rehabilitation and vocational training may be a part of the program. Employment placement and other phases of social service and character building may be carried on.

Eligibility for such services varies considerably from one agency to another. The applicant must be free from venereal disease and admission may be determined by residency, ability to pay, race, color, religion, and absence of certain disease conditions, such as tuberculosis and mental disorders.

Homemaker Service. These services are traditionally designed to supplement family resources in maintaining homes during absence from home or illness of one of the key members of the family. In this instance the service may be needed because of the temporary absence of the mother. If relatives or neighbors are unable to assume full-time responsibility for the care of the home and the children, the homemaker service provides for home management and includes shopping, preparation of meals, etc. With this assistance the father can continue working at his job and can be home with the children at night. The children can receive adequate care, remain secure in the familiar surroundings of their home, and remain in school. The employing agency pays the homemaker's salary. Families who use this service are charged by the agency according to their ability to pay. Those in need of the service and unable to pay usually receive the service without cost.

Temporary Home Placement in Foster Homes or Boarding Homes. Foster homes or boarding homes are nothing more than homes of private families in which children are placed for care. Care is usually provided on a short-term basis or until some arrangement can be made for permanent care or adoption. Every precaution must be taken in the selection of foster parents. Interest in children and ability to provide love, affection, and security are essential constituents for foster parents. Foster home care, while not ideal, does provide some of the experiences children would normally receive in their own homes and is much more desirable than institutional care.

This kind of service is needed for the mother who, for a variety of reasons, cannot take her baby with her when she leaves the hospital. Some mothers are unable to provide suitable homes. The unmarried mother may have been living in a hotel room or a room with sleeping facilities only. Formula preparation in either instance would be quite difficult, if not impossible. In some instances it is necessary for the mother to return to work immediately. In some communities the official social agencies are responsible for foster home care. Some agencies provide care for children of any denominational group.

Planned Parenthood. Family planning is an extremely controversial issue in many sections of the United States. The merits of the program seem submerged by strong beliefs which are primarily religious in nature. The nurse should be in a position to share information of this resource when the need for such services occurs. Again in this situation it is not for the nurse to decide what is best for a family or to decide the acceptability of family practices based upon her own feelings and beliefs. Many families for individual reasons desire to limit the number of children, others prefer spacing them over a period of years in preference to having one each year. Some of the factors which may make spacing of children desirable are the mother's health, housing facilities, economic status, career, and education. One young father expressed his need in these words, "I want my children four years apart. I want them all to have a college education, and I know I will not be financially able to have more than one at a time in college." A young woman analyzed the situation this way, "I have two years left to finish my degree in nursing. I want to postpone my first child until after I have graduated, then I can devote my full time to motherhood."

Planned parenthood can be considered a social force and is a product of twentieth century society. The value of this service is widely recognized by religious, educational, professional, and civic groups. Planned parenthood programs embody four distinct functions: control of conception, or birth control; medical care and advice for infertility; education about marriage and parenthood; and research in the field of human reproduction.

At present planned parenthood services are available in 516 centers operated under medical supervision. Many of these are affiliated with the Planned Parenthood Federation of America and its state organizations. The services may be found in church centers, settlement houses, hospitals, and clinics, and in medical offices. All

states but two, Massachusetts and Connecticut, make it legally possible for husbands and wives to plan their families.

The Roman Catholic church takes the position of approving certain practices while at the same time condemning others:

> Any thing or method which prevents conception can be called birth control. The moral issues, however, do not center so much about birth control taken in the etymological sense. Celibacy, for instance, sterility, impotency, physiological deformity, more or less lengthy periods of separation between married people, can prevent, or control, conception and birth. But they do not appear prominently in the usual moral problems which are associated with contraceptive practices.
>
> Any control of conception by married people who are using their conjugal rights must have morally valid reasons. They then can employ, and the nurse may advise and give instruction in, the use of periodic abstinence, known as the Ogino-Knaus theory—if this provides the protection needed. Otherwise total abstinence is the only answer. Any sensible person knows this involves extremely grave consequences. But any sensible Christian knows just as surely that God's help will not fail those who sincerely try to do what is right. If recourse is had to the "rhythm," both partners must agree to it and there must be no grave danger of incontinence to either.[2]

SUMMARY

The cycle of the nurse's contacts during the maternal and newborn period should be a continuous one. A number of nurses are involved, in a variety of situations. Family relationships during this entire period are particularly important, and the nurse gives full consideration to this factor as she works with the prospective mother, the husband, and others who may be interested. The first contact the nurse has with the pregnant woman sets the tone of future relationships where other nurses are involved. Early in pregnancy the nurse makes an attempt to meet the husband, for he will be one of the strongest elements of support in the usual pregnancy situation. The attitudes of the parents-to-be are frequently indicative of what is in store for the new baby. The nurse will make an effort to gain family interest in increasing its understanding of the needs of the new baby, especially the means of satisfying the essentials considered desirable for normal growth and development. Careful explanation of their roles will give the nurse opportunity to accord status to the new parents and point out the importance of their cooperative effort in the care of the newborn.

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[2] Joseph B. McAllister, Catholic University of America, *Catholicism and Some Moral Problems in Obstetric Nursing*, February, 1953 (from critique prepared especially for the publisher, pp. 8–11).

The unmarried mother is usually faced with problems of considerable magnitude and should be given guidance in a non-judgmental, understanding way. She has faced many problems prior to delivery, and in most instances must face more after she leaves the hospital with her new baby.

Community resources offer a variety of special services for the mother, her new baby, and the family. The family can seek improved care, financial assistance, etc., if the need exists, and thus relieve stress and strain during this period. The skilled nurse will give guidance in such a way that the family can assume responsibility and continue to benefit from improved practices and care. Community resources deserve much of the credit for improved programs for maternal and newborn health.

FOR INVESTIGATION AND DISCUSSION

1. Why is it important for the nurse to consider social factors in a normal pregnancy?

2. What factors in the every-day social life of the family must be considered by the nurse as she works with the mother and baby?

3. How do the neighborhood and community exert influence upon the nurse as she plans for care in nursing situations relating to maternal and newborn health?

4. Should the nurse be more concerned with the mother and baby than with the family? Give the reasons for your answer.

5. How can the nurse determine the effectiveness of her reassurance of mother and family?

6. What behavior patterns are evident as the newborn begins his adjustment to the social environment?

7. Compare the types of maternity service which are offered in your community hospitals with the different ones available throughout the United States.

8. What responsibility does the nurse in the hospital have for the baby after dismissal, in relation to continuity of care?

9. What resources are there in your community which offer assistance to prospective mothers and their families? Secure annual reports from several of these agencies and find out the following: their purpose, services offered, number of families contacted, and source of funds.

10. Talk with a mother who has a young baby and find out what preparation she had for her hospitalization, how she feels about the instructions in newborn care which were given to her while in the hospital. How do her answers compare with the recommended teaching described in the chapter?

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Chapter 15

NURSING SITUATIONS IN THE INFANT PERIOD OF LIFE

The nursing situations in which the nurse finds herself in a professional relationship with the child vary from one age group to another. In each instance, however, the nurse will need to acquire some knowledge and understanding of the normal healthy child in order to work effectively with the child who is sick. The content of pediatric textbooks acquaints the nurse with the physiological and psychological factors of growth and development. The former kind of information is not difficult for the nurse to apply. For instance, she can quickly recognize deviations in weight, body dimensions, or gross anatomy. Application in her daily work relationships of the concepts advanced in Part One of this book is more difficult. This chapter is designed to assist the nurse in structuring nursing situations for the infant and to aid in the identification and application of the sociological concepts in understanding the growth and development of the child.

It is not the intent of the authors to consider the child in segments as growth and development in the various age groups is discussed. From birth on the process is recognized as a continuous one, but for purposes of analysis and clarification it seems desirable to give consideration to specific age groupings, with full realization that the whole matter of application in nursing situations is individual. John at one year of age may be in an almost completely different world of reality than a child next door who is also one year of age.

THE INFANT

Early Contacts. The nursing situations for the infant (up to one year of age) will be more limited than for older children. The child at this age is less mobile and must depend on an adult to accompany him wherever he goes. Specifically, where will the nurse have contact with the infant? The normal infant, free from disease or illness,

may be seen in the well-child conferences, in the home, and in adult group activities. Although either or both parents may be present in these situations, the nurse has her most frequent contact with the mother. If the mother attends group meetings it is usually necessary for her to bring the infant along.

The full meaning of behavior and how it comes into being, its significance, and its variability have been discussed in detail in Chapter 4. How does the nurse utilize this information and how can it be helpful to her in nursing situations with the infant?

In becoming aware of all the facets of each individual situation the nurse will want to make careful observations which she must correlate with the knowledge she has about physiological and psychological growth and development. In this early period of life the observations will be simple but will increase in complexity as the infant advances in years and his scope of human contact broadens into an ever-enlarging and complex social world.

A LOOK AT THE PICTURE

The Place of the Infant in the Population. Here the nurse can utilize statistical tables, etc., to determine the number of one year olds in the population. This number increases steadily because of the continued climb in the birth rate. Increasing numbers mean more infants, with more opportunities for the nurse to function in nursing situations with the one-year-old group. More infants live because of improved care. National figures are usually readily available, and the nurse can compare these with regional or local figures to determine how the particular community in which she is interested contrasts with the national average.

Mortality and Morbidity in the First Year of Life. Various sources provide accurate information in easily understood tables and graphs to assist the nurse in evaluating infant health. The nurse will need to keep current her information on what happens to babies during the first year of life. Health supervision will be directly influenced by causes of death and the incidence of disease and illness. What kinds of accidents occur? What months of life are most hazardous and why? (For graphic presentation of infant mortality rates by age and the main causes of infant mortality in the United States see Figures 14 and 15.)

THE INFANT AND HIS FAMILY

The first month of life, the newborn period, passes very quickly. The mother and father are learning to know their new baby.

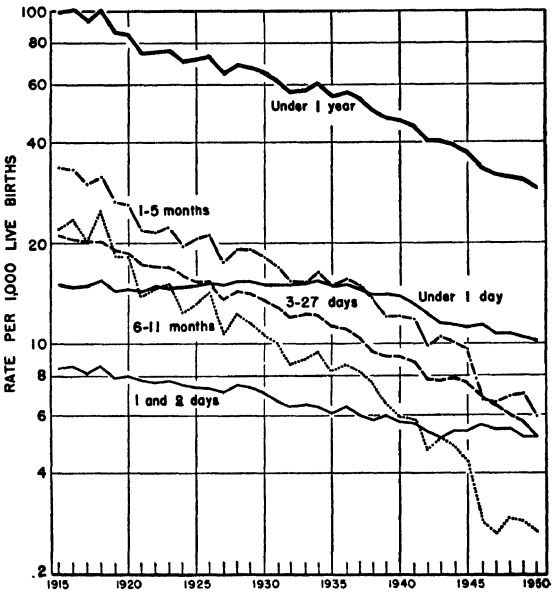


Fig. 14. Infant mortality rates by age in states registering births from 1915 to 1950. (From United States Department of Health, Education, and Welfare, Public Health Service, National Office of Vital Statistics: "Infant Mortality Statistics United States, 1950. *Vital Statistics Special Reports*, Vol. 37, No. 18, Feb. 9, 1954.)

Already they see him as an individual, perhaps quite unlike what they had anticipated. His care takes a lot of time. Household duties, and leisure-time and social activities have been adjusted to conform with the increased responsibilities. The parents, particularly the mother, have learned to interpret the meaning of his crying. His behavior is beginning to have significance and he has established a pattern of eating, elimination, sleep, etc., with sleep occupying the largest proportion of his time during the early months.

Family Structure. Continuing from the newborn period the nurse finds the infant established in a family group sharing a home environment. A study of the family structure will provide a background of understanding for the situations involving the infant.

The institution of family as a social unit is the structural aspect of concern here. There are the mother and father and the infant, or the immediate household group. Other children may be included in the family constellation. The spatial proximity of the kinfolk determines the diversity of influence upon the family unit of grand-

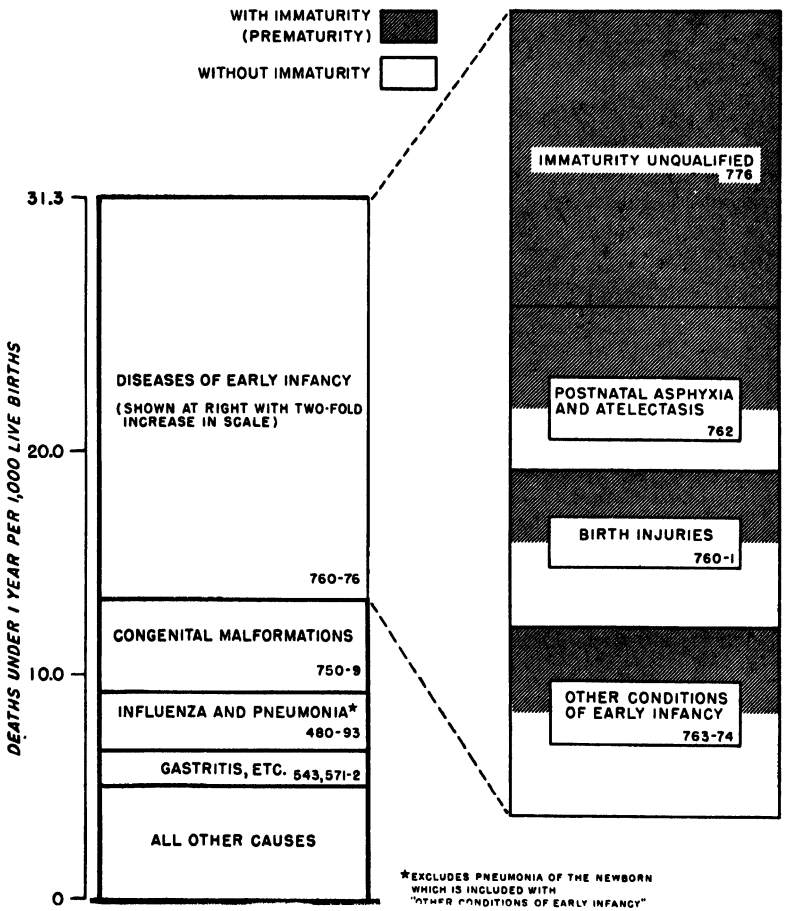


Fig. 15. Main causes of infant mortality in the United States in 1949. (From Federal Security Agency, Social Security Administration, Children's Bureau: *Charts on Infant, Childhood and Maternal Mortality, 1949.* Statistical Series, No. 9, 1951.)

parents, aunts, cousins, etc. The concept of family in terms of a larger kinship group is disappearing from society in many areas, particularly in large urban areas. The size and composition of the structure of the family group give the nurse an idea of the human beings present in the infant's social world. It is possible that the infant may continue life in a family situation differing from the above illustration. The mother, as well as the father, may work, and

in the absence of both parents the infant may be cared for by one of the kinfolk group, a mother substitute, or an employee paid by the family.

Husband-Father and Wife-Mother in Their New Roles. The advent of the infant into the family structure has created parental roles for the husband and wife. How do they function as father and mother? Observation and analysis of the parents' understanding of each other and their understanding of the infant and his needs help the nurse determine her own role in relation to each family with whom she functions professionally. While in the home or in other nurse-parent-infant situations it is helpful for the nurse to determine roughly the degree of satisfaction evidenced by the mother in her role as homemaker and parent. The father may or may not be present when the nurse has her contact with the mother, but elements in the conversation with the mother should reveal the father's acceptance and satisfaction in his new role if actual contact with him is infrequent or impossible. Conversation reveals what the father does in the care and shows the cooperativeness that exists between parents as they fulfill their new roles. The mother may say, "I will have to discuss this with my husband," or "We will consider your suggestions."

Housing. The rooms in the dwelling unit and the number of members in the family will determine the kind of accommodations available for the infant. If the family is large and they live in two or three rooms, the infant will not have a room of his own. His bed may be a box or an improvised dresser drawer. Crowding alone presents the parents with many problems, some possible of adjustment, others for which there seems no solution. Less desirable situations are most frequently found in the lower-class groups of society where crowded tenement living is endured. A family in the middle- or upper-class group can frequently provide a separate room and furnishings suitable for the infant's care.

Family Economic Resources. The income of the parents will directly influence the facilities available for the care of the infant. If income is limited the nurse will need to give suggestions about minimum essentials or ways of improvising. The nurse can rather accurately determine expenditures if she knows the total amount of money available to the family after considering number of members, and the needs for rent, food, and so on. A rather serious problem may be faced by the mother who must return to work while her baby is still very young. More will be said about this in relation to the role of the mother.

Cultural Heritage Influences Parents. The person who has had a congenial home life as a child, perhaps sharing this with brothers and sisters, usually brings to parenthood a personality which emits understanding, kind behavior, and willing cooperation, and he receives happiness from his interaction with people. The atmosphere of a home with such a person as a parent will give the infant a good start, for he will be beginning life as an integral part of a congenial, happy environment. Conversely, if the parent, as a child, did not get along with his mother and father, or had difficulty with his siblings, the infant is quite likely to begin life in an atmosphere of tension and strife. The infant begins to understand before he can talk, thus before he reaches a year of age he gets the feeling of the atmosphere of the home in which he lives. When parents quarrel, or shout loudly at one another, the infant is quite aware of the relationship existing between them. He learns to react more quickly and more positively to pleasant, enjoyable situations than he does to unpleasant ones; those he attempts to shun.

Orientation of Infant's Basic Sense of Emotional Security and Dependence. Satisfaction of the physiological needs of the infant is most frequently furnished by the mother. The social acts through which the infant's needs for sustenance, bodily care, and protection are satisfied lay the groundwork on which to establish love.

Day by day these social acts continue, the interaction resulting in the emergence of habits. The infant's habit patterns for care, feeding, sleep, elimination, etc. become established. The infant early experiences some restrictions. Without fully realizing it, he must begin to adapt to the environment and to the demands of others.

The mother and father will indicate through behavior such as kissing, rocking, patting, and the like their warm affection for the infant. Such behavior, when accompanied by pleasant vocal sounds, gives the infant a feeling of being wanted and adds to his feeling of security. The nurse should not miss an opportunity to explain to the parents the importance of these feelings to the infant and dismiss any fears the parents may have about spoiling the infant. If the parents are able to understand the difference between a happy infant and a spoiled one, they accede more readily to the desirable behavior pattern.

Breast feeding, unless contraindicated, will be continued by the mother regardless of inconvenience if she realizes that she can give her infant a good start in life by nursing him. This mother-infant relationship has reciprocal benefits, the mother recognizes her im-

portance to the infant, while on the other hand the frequent physical closeness makes the infant feel he belongs to his mother. This association typifies the early beginning of one of the infant's primary group relationships. During infancy as well as throughout life human existence depends upon social contacts.

Attitude of Parents. Are the parents really happy about the new baby? Do they love this new member of their family? Do they look upon the infant as theirs, belonging as much to one as to the other? Chances are that, if they planned together throughout the prenatal period and shared the anxious anticipation, their enthusiasm has not diminished. The behavior of the mother and the father alone with the infant and together provide the most accurate criteria for evaluating their real feelings. Verbalization of feelings provides important clues too. A mother expresses some of her real feeling with the comment, "Oh! let him cry, he is always wanting something. I never have time to read or do the things I like to do." Contrast the attitude portrayed by such a remark as, "Yes, he takes a lot of time but it's all so fascinating and I enjoy him so much." The father may make his attitude evident when he says, "I'll have to begin leaving the office on time now. I have a new son and I want to see how much he has changed since morning," or "My home life is different now, the baby has certainly upset our routine." The quiet, tender handling of the baby indicates parental feeling, as does the general concern for his comfort and well-being. One mother said, "We can't give him many of the things it takes money to buy, but he'll get lots of loving," and no doubt this will be of greater value.

Communication Early in Infancy. The only means available to the parents for communication to the infant is through handling, although tone of voice regardless of words also gives assurance and security. Parental feelings are made evident to the infant through their tender handling, the warmth of their bodily contact, the gentle holding which he receives when fed, bathed, etc. The infant knows he is loved and feels warm and protected. These feelings are so reassuring to him that he feels good about living and begins a satisfying adjustment to his environment. Successive steps in communication will be discussed elsewhere.

The Infant Begins Social Interaction. Interaction of the infant with his environment begins at birth. During the first month of life this interactive process centers around the satisfaction of his needs for warmth, food, and protection. The speed and enthusiasm with

which the infant develops depends to some extent on his interaction with his environment. If he is left unnoticed for long periods of time, fed, diapered, and put back to bed without any extra time or attention, he develops more slowly. Indulgence from his parents in such forms as holding, rocking, kissing, and talking, increase the depth of his feeling of security. His initial experience in interaction began with the mother-infant relationship of nursing previously described as a basic social act. This first interaction initiated a whole array of interactions to follow. However, in this early period of the infant's life social interaction is confined almost entirely to person-to-person relationships.

Control as Part of Interactive Process. Interaction for the infant starts within the family. Some of these interactions have been identified as set by culture, others are in the personal-social realm. Very early in the infant's interactional cycle he begins to experience controls from which he receives varying degrees of frustration. He begins to adapt his behavior to restrictions imposed by the human elements of his environment as he seeks satisfaction of his needs for food, comfort, etc. Older brothers and sisters may contribute to his feelings of frustration. Love from the family members tends to lessen the depth of his frustration. He begins to learn that certain conformity to cultural-social standards adhered to by his family are expected of him, too. Thus, early in life the infant learns that certain kinds of behavior not only are more acceptable to his primary group members but provide him with much more satisfying experiences. He tends to repeat those from which he receives the greatest satisfaction.

At about six months of age the infant can tell the difference between the persons who are strangers to him and those persons whom he knows. Gradually he becomes aware of other humans in his environment besides his parents, siblings, and kinfolks, with whom he has had more frequent contact. His social world begins to enlarge, but he probably will not be too friendly to strangers and interaction should proceed gradually and not be forced.

Improved Care as a Result of Teaching. The educational program which was begun in the prenatal period, if not before, was designed to prepare the parents for the care of their baby. Much of the responsibility for the content and execution of the teaching was the function of nurses who participated from time to time in various situations with the parents. The nurse interpreted and emphasized teaching done by others. The parents have learned what

to expect of their baby in the way of posture and activity. Teaching has helped them recognize his normal movements and sounds, thus increasing their security in parent-infant relationships.

CULTURE AND SATISFACTION OF INFANT NEEDS

Infants everywhere in all societies have the same biological and physiological needs. These necessities are for food, sleep, elimination, and protection. The culture of the group into which the infant is born will determine the manner in which these needs are satisfied.

Impact of Culture. The impact of culture upon the infant begins immediately. As previously stated, the content of culture includes folkways. The parents will enter into this new relationship with customary patterns of behavior which have resulted from their cultural heritage. The parents' cultural heritage has been responsible for their way of living, and has given meaning to certain material aspects of their environment. Now the infant is to share this way of life as a new member of the family group. The family thus provides the infant's first introduction to culture. The material aspects of culture begin to be a part of the newborn infant's life as soon as he arrives in his home. Although other factors mentioned earlier have some effect on the type and quantity of materials available, for the most part the kind of sleeping accommodations and the variety and kind of clothing provided are culturally determined. Some parents sleep with their baby between them, even though adequate space and facilities may be available for the baby to sleep alone. Some mothers insist on certain articles of clothing such as a petticoat, long out of use in many areas, but which they believe to be quite essential. All these things serve to initiate the infant, quite early in life, to the culture of his parents.

Individualization. One of the most important considerations in the early care of the infant will be the parents' attitude toward existing regularity in feeding, sleeping, and elimination. Nurses and parents who fully realize the significance of individual differences in infants will accept the pattern of behavior developed by the infant as he begins to fit into his environment. Continued emphasis is being placed on the fallacies of standardized routines of care and the nurse should continue her effort toward encouraging parents to grant the infant's pattern of individualism. Understanding parents are little disturbed when the infant still wants to be fed during the night or has three bowel movements during the day instead of sleeping all night long and having five defecations as does the baby next door. The question to the nurse from a mother who understands and

accepts her infant as an individual will be, "What can I expect my baby to do next?" in contrast to the mother who says, "Why doesn't my baby want to be fed every three hours, and why does he sleep all afternoon?" During the first year of life the infant's needs change markedly, and the nurse must be well informed on the physical and social components of developmental patterns. Interpretation to parents helps them recognize the sequence of development rather than to expect certain accomplishments at a designated age.

Feeding Practices. Concurrent with the aspects of his development which have sociological implication for the infant during his first year of life are changes in his eating habits. He goes from breast or bottle feeding through the process of weaning (in some cultures mothers nurse their babies until they are three or four years old) to experiencing additional new foods not only in numbers but radically changed in consistency. The culture brings into being cod-liver oil, orange juice, cereals, fruits, vegetables, eggs, meat, fish, bread, cookies, and simple desserts. Culture also brings him into the pattern of three meals a day with in-between meal nourishment to prevent hunger.

The infant emerges from his original helpless state to feeding himself. To accomplish this new learning he utilizes the tools provided by his culture. At first a spoon and a bowl, a cup or glass instead of a bottle for liquids, and his own particular chair, perhaps a high chair, designed to facilitate the feeding process, will be used. All these things, especially his high chair, increase his feeling of really being a participating member of the family. He is beginning to feel a part of his primary group. He has begun to use culturally defined articles of clothing, such as a bib. He learns quickly to pattern his likes and dislikes after persons in his environment. He learns to express strong feelings about his likes and dislikes.

Preventive Health Practices for the Infant. The mother and infant will secure health supervision in the office of the family physician or from a clinic. Visits should be made regularly and are usually spaced a month apart. These visits provide the physician with an opportunity to give any needed guidance for optimum physical and emotional care. His support adds security for the parents who may feel inadequate in their new roles.

The nurse in the physician's office, in the clinic, or visiting in the home gives assistance to the parents in coping with the problems that arise in the daily care of the baby. Agency policy will determine the frequency of the public health nurse's visits in the home,

but as a general rule the number of visits may be partially determined on the basis of need. Some parents need more guidance and support than others. Besides supervision and guidance in the purely physical aspects of care, general hygiene, feeding, elimination, and so on, the nurse should watch for indications of anxiety. Her understanding attitude should be helpful to parents as they attempt to understand their roles in this new triangle relationship. Elimination of anxiety and fear, accompanied by increased understanding and knowledge, results in an improvement in the atmosphere of the home.

The nurse will review the desirable preventive health practices against diseases like smallpox, whooping cough, diphtheria, and tetanus, explaining when necessary the benefits of early inoculation and indicating the time when it is recommended that these practices should begin. There will be instances, more frequent in some areas than in others, where culture patterns prohibit parents' acceptance of such protective practices. Some parents have strong beliefs, religious and otherwise, which form the basis of their objection. If this is the situation and the nurse has knowledge of their religious preference and some of the doctrines of the particular belief, she can avoid damaging her relationship with the parents by not insisting upon acceptance of the practice. Her efforts in such instances should be directed toward providing by other means a safe environment for the infant.

The Nurse and the Normal Infant. A first essential for the nurse who is to function effectively in the care of the newborn infant is a depth of understanding and knowledge of the normal infant. This prerequisite will provide a background on which she can compare deviations that become evident when the infant is sick. Many learning experiences are provided, in both formal classroom presentation and ward situations, to insure information about general hygienic care with special emphasis on the care of the skin, feeding, elimination, sleep, and proper clothing. Most nurses have a wealth of knowledge about average weight, length, and reflex action and its significance to a not yet fully developed nervous system. The nurse is acquainted with essentials of care necessary to maintain health and the early signs and symptoms indicating deviation from the normal. She knows about the physiological changes which must take place immediately after birth, changes relative to circulation, heart action, respiration, etc. She has heard over and over again that she must include physical, mental, emotional, and social factors in her concept of infant growth and development. Actually what are

some of the processes which are taking place and what significance do these lesser known factors have in the development of the infant? It is relatively easy to discern the nurse's skill in providing for the physical needs, but how does she provide for the social needs? The mental-emotional needs?

THE INFANT BECOMES A HUMAN INDIVIDUAL

From Biological Organism to Human Being. What happens to bring the infant, a biological organism at birth, into a human individual? The infant cannot become a personality without contact with other human beings. While in the hospital-nursery environment these contacts are varied, numerous, and largely impersonal. But when the infant is dismissed to enter his home environment his human contacts become intimate; they are no less frequent, and imbued with warmth and understanding. What has happened? He becomes a member of a primary group and begins to reap the multiple satisfactions described earlier in the discussion of primary group relations. He is completely dependent upon the humans in his environment for his very existence. The care he receives primarily at the hands of his mother will influence his survival. In this intimate relationship within his primary group he begins his first adaptation to a social world. He develops his human nature.

The Rise of the Self. The rise of the self has been discussed earlier in Chapter 4. The nurse must grasp the full significance of this process if she is to understand and appreciate the infant in her relationship with him, and if she is to give the kind of guidance parents need to fulfill their roles in the all-important development of their baby. The infant begins by anticipating what to expect from certain persons, sounds, and patterns of care. Until he has learned to anticipate the behavior of others he cannot realize the fulfillment of his needs, or learn to pattern his actions appropriately to meet situations arising from the interaction that takes place as his needs are gratified. The earliest manifestation of self-development is the infant's identification with his mother as he learns the relationship between his own drives and responses to his mother's behavior—her response to him and her actions.

HOSPITALIZATION OF THE INFANT AND YOUNG CHILD

Facilities may be provided in a hospital where only children are admitted or in a large general hospital with a unit designed especially for the care of children. The specific disease conditions or causes of

accidents and illnesses found in infants and children in the early years of life will not be discussed here. Disease conditions and specific causes of illness are thoroughly covered in pediatric textbooks. The nurse should learn more than diseases and their effects upon children; she should be aware also of the implications of sociological aspects. When giving care she must have more to offer the child and his parents than technical skills and perfected procedures.

When the child comes to the hospital the nurse immediately assumes the role of mother substitute. She will be the child's most frequent source of supportive therapy since his parents may be part of his environment for only short intervals of time while he is in the hospital. The nurse's own personality will be the greatest determining factor in the ease with which she establishes her relationship with the child. Her friendly, understanding manner, her real liking for children, and her genuine interest in each individual child contribute much to the success of the relationship.

The nurse will need to apply the knowledge she has gained about primary group relationships and their significance to increase her understanding of just what happens when the child is removed from a familiar home environment and from parents who have protected him and given him satisfying experiences as they provide for his needs. Just being removed from the familiar surroundings of his home is frightening to the ill child. The child in the hospital is in a new environment with many strange people, noisy equipment, sounds of pain and discomfort emanating from children receiving treatment, and perhaps he too is the recipient of painful procedures.

Long periods of hospitalization are a definite threat to family relationships and a variety of circumstances arise with both the child and his parents. Visiting hours provide the best opportunity for maintaining previously established parent-child relationships and should be permitted as frequently as possible.

The nurse understands the emotional components of illness as manifested by the sick child and his parents. Explanation and reassurance help in minimizing the emotional disturbance for the parents and they in turn can decrease the emotional trauma for the child.

Admission Data and Uses. Most pediatric departments prepare and attach an informational sheet to the hospital record. These data help the nurse increase her understanding of the child, the home he came from, his stage of development, and his individual peculiarities.

The maintenance of his status is aided by knowledge and use of

his nickname by those around him. Is this his first experience away from home, and was he prepared for his hospitalization by explanation, role playing, etc? The sheet may include such information as that he is the baby, last born, in a large family, having eight brothers and sisters. One of his older sisters gives much of his care as his mother is employed outside the home. Notation is made of his food likes and dislikes, and that he needs help in feeding himself. He drinks his milk from a cup and can identify some foods by name. The nurse learns the words that are used for urination and defecation, and has some idea about the extent and success of his toilet training. Information about his sleeping habits reveals what toy he takes to bed with him, when he goes to bed, the kind of bed he uses at home, whether or not he sleeps alone, and other aspects of his behavior, such as talking in his sleep, restlessness, or enuresis. His fears are recorded, and the extent of his vocabulary development is described. From such factual information and observations of the child, the nurse gains an understanding of him, as he is, and why he is what he is, and can identify his needs more effectively. She can practically visualize the culture of the home. The address gives her an idea of the neighborhood from which he comes. Her contacts with his parents increase her knowledge of the contributions they have made or can be expected to make toward his hospital adjustment and his subsequent return to home and family.

The parents also gain assurance from giving the nurse the type of information mentioned above. They realize that the more the nurse knows about their child, the better understanding she has and the less difficult the child's adjustment will be. Parents usually have less reluctance to leave their child after they have shared knowledge of his individual differences and habits with the nurse.

The age of the child is important in determining the amount of explanation and interpretation that can be done by the nurse. A small baby will understand only what is so glibly referred to as "tender loving care." He likes to be held, talked to in low soothing tones, and even rocked in a chair. Doctors feel that tender loving care is so important that they frequently order it along with medications and treatments. The purpose behind such an order is an effort to diminish the trauma that results from the change in environment from home to hospital and in-group to out-group relationships.

THE INFANT WITH CONGENITAL ANOMALIES

Congenital anomalies may range from those difficult to detect and relatively minor to very severe ones frequently incompatible with

life. From available statistical information the deduction can be made by the nurse that congenital anomalies cause many infant deaths. Many of the deaths occur soon after birth. Some which are not quite so severe leave the infant with a permanent handicap varying considerably in degree of severity. Remedial surgery offers possibility for decreasing the degree of disability and, in some instances, produces a permanent cure. In some cases, prolonged hospitalization of the baby may be necessary. But what does the presence of such anomalies mean to the parents? One of their strongest hopes was for a "normal baby."

The socialization of the newborn infant in his primary group may be delayed if hospital dismissal is not possible at the time when the mother goes home. Parents are fearful. "Will my baby live?" "Will he be able to talk?" "How long will he have to stay in the hospital?" Such questions portray parents' anxieties. The nurse can do much to lessen these fears and anxieties. Parents have to be helped to accept their baby as he is. In some instances one or both parents may become strongly attached to the infant.

The infant with a congenital anomaly may arouse feelings of guilt in one or both parents. "Was I careful enough during pregnancy?" the new mother will fearfully ask herself. "What did my wife or I do to deserve this?" the father inwardly questions. The physician will explain the anomaly and its probable origin to the young parents but the nurse, seeing the mother more frequently, can answer further questions and provide additional comfort in her replies. The nurse can also instruct the young mother in giving any special care required by the infant because of the anomaly.

Along with the guilt feelings, or even in their absence, the parents may have fears that future children will be born with similar or worse conditions. Again the physician with the nurse's assistance must give comfort and reassurance.

The infant with a congenital defect may require additional care, in some instances so much more that the mother may devote the major part of her time to this baby. This may cause friction and controversy in the home that will show in the parents' behavior as well as in the behavior of other siblings. The nurse should encourage and help the mother to budget her time, explaining that overprotection and solicitation toward the baby may be harmful for the entire family. She should further explain that insofar as possible the infant must be treated as any other baby, yet with adjustments for any special care.

It may be well for the family not to expose the baby to other

people if the anomaly is very marked or disfiguring. In addition, this baby may be very susceptible to infections and so should be protected from a large number of contacts. In every way possible, the nurse must aid the parents in adapting and maintaining a healthy attitude toward the baby.

PARENTS AND THE PREMATURE

Premature birth leads the list in causes of death during the first month and year of life (see Figure 15, Main Causes of Infant Mortality in United States in 1949, p. 293). Adequate care for the premature requires special equipment, in a special kind of unit, administered by especially prepared personnel. The length of the hospital stay for the premature depends upon many factors such as birth weight, general physical condition, growth, and development, and tolerance of and benefit derived from feedings. During the period of hospitalization the parents view their baby through the glass windows of the nursery. Isolettes look complicated and confusing and give the appearance of impersonalness. With each visit the parents' feelings of fear and insecurity tend to increase. Teaching is about the only tool available to the nurse for preparing parents emotionally, socially, and physically to assume the care of the premature infant in the home when hospital dismissal is possible.

Parents relate as one of their most frustrating experiences the nurse on one side of the glass and they on the other side, unable to talk to her or ask her questions. Personal contact with the parents, learning to know them, and their learning in turn to know the nurse, works wonders toward increasing their confidence in their own ability to provide sufficiently for the premature infant later on. Helping the parents understand the various aspects of care, knowledge of weight gains, more normal feeding techniques and other such factors help them feel that the premature is really their child. The nurse can assure parents that oxygen administration through a tube or through complicated equipment with puzzling dials will not be necessary in the home.

Environmental adjustments are the same for the premature as for any other infant. He just begins his adjustments earlier and the whole process is perhaps more difficult for all concerned. His needs are the same, and his development follows the same pattern; many accomplishments come more slowly, but he catches up with his more normal counterpart usually by the end of his second year of life. He will be bottle fed and more susceptible to infection. However, effective adjustment to such differences are relatively easy for parents

to make if they have had the advantage of a good teaching program begun immediately after the premature's birth and continued throughout the period of hospitalization with further teaching provided by the public health nurse in the home.

If facilities are provided in connection with the premature nursery, the mother can come into the hospital daily and share in the care of her baby. Individual instruction and guidance help establish an early parent-child relationship, and the mother becomes q uite confident of her ability to provide care. If the father can accompany the mother on these visits, he too can learn to assist in the care and can develop early an understanding of the infant's behavior. Frequent nurse-parent contacts provide opportunity to evaluate the home environment, and the parents with the nurse can plan for eventual home care.

THE ROLE OF GOVERNMENT IN INFANT CARE

Government—Federal, State, and local—has increasingly expanded benefits directly related to improved infant care and allied aspects of general welfare. It is the responsibility of state governments to develop procedures and practices best adapted to meet individual needs within each state. The scope and adequacy of various state programs depend upon personnel and money available. The Federal government gives assistance to states in the form of grants-in-aid and consultation services. Voluntary agencies on the national level devote much time and money to research. Organized effort against major preventable causes of death is a positive approach with unlimited benefits and needs to be intensified.

Education of the public through publication of pamphlets, bulletins, and reports is another service rendered by Federal government agencies. Perhaps the best known and most widely used of the Federal agencies is the Children's Bureau in the Department of Health, Education, and Welfare. The purpose of this bureau is to investigate and report upon all matters pertaining to the welfare of children and to administer grants to states under the Maternal and Child Welfare provision of the Social Security Act. Among the publications of this Bureau is "Infant Care." This booklet is standard reading in many homes, and the information which it contains is most helpful to parents and others. The distribution of this publication increased from slightly over one million copies in 1940 to almost two million copies in 1953.

The services of the local health department are designed to prevent disease, prolong life, and protect and improve the health of the

people in the community. The infant benefits directly from a safe food, water, and milk supply. Health departments provide to local physicians facilities and serum for widespread immunization against communicable diseases, thereby preventing epidemics and protecting infants and older children. Personnel employed by the department provide consultation services, home visits, and demonstrations of care.

COMMUNITY RESOURCES OFFERING SPECIALIZED SERVICES

Many communities establish and maintain programs offering special services that benefit the infant age group directly or indirectly. The nurse should be acquainted with the local services available, both official and voluntary. She may need to solicit their assistance or may need to cooperate with them in the provision of improved infant care. Community services should be responsive to community needs.

SUMMARY

As an individual the infant has developed at his own rate. The sequence of his various attainments has followed the usual pattern of growth and development. As an infant he has learned to smile, to laugh, to make sounds, to say a few words, to recognize locations from which sounds come. He can imitate; he can grasp objects in his hands; he can lift his head; he can roll over; he can sit up; he begins to crawl; he can pull himself up to a standing position, and he can walk when helped. He is becoming quite curious about his environment and all the fascinating things it holds. He is a person.

Because of the limited number of contacts which the nurse will have with the infant, she must be prepared to make the most of each opportunity. Statistics will provide her with a concept of the infant health problems. From the use of these materials she can determine the number of infants in her community, the most common diseases, the morbidity and mortality rates, and so on. The nurse will know which direction her cooperative effort, preventive teaching, and health guidance should take.

The significance of family begins to have real meaning as the nurse evaluates optimum environment and relationships conducive to infant growth and development. The attitude of the parents toward the infant will be one of the strongest determinants in the early interactive process as experiences bring the biological organism to a human being.

The nurse will meet situations with the sick infant in the home or hospital more proficiently if she fully understands the well infant. Regard for individual differences will allow for appreciation of peculiarities not directly associated with illness or a disease condition. The nurse is obligated to consider the cultural pattern of the family in her plans for teaching and care.

The premature infant presents special problems, but basic needs remain unchanged. The nurse will avail herself of every opportunity to increase parents' confidence in their ability to provide adequately for the premature.

Full utilization of governmental services improves the infant health program. The nurse will familiarize families with services available and resort frequently to many of the facilities for strengthening her contribution in improving the general health and well-being of infants and their families.

FOR INVESTIGATION AND DISCUSSION

1. Can you the nurse identify, analyze, and evaluate the factors prevalent in the family group which will form the foundation upon which the infant will construct his personality?

2. Why is the culture-transmitting role of the family so important to the child?

3. What possibilities does the nurse have to give guidance to families which can be used to structure an environment conducive to optimum growth and development?

4. What opportunities do nurses have to influence the development of healthy personalities?

5. What information can the nurse use in giving guidance to parents that will help in the new baby's adjustment to the home?

6. How can parents make the infant feel he is wanted?

7. How can the nurse help the parents institute adequate methods of child care?

8. What are individual differences and how do they influence nursing care?

9. Explain the influence of some of the early reciprocal relationships which the infant has in his social world.

10. How does the family react to deviations from the recognized "normal" pattern of growth and development?

11. Observe a young baby and compare his development with that expected for his age.

12. What information other than medical is secured from the parents at the time their sick baby is admitted to the hospital? Evaluate the effectiveness of this information in the plan for care of a particular infant.

13. Secure any available statistics on the number of premature infants in your community and compare with national figures.

14. What is the plan for care of prematures in your community?

15. What are the available resources in your community for care of infants with congenital anomalies?

16. Discuss with a social worker the reaction of a particular family toward their child who was born with a congenital anomaly and find out how the social worker was able to help the family.

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Chapter 16

NURSING SITUATIONS IN THE PRESCHOOL PERIOD

"What the infant and child is the man becomes and what the man is the child once was."[1] The nurse should know the community in which she works. Her contribution will be greater if she is aware of the many forces which have influenced the lives of the children she will encounter. Analysis of the community's cultural background and ways of living will provide the nurse with practical information which will be necessary for her work with children and basic to understanding of their needs.

LIFE BEGINS TO HAVE REAL MEANING

Harmonious family relationships have laid the foundation for the child's growth and development, and life begins to have real meaning for the child from one through five years of age. His experiences, which were confined almost exclusively to his immediate family during infancy, are now in the preschool period becoming wider and broader, encompassing more territory and more people. During this age period he has many accomplishments to his credit. He has learned to walk and can coordinate his motor skills. He has most of his first teeth and now eats foods prepared for the family group. He learns to carry out some of the simple daily health practices. He dresses himself. His skill in communicating has shown marked growth. He has new and different kinds of toys. He has accomplished bowel and bladder control. Now he can really do things. His early curiosity about people and things in his environment is still a strong motivating factor, and his many questions and the ever-present "why" bears out his continuing curiosity. Pets have been introduced to his environment, and he has learned to share

[1] Young, Kimball: *Social Psychology*. New York, Appleton-Century-Crofts, Inc., 1944, p. 43.

responsibility for their care and derives much pleasure from play with them.

SOCIAL WORLD ENLARGES

The life of the child prior to one year of age is bound up entirely with his primary group. In the preschool period of his life, other primary group associations come into being, thus enlarging his social world.

Play Groups. Parents should provide opportunity for the child to play with companions of his own age, since one of the child's needs is to play with other children. This is especially important for the only child in a family. The child's association in play groups teaches many things. He learns to share, to be considerate of others, to adjust his own activities to meet the demands made by others in the play group. Through group interaction he learns to be a leader and he learns to be a follower. He develops initiative and self-reliance.

The neighborhood in which the family lives will determine the possibility of immediate play groups. Some neighborhoods have few small children and parents may overcome this handicap by sharing the care of children during the day, thus creating play groups, or mothers may utilize some community facility such as a park, where children come to play. Nursery schools also offer opportunity for young children to work and play together. These will be discussed later.

Play groups composed of children varying in age may create problems that are not always conducive to desired results. For instance, a child who always plays with younger children may develop patterns of aggressive, domineering behavior which will make future group adjustments difficult for him. A play group so composed gives the younger children little opportunity for trying their wings at leadership.

Supervision is necessary for the play group. Frequently it will be necessary for the adult to settle differences that arise or to intervene in a quarrel. Since children learn quickly by copying from others, parents need to learn something about the other children in the play group. Undesirable patterns of behavior and unacceptable speech may influence choice of playmates. Some mothers do not seem to care, but others understand the influence of children upon one another and prefer to be selective in an effort to create a more desirable learning environment for the child.

Within the play group each child will need to feel that he is recognized as a person. Children like to be approved of by other children, and each child wants to be liked by his playmates. The child's needs in this early group relationship differ little from the basic needs throughout life: recognition and response.

The Neighborhood. Social interaction for the child progresses from the home and play groups into the neighborhood. The neighborhood in which the child lives contributes to his learning by influencing his behavior and thinking. Conflict situations may arise because the things he has learned at home are different from those in the neighborhood. Here, too, the child is introduced to countless social pressures to which some degree of conformity is expected. In the neighborhood environment he has contact with others his own age who are not members of his play groups. Neighborhood contacts exert a great deal of influence on personality development, formation of activities, and determination of the activities in which the child engages as he grows older.

DEVELOPMENT OF COMMUNICATION SKILLS GIVES IMPETUS TO SOCIAL INTERACTION

Language development is another step in the process of changing the baby into a human being possessing the cultural patterns of his primary group. Language is one of the components of culture. The most effective way of transmitting culture patterns is through language. Folkways, mores, and taboos are thus transmitted. Parents communicate aspects of their culture to the child through vocal, graphic, and gesture language. The language which the child is to speak will be that used by the parents. The child not only learns words which he can form into sentences but he conceives the meaning of words. Frequently his comprehension for meaning is greater than his vocabulary. Attainment of language does at least two things for the child in relation to his human environment: he can communicate his thoughts and ideas to his associates and he can comprehend the meaning of their communication. Social interaction becomes more meaningful with his ability to convey meaning and his ability to perceive meaning. Understanding of language aids in the socialization of the child.

It will be helpful for the nurse to recall that an individual's background has contributed meaning to words. The same word does not have the same meaning to all people. To illustrate the point, "shot" might refer to a gun or in another category of society to a measure of whisky; to others it might mean a hypodermic

administration of medicine. Inharmonious relationships may result from misunderstanding of the meaning of words. As a safeguard it is well for the nurse to make clear her intended meaning, especially in relation to technical words. Every culture places a taboo on certain words. To illustrate, only recently has the word "pregnant" come into common usage. Some years back it was taboo, and for it "in the family way" was substituted.

A child of preschool age has a strong urge to imitate, and parents will find it necessary to eliminate from their vocabulary words which they do not wish their child to learn or repeat. The nurse's ability to interpret word meaning gives her many clues about the child's past experiences, family or group—about the culture patterns, folkways, mores, and the like.

THE SELF BECOMES A REALITY

It has been stated that the child acquires his human nature from interaction with the humans in his environment. From birth on the interactive process becomes increasingly intensified and the child begins to play certain roles within the family. He is accorded definite position. This is his status. He functions within the family group by developing certain habits, attitudes, and values. The child becomes consciously aware of his behavior and his thoughts as they relate to other people. The self as a phase of internalization has been discussed in Chapter 4. During the preschool period the child learns to pattern his behavior to fit the expectations of others. Communication helps the child identify what is expected of him; he can express his wants. The self becomes a reality when the child can internalize into thoughts things that are communicated to him. When the child has developed the ability to become an object to himself, self has become a reality. The child's conception of himself is established in his primary group relationships.

Children of this age assume the roles of others in their play activity. This is important to the nurse, for observation of the child's behavior will give her insight into the attitudes and feelings of the child. The small girl, while playing with her dolls, will behave in the same manner as her own mother has behaved toward her. She will repeat to the doll things that have been said to her. Her gestures may even be identical to those she has experienced. In a short span of time the child may assume the role of father, sister, and mother, changing from one to another as she plays. From now on the child can call forth a different self as roles are accepted in an increasing number of groups.

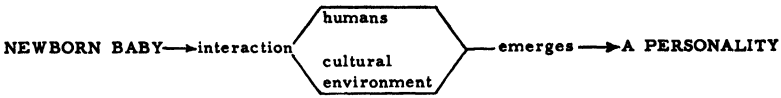


Fig. 16. Factors which influence personality development of the individual.

EMERGENCE OF A PERSON-ality

The approach to personality development in this part of the book will be from the sociological point of view, and it is taken for granted that the nurse already understands personality development as outlined in textbooks of psychology and physiology.

The Child Becomes a Personality. Parents want their child to be happy, friendly, and adequately prepared to cope successfully with life. Handicapped though parents may be because of their own past experiences, during pregnancy they lay the foundation for the attainment of this goal. The parents' feeling about their baby, their thoughtfulness and consideration of him, and how they treat him, all combine to influence his early personality development and exert a lasting effect upon it. Reiterating, it is within the family that the child first experiences the interpersonal relationships which will structure his personality.

Parents Guide Personality Development. The most important influence in any child's life is his parents; however, it is unfair to hold them accountable for everything that goes into the personality development of any child during the formative years. The child, the parents, and all human contacts in the environment in which personality development takes place, each adds an influence in molding the clay. The child is a personality and, as a distinct individual, he will continue to add years to his age as well as to broaden the scope of himself, a personality.

STRUCTURING ENVIRONMENT FOR OPTIMUM GROWTH AND DEVELOPMENT

Accomplishment of optimum growth and development presupposes that each individual, particularly the parents, will contribute to the maintenance of a wholesome, happy environment. Parents limit the environment for the child, both human and material, and as the child matures the boundary lines are extended to encompass more persons and additional material things. Many aspects are considered as environment is structured.

Setting Limits for Behavior Maturation. The young child needs to experiment, to discover for himself, and to learn, but he

must accomplish this important phase of development within boundaries that are set by his parents. The wise parents are consistent in their "no's," saying them only when necessary and then in a calm, matter-of-fact manner without anger, without nagging. The child is trying to find himself, asserting his independence and desire for freedom but needing the limits that his parents must set as much as he needs their love. To the young child, as he tries to find himself, the world seems large and limitless, even frightening. Again his mother and father are aware of his feelings, so each helps him see his world as a good place to be, a secure friendly place which accepts him without qualifications.

SIGNIFICANCE OF KINSHIP GROUP

The family's relationship with the kinship group is an important aspect in the child's background. The amount and frequency of a child's contact with grandparents and others in the kinship group depend upon spatial proximity. Some families are separated from kinfolk by great distances so that any influence exerted by the extra family members may be minimal. On the other hand, however, the contact is sometimes frequent and exerts varying degrees of influence upon child rearing. If both parents work, the care of the child may be the responsibility of the grandmother, either in her home or in the child's home. In this kind of an arrangement the influence is great. The grandmother's ideas about child rearing may be quite different from those of the parents and furnish the basis for conflict. Such conflict may be in ideas and beliefs, culture, discipline, foods and eating patterns, and acceptability of behavior. In contrast, the parents' role may be supplemented by a strong grandparent-child relationship. If all members live in the same household, the grandmother may perform many of the routine duties of the housework, leaving the mother free to give more care and companionship to the children. Grandparents receive considerable satisfaction by contributing to the duties necessary for maintenance of the home.

The social relationship between the family and kinfolk is more important than the blood relationship. Children should learn to respect grandparents, and they can learn a great deal of their cultural heritage through stories of the grandparents' early life experiences which most children find so fascinating. Children will pattern their acceptance and feelings toward the extra-family members after those manifested by the parents. The child who does not have contact with grandparents stands to lose much rich heritage and an influence which is frequently stabilizing and beneficial.

SIBLING GROUP

The order of birth in the sibling group has many ramifications. The first born child has experiences that are not duplicated for any other child in the family. His relationships as an only child are not possible for those children born later. Parents do not have the same relationship to other children that they had with him. They have been learning their roles as parents and upon the birth of a second child can draw upon their experience with the first to pattern their behavior toward the second and successive children.

Another factor is the length of time between children. In a family with a new baby each year there are different kinds of relationships than in a family with three or four years between successive children. Some families are large, and the oldest may be fifteen years of age when the new baby arrives. In each family the relationships undergo changes and adjustments, with each child presenting different problems for the group and for the individual child. Frequently the oldest child must accept considerable responsibility for the care of the smaller children. Wisely planned, such experiences can be helpful, particularly when the older child reaches adulthood and has a family of his own.

Sex differences are important too. All the children may be boys and then a baby sister is born. Sex differences frequently furnish the basis for inferiority-superiority feelings.

The first-born child develops his personality in a triangle relationship: his parents and himself. Each additional child must develop in a more complex human environment with interaction among a greater number of personalities: his parents, any older brothers or sisters, and himself, the complexity increasing with each successive child. Wise parents attempt to structure the home environment in such a way as to avoid jealousy, resentment, and open conflict within the sibling group. Each child is assured of his place in the family constellation, has his role defined, and is aware of his status; at the same time, mutually satisfying primary group relationships are maintained for all, the parents and the sibling group.

PREPARATION OF AN OLDER BROTHER OR SISTER

What does it mean to the older brother or sister when a new baby makes his debut into the primary group? The older child is removed from the position of being the "baby of the family." All attention was recently centered around him, but now he begins to realize that another is taking his place, or at least consuming part of the time formerly devoted to his care. He no longer has the center of the

stage. How can he be helped to accept the new member of the primary group? What are his needs now?

His needs have not changed. A deep feeling of security is still essential; abundant love and affection are still important. He needs time, too, and lots of attention. His little accomplishments need to be recognized, and as an individual he needs to become increasingly aware of his status.

Preparation for the advent of the new baby should begin a few months before delivery is expected. If the older child is to give up his bed and other things that were essential for his care, he can be helped to understand he is old enough for a new bed of his own, and the transfer can be made well in advance of the new baby's arrival. He can feel proud that he has advanced in some of his accomplishments, that he no longer needs certain articles for his care. He may be moved into a new room of his own. This process should be made to appear as a privilege and not a sacrifice.

The age of the child is the factor determining how much parents should tell him as well as the kinds of questions he will ask regarding the expected event. Concern here is for the child from one to six years of age. The coming of the new baby should be a very normal and natural part of the parents' conversation. Any questions should receive simple, truthful answers, with effort directed toward phrasing the answer in words meaningful to the age child involved and in a manner which can be understood. Even a very limited degree of understanding diminishes the feeling of threat for the child.

Parent behavior will do much more toward convincing the child he has nothing to fear than anything they can say. Before and after arrival of the new baby each parent should find time to give the older child lots of attention, continue building his feeling of security, and provide him with love and affection as before. The demands made on time by the new baby are great. His physical care requires many hours of the parent's time. In order not to neglect the older child some parents divide the responsibility, one caring for the new baby while the other does something with the older child. Parents alternate their care so that the mother is not always engaged in doing things for the new baby. One father gives the new baby a bath in the evening after he comes home from work and assists with its care throughout the evening, such as diapering and feeding. The older child's help may be enlisted and he may be able to feel that he is an important contributor to the infant's care. This must be accomplished gradually and naturally, so that the older child will not feel imposed upon or that his time is being given over to the

baby. Regardless of how well the parents work out the routine for the care of the children there is a sharing at best. It is almost impossible to relieve all feelings of jealousy but, if handled wisely and with understanding, the feeling of jealousy on the part of the older child will be of little consequence.

Both parents should observe behavior that indicates the older child feels insecure in his primary group. His behavior patterns may show marked regression. He may want to have a bottle again; he may regress and need diapers again in his toilet training process; thumbsucking, if present, may be intensified. He may attempt physical harm to the new baby.

Members of the kinfolk group and friends of the family can minimize the trauma for the older child by their behavior when in the home. Each should show the older child interest, affection, and concern. Their interest should not be immediately directed toward the new baby. If they bring gifts to the new baby, they can also bring some small gift for the older child. If they hold the new baby, they can hold the older child too. Parents should encourage this behavior from friends and relatives. A harmonious happy home environment will do much to help the older child accept the new baby and his changed role in the family.

THE CHILD AND RELIGIOUS INFLUENCE

The family in the home will introduce the child to their religious beliefs and practices. The nurse will find wide variation from family to family and from community to community. Religion has great influence on acceptance of medical and nursing care, regarding both the preventive and the curative aspects. Human behavior is influenced by religion.

Some families weave religion into their pattern of daily living. The customs of saying grace before the meal and of bedtime prayers may become part of the child's early experience. The child may wear a religious medal before he is able to understand the full significance of its meaning.

The family's participation in church activities introduces the child to one of his first secondary group associations, the Sunday school class or a similar religious gathering, depending upon the family's religious faith. The child learns to play with others of his own age and learns to know his Sunday school teacher, but from this there is something more—the child begins to believe in a God.

From birth on the child's personality is constantly being affected by experiences, so that church attendance early in his life adds to

personality development. In this environment the child learns new patterns of behavior related to participation in a secondary group. Participation in church activities tends to make family life more successful and provides inspiration for the entire family group. The influence of religion upon moral standards and values will be discussed later in relation to the older child.

BRIDGING THE GAP BETWEEN HOME AND SCHOOL

Nursery school is one of the experiences that contribute to the physical, social, and mental-emotional aspects of the child's development at this age. The nursery school provides an important link for the child between the family and home and a full-time school program which comes later. The environment of the nursery school initiates the child into planned activities differing from the informal atmosphere of his home. Nursery school brings another adult into the child's life, a teacher or the person in charge of the nursery school. In this environment the child continues with learning experiences similar in many respects to those encountered in play groups. Here the child has opportunity to learn creative activities which allow for initiative and sense of accomplishment. Cooperating with other children becomes important, and the child's experience includes sharing and mutual accomplishment. The person responsible for supervision can do much to encourage the cooperative spirit and propose activities to provide leadership experience for the child who tends to be a follower while at the same time encouraging the aggressive, domineering child to accept follower roles. Adjustments in behavior patterns are frequently required and can prepare individual children for those that will be necessary later when the full-time school program begins.

Day Care Centers. Day care centers provide care during the day for a group of children who cannot be cared for at home usually because their mothers are working. In many respects the program of activities in these centers resembles that of the nursery school. The main purpose of the centers differs, however, for they are maintained primarily to aid working mothers, whereas a child is sent to the nursery school from choice rather than from necessity. Day care centers provide excellent opportunity for the early detection of behavior disorders or of emotional disturbances.

Eligibility for care may be determined by several factors such as income, race, and age, with centers offering their facilities to children ranging from one to fourteen years of age. Some are sectarian and offer services to children of certain religious faiths only.

Since the needs of different age groups differ widely, separate programs must be planned and maintained for children of different ages. Play activities for school age groups after school hours may be part of such a center's program. Such centers are especially valuable for children who need group experience. Programs are designed to continue character-building activities and include outdoor activities, positive health practices, nature lore and socializing experiences of being together with others of one's own age group, away from home and family ties, and temporarily removed from family conflict and tension. Nursery school and day care centers may constructively influence the relationships between parents and children and improve family living.

Nursery schools and day care centers provide opportunity for the nurse to work with and observe well children in group activity. The nurse can evaluate social development in group relationships and, if familiar with the home environment, can assist in interpreting the needs of individual children. In turn, after careful study of the family situation, she can work with the parents in the home to accomplish desirable changes or adjust behavior patterns.

CONTINUING PREVENTIVE HEALTH PRACTICES

Regular visits to the family physician should be maintained for the well child. The young child seems to be especially susceptible to respiratory infections. The nurse, through teaching, helps the parents to understand the benefits of early medical supervision when signs of illness develop. Emphasis is placed upon prevention of complications.

This child, experiencing an ever-expanding world, begins to interact with new persons and his human contacts broaden. Visits to the physician's office or the clinic should be explained by the parent in order to avoid a feeling of fear. The child may cry at the sight of the physician, or even at the sight of his office or the clinic, but fortunately his memory is not long and his attention can be almost immediately directed to pleasurable situations.

Booster inoculations are a part of the plan for prevention of disease and should be continued during this age period. It is helpful for the mother to keep a record of dates, kinds, and so on, of such treatment. Such records are very useful if continued residence in the same town is not possible.

Regular visits to the dentist begin during this age period, with the first visit coming at about two years of age and successive visits

at six-month intervals. Children's teeth need to be cleaned regularly, and small cavities should be filled. Such visits help to prevent the development of fear, and usually the child learns to anticipate his visit to the dentist as a non-frightening experience. Some dentists who specialize in child dentistry afford opportunity for the child to become acquainted with the many fascinating things in the office and thus further alleviate feelings of fear. Parental attitude is especially helpful in minimizing fear of the physician and dentist. The nurse has an important role to play since she is so often a part of the environment of the physician's and dentist's offices. She contributes much to making such visits pleasant experiences, ones that the child will not mind repeating.

A STEP-MOTHER OR STEP-FATHER

The role of a step-parent is a difficult one at best. The child may be slow in accepting the situation, or even resentful, although some children develop a rather satisfying relationship fairly quickly. This acceptance works both ways. Perhaps the step-parent resents the mate's affection for the child or even becomes annoyed by the existence of a close child-parent relationship. Such feelings are dangerous and delay the process of healthy, realistic adjustment, individual to individual, and of the family as a whole. Anxiety is often wholly unfounded. Actually many step-parents turn out to be nice persons, and the step-children are often recognized as not such bad youngsters after all. No matter how ideal the situation or how lacking the relationship may be in friction, children in a step-parent–child relationship experience a variety of disturbances to a lesser or greater degree. Should a child lose his own mother by death or divorce, what are some of the problems he faces?

The child's basic needs remain the same. The age of the child will make some difference, since each age group presents particular problems, but the needs for love, a deep feeling of belonging, and good physical care are still essential. Being friendly, kind, and considerate, proceeding slowly, objectively evaluating behavior and the underlying meaning and feelings should aid the step-parent in establishing a role affording happiness and satisfaction. Becoming a part of the primary group will depend largely upon acceptance of the step-parent by members of the immediate family, i.e., husband or wife, and child. Learning about relationships, each to the other, will help cement all individuals involved into an in-group relationship. The relationship of the parents with each other is probably

the most valuable asset in building and strengthening in-group feelings and creating an atmosphere conducive to happy living.

FOSTER HOMES

Society makes use of foster homes for children who have suffered the loss of a parent by death or by desertion or divorce, or whose mother is not married. Family economic situations or chronic illness may make foster home care a necessity. In some instances parents are unfit to care for their children. The child's difficulty in making adjustment to new parent figures depends upon his age and previous experiences. Some children are so consistently shuttled from one person to another that they do not have close attachments to a parent. For others death may terminate close interaction with loving parents. Foster homes may be utilized on only a temporary basis until the child's natural parents have had an opportunity to formulate a plan of care. Foster homes are usually carefully investigated and provide a more suitable environment for the child's development than such an institution as an orphanage.

Foster parents are interested in the child's needs and quite adequately compensate for his real parents. The child's emotional needs for security, recognition, and response are satisfied. The child learns to rely upon foster parents and receives much more love and affection from them than is possible in a less desirable arrangement for care. Child welfare workers follow such placements closely and give foster parents any guidance they may need in providing for the needs of the child.

ADOPTION

Many married couples who cannot have children of their own resort to adoption, which is a method provided by law and administered by child-placement agencies. It establishes a legal relationship between parents and child and protects both the child and the adopting parents. Once the child is happily established in his adopted home it bars his real parents from any legal claim on the child. Effort is made to choose the child to fit the family, and vice versa. For the child who cannot be cared for by his natural parents, adoption provides the security of a home, and the adopted child has the same rights and privileges he would have had in his natural home. Usually the child is placed with his adoptive parents for a trial period, as long as one year, before final adoption is permitted. During this period of trial residence a case worker will visit, observe

the home, and the child's adjustment, and evaluate the care and behavior of the adoptive parents.

The nurse should encourage adoptive parents to begin early to explain to the child that they are not his natural parents. If the child reaches school age without such knowledge he may be exposed to some rather traumatic experiences as his young associates taunt him with such a remark as, "She isn't your real mother." The parents will be relieved of much anxiety, too, for they will not constantly fear that the child will learn of his adoption from some other source. Some adoptive parents give the child very satisfying explanations. An example is the case of Nancy, who, at the age of three and one-half years, very carefully explained that when babies were born into families the parents had to take them as they came, but Nancy had the advantage of being picked from a group by her parents. It was easy to see her deep feeling of belonging and her delight in her two birthdays, the one for her birth and the one for the day she was "chosen."

SUMMARY

The social and environmental world begins to enlarge for the preschool child. The influence of the family still predominates, with play groups affording opportunity for learning experiences with children of the same age. Continued development and refinement of skills increase the child's activities and group participation. He becomes a "doer."

The child's awareness of his environment is indicated by his interest and curiosity in people and things. His inquisitiveness is evidence of his development. Adults are beginning to understand the child as a person and he is accorded status in his family group. He also becomes aware of his status in other group relationships. These formative years are the most important, for they lay the foundation for future mental health and life adjustment. The child becomes aware of boundaries which control his behavior and learns to pattern his behavior in acceptable ways. Preparation for future experiences is begun through planned activities outside the home. Preventive health practices continue to be important, and some responsibility for simple procedures can be assumed by the preschool child under supervision.

Community resources offer facilities for the less fortunate who have need for care outside the family group. Active interest in higher standards assures further improvement, increased financial

support, and a more optimum environment for growth and development of the preschool child.

FOR INVESTIGATION AND DISCUSSION

1. What factors in the social world influence the personality development of the child?

2. Can you determine the strength of the influence of each of the above factors?

3. What is the relationship between personality and satisfying group relationships?

4. What are some of the indices of normal development which can be observed in nursing situations involving the preschool child?

5. What can the nurse learn about a family from her contact with the child?

6. Identify ways in which the family transmits cultural standards to the child.

7. How is the preschool child taught to conform to family standards?

8. What are the factors which create a harmonious relationship between parents? Is child behavior influenced in any way by parental relationships?

9. What social and environmental factors does the nurse consider important in assuring a sense of security for the child?

10. How can the nurse tell when the child feels that he is wanted, loved, and enjoyed by the members of his family, primarily his parents?

11. Explain how the changing needs of the preschool child are related to his individuality, his social relationships, and family practices.

12. Visit a day care center and note the following: number of children, length of stay, facilities for play, group relationships, general attitude of group toward center and personnel.

13. List the preventive health practices encouraged by your local health department.

14. What are the criteria for good foster home care and how are these enforced in your community?

15. What are the adoption laws in your state? How do they compare with other states? What agencies in your community assume responsibility for adoption?

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Chapter 17

NURSING SITUATIONS IN THE EARLY SCHOOL YEARS

Most six-year-olds anticipate a full time school program with mixed emotions. Going to school sounds exciting, but there are also some deep feelings about being away from home all day, being lonesome for mother, for playthings, and for pets, for primary group associations and items of material culture which have come to have great meaning. School offers opportunities for new experiences, for becoming acquainted with a different environment, for meeting new people—the teacher and others, and for associating with many strange children, the most overwhelming experience of all.

One of the new persons in the school environment will be the nurse. As a pupil in the school the child may benefit indirectly and be less aware of the nurse's contributions and physical presence but, on the other hand, he may know her quite well. He may even recognize the nurse as the same person who has visited in his home and, if this is true, he will take great pride in calling her by name. She may have been part of his environment in the nursery school or day care center, or the nurse may have participated in adult activities and the child may limitedly recognize her from this role. In the early school years the nurse-child situations will occur within the school environment, in the home, in the hospital or clinic, and in organized group activities.

In most of these situations the nurse's role will be primarily in the area of education. Previously her contribution in this area was accomplished through parents but now she can teach the child and, through consultation, influence what the teacher and other school personnel contribute to his learning. To function effectively in any situation with the school-age child, the nurse will need to know what the child is like. What can be expected of him at this age? What are his needs? Do his parents still have a contribution to

make? What role does the community play? What does society demand, and what adaptations must the child learn to meet these demands?

In any nurse-child situation it will be profitable for the nurse to explore the child's relationships within his family. Awareness of the child's interactive experiences within the family and all group associations during his early years of life will be beneficial.

THE NICHE OF THE SIX–TWELVE YEAR AGE GROUP IN SOCIO-ECONOMIC STRATA OF SOCIETY

The nurse needs some concept of the number of children in the population falling into this age category to give her some insight into the problems that occur. To know that this age group consists of a certain percentage of all the children in the population will provide source material from which she can make some generalizations about needs, facilities, patterns of health care, and so on, thus visualizing the magnitude of the problems she will encounter.

Analysis of available data will show that approximately sixty out of every hundred children are found in families of the lower-class group. Families in the lower economic group have more children than in the middle or upper economic groups. From such revealing information the nurse knows the kind of housing available to this group, the nutritional status, the health practices, disease prevalence, and the limitations in providing many of the necessities for a happy, comfortable life.

COMPENDIUM OF PHYSICAL GROWTH, MENTAL DEVELOPMENT, AND ACQUIRED SKILLS

From her study of anatomy the nurse will be familiar with the skeletal growth for the children in this age group. She is already familiar with the slow increase in height and weight, with the accelerated increase in weight for girls as they reach the upper limits of this age group. The physiological function of menstruation begins for some girls. In this age period children are assuming partial responsibility for their personal needs, such as bathing themselves, and dressing, and later progress to particular concern for and time spent on their personal appearance and cleanliness.

Play activities continue in importance and show wide variation, with some kinds of games and activities more popular with girls than with boys. Much play activity centers around toys which require muscular coordination and skill. Hobbies and handcrafts

assume importance in children's activities and interests. They require varying degrees of knowledge and dexterity. Boys are frequently the most active and tend to rough play. Individual likes and dislikes act as strong motivating forces in the selection of play for the children nearing the twelfth year of age.

Fascination in the culture of the past is evidenced by the child's interest in stories. Radio and television become an essential part of each day's activities. Concern about sex differences, and how babies come into being, and an increasing awareness of reality are noted. This child can assume an increasing number of duties in the family's daily activities and can be quite dependable. Concern here is in the social progress the child makes during this period of growth.

THE FAMILY

Many changes in family life have already been noted. The nurse is aware of the decrease in family size, the changes brought about by urbanization, increased apartment house living with crowding and less privacy, the influences of inventions on family activity, and the like. What role should the family play? Does the role change as the child grows older?

The family provides the child with valuable experiences in co-operative living. Here children learn to respect the rights of others, to be kind and thoughtful. The need to feel secure is as great as during the early years of life. Each child still needs an abundance of love and affection, needs to be respected as a person, and should receive guidance and discipline as before. Parents should believe in their children and be proud of them.

Increasingly the child's activities will be outside the home. Many of the conditions listed above make this necessary. The trend toward commercialized recreation has aided in taking children out of the home environment. The early years of family life should have prepared children to make a comfortable, happy social adjustment outside the family. Children should feel free to bring their young friends into the home. Parents who show an interest in their children's friends and activities promote social development in the youngsters.

If parents are having their first experience with a child of this age the nurse may help them in understanding many aspects of maturity which are puzzling and problem producing. She can help them to understand what to expect of the child, what are the differences between boys and girls, how to answer questions, and how to maintain confidence and respect.

RECOGNITION AND ACCEPTANCE OF DIFFERENCES IN CHILDREN

The nurse should have sufficient understanding and experience to recognize and accept the differences in children. Her own behavior will be influenced by the degree of her acceptance, but more important the quality of her guidance will be influenced by the effect of these differences upon the children themselves. Many differences such as color, speech, etc., may be noted, but the number and kinds of differences are not as important as the circumstances which arise as a result of them. Children's attitudes about differences have a marked effect on group acceptance and determination of values. Different patterns of behavior, different social customs and practices may limit in-group participation.

RESPONSIBILITIES IN AN ENLARGED SOCIAL WORLD

The school-age child is becoming aware of the importance of group contacts as well as the social significance of ownership. He has a sense of pride in owning something. The child has feelings about his possessions, "This book is mine." Depending upon the individual child, he may share his possessions with others or he may be selfish. Ownership may enhance his status within a group or have the opposite effect of preventing his inclusion in certain groups.

Respect for Property Rights. The child learns to respect those things which belong to others. He begins to assume some responsibility for his behavior as he interacts with an enlarging social world. He learns that he must accord other people's property the same respect he expects for his own. If he is not allowed to mark on the outside of his house with pencils, neither can he do so on the house of his neighbor. Parents give the child some concepts about avoiding destructive behavior and explain to the child why he cannot take or have everything he sees, particularly those things which belong to others. Respecting the property rights of others becomes a custom.

Manners. Manners are little more than designated behavior patterns meeting standards set by social groups. A certain conformity and certain ways of doing things are necessary for satisfying experiences. A child may be made aware of the degree of his social acceptance by the mother who says, "You can't play with my little boy, I don't like the way you talk." If the child has a warm friendly feeling about people he will usually be kind and courteous. Children learn good manners by seeing good manners and by practicing them. Guests in the home give the child excellent opportunities to

practice good manners. Families should introduce the children to social customs which are necessary if they are to function acceptably in society.

Money. Not only is the school-age child aware of money as a means of securing necessities and pleasures but he begins to learn how to earn it, how to spend it, and the value of saving. Many children are given a regular allowance and thus realistically become aware of the value and use of money. Children at this age should share family experiences in order to learn how much things cost, and the merits of budgeting and saving for future needs and wants.

COMMUNICATION

The school-age child develops new communication skills and perfects those acquired at an earlier age. If the child could write before school attendance started he will now learn how to do it better. Each new experience enlarges his vocabulary and he is always anxious to make an impression by using newly acquired words. He learns to write, advancing from printing single words to writing sentences. With the acquisition of these new skills the child can read books about happenings of the past, can broaden his interests and increase his knowledge.

His skill in mastering new methods of communication will increase his status in school and in other groups as he competes to "do things better than his playmates," and will also improve his social interaction and interplay with the environment. With the advent of additional communication skills increasing ease in transmission of culture is possible.

PERSONALITY DEVELOPMENT CONTINUES

Life is one learning experience after another, so it can be assumed that personality development is continuing. Personality in later age periods of life is markedly influenced by development during this all-important period of childhood. As growth continues personality development becomes increasingly complex. Part of this personality development is shown in the child's efforts to succeed in any job that he sets himself, in his ability to acquire certain skills, and in his desire to accomplish definite tasks. Each child needs to believe in himself as a self-respecting person if he is to grow into a worthwhile, contributing individual. He is exceedingly loyal to members of his own age group, which is a useful base for his later conformance to law and order.

The nurse, being aware of the many forces which affect personal-

ity, must be understanding and sympathetic if she is to help the child and his family during the early school years. She can encourage his self-respected self-confidence through her contacts with the child and his parents.

THE SCHOOL HAS AN IMPORTANT ROLE TO PLAY

The nurse should have some understanding of the functions of the school as an influential institution in society. Although it remains primarily the responsibility of the parents to assist the child in making favorable social adjustments, the teacher in the school and the nurse are obligated to contribute. The school environment gives the child an opportunity to participate in group activities and projects. The socialization process continues with the child's progressive acquisition of social attitudes and behavior patterns that will be acceptable to his groups and deemed desirable by society. The child's social interaction within the school group may determine how well he likes school. The nurse has frequent opportunities to evaluate the child's behavior in his groups. It will be well for her to remember that the influence of the school personnel will be rather limited in comparison to other forces in shaping or changing the child's behavior and influencing his learning. The influence of the home predominates, with radio and television strongly influencing the child's learning.

The school accepts each child where he is in his development and contributes a share in the over-all education of the child. One of the functions of the school is to introduce the child to the rich cultural heritage of his past. The school shares the job of transmitting cultural heritage and serves as a medium for familiarizing the child with his social environment. Here the child learns additional ways of adjusting to his environment, of getting along with people, and of meeting the demands of daily living. He broadens his realm of participation and becomes more aware of his place in the social world. Effort is made continually to enlarge his environment and cultivate his interests in an ever-expanding environment by creating challenging learning experiences. An increasing number of schools are placing emphasis on family living in their curricula. Many children are introduced in school to the rich culture of society, embodied in music, art, and literature, which they otherwise might not experience until a much later age or might miss entirely.

The nurse in the school works largely through the teachers, although she has many direct contacts with the children and some with their parents. The nurse, teacher, parents, and child constitute

a team which functions most adequately when they are in accord and directing their mutual efforts toward the child's welfare. Conferences with the teacher regarding individual children offers unlimited opportunities for exchange of information which would require much more time and effort if the nurse were to attempt to find out about the children without the teacher's help.

Participation in meetings of parent-teacher organizations and mothers' clubs and in neighborhood get-togethers affords invaluable sources of information for the nurse. She can use such meetings as an educational tool as well as an opportunity to get acquainted with parents. The nurse may be asked to participate in programs or be available to answer spontaneous questions. Her contacts with parents make it possible for her to understand the children and their behavior and to meet their needs more effectively.

GROUP ADJUSTMENT IN SCHOOL ENVIRONMENT

In many of the child's past experiences he has been treated as an individual. School is different in some respects. Gaining recognition as an individual is more difficult, for the child finds himself just one in a large group of pupils in the classroom. One of his first tasks is to make a successful adjustment to this large new group. Frequently the nurse will encounter children who, for one reason or another, have difficulties in learning or whose behavior tends to interfere with group adjustment. Fulfilling one aspect of her role, the nurse will, alone or with others, attempt to find the cause of the trouble. She may find that the child's behavior results from his home situation. She may further discover that strict disciplinary procedures exist, perhaps there is no discipline at all, or the atmosphere of the home may be filled with tension. Recalling that the child is largely a product of his home, the nurse as mentioned previously will share any information she has with the teacher and other interested school personnel and cooperate with them in providing, within the limits of the school environment, a solution of the child's problems. The background experiences of some children make group adjustment relatively easy, whereas for others it creates many problems the solution of which comes only after years of effort, if ever. A problem child is usually an unhappy child who lives in a problem-home environment.

GROUP INTERACTION BECOMES MORE DIVERSIFIED

Children of this age begin to increase their group participation. They have progressed from interaction within primary groups al-

most exclusively to interaction in an increasing number of secondary groups. While the family and neighborhood groups still retain importance, the significance of other groups can be noted. The school-age child becomes interested in team play and proceeds one step further in the socialization process. Acceptance as part of the group is very important to the child, and he learns to direct his energy toward the group goal. The importance of cooperation begins to dawn. The child is introduced to competition, both conflict and opposition, and learns some elementary facts about in-group, out-group relationships. He begins to attach strong feelings to this kind of relationships. Children soon learn the importance of fair play and begin to develop the kind of behavior required for group acceptance. The feeling of belonging is all-important to children of this age.

The self-confident child has less difficulty in becoming a member of the group. His social world has broadened and he now considers himself a member of his social group and of other groups with special interests, and he participates actively in his neighborhood group. In most of his activities he will be more interested in members of his own sex. He may show interest in certain friends for brief periods of time, as mentioned previously, and groups interested in some special hobby come into being.

The nurse will have many opportunities to observe the social behavior of children in this age group, to recognize the healthful benefits of play, and also to understand that these group activities provide opportunity for personality development and expression.

FOLKWAYS CONTINUE AS A MEANS OF SOCIAL CONTROL

Each family group will transmit its own folkways and mores. Early in the child's life the family begins to influence his ways of acting. Family folkways unconsciously become patterns of approved ways of action for the child. Conformity to group ways of acting become important for the child, because it provides him with more satisfying group experiences. At the same time, folkways serve to delineate the unacceptable from the acceptable, and if the latter pattern is to be followed certain control is necessary on the part of the child. Folkways are the customary or habitual aspects of behavior. Parents expect certain behavior from the child, and this forms another aspect of control through folkways. Although there is no strong feeling that folkways are right or wrong, the child has learned to value the opinion of his parents and others, and thus

tends to behave and conduct himself in a manner which will assure a favorable response.

The nurse has learned of the universal existence of folkways, their meaning, and the unconscious acquisition of them. In her work with this age child it will be important for her to recall the meaning and significance of folkways so that she may better understand patterns of behavior. The way children eat, the way they dress, the way they play, all come into being through the folkways of the family.

MORES

Folkways are not too important, but there are ways of doing things which are considered more essential, i.e., mores. Mores have been clearly defined in an earlier chapter. It is important for the nurse to recall that the child learns early that nonconformity as far as mores is concerned results in much more serious consequences than those which result from noncompliance with folkways. Although the child at this age does not understand the full significance of compliance with mores, he is beginning to learn that observance of them wins for him the approval of his parents and others and that interaction within groups is less frustrating and not so traumatizing. In some instances the nurse will encounter a child who feels he has lost the approval of parents and friends because his behavior has not been consistent with group mores. The nurse may also become aware of conflict situations which arise as an aftermath of behavior contrary to the mores. The mental health of the child and others is better if adherence to mores is understood.

THE SEED OF PREJUDICE IS SOWN

In these early years parents are chiefly responsible for the emergence of prejudice in their children. They structure the cultural environment in which the child matures. Their speech about and behavior toward persons who differ in such factors as color, economic standing, and religious belief form the basis on which the child builds his own attitudes, copied almost identically after those of his parents. Other adults in the child's environment contribute too, but their contact is usually less frequent and for a shorter duration. In-group behavior tends to influence the child's attitudes toward and participation in out-groups.

Prejudice has been explained earlier; the important consideration here is the influence of prejudice on the attitudes and behavior of the child who is beginning to establish a social position as an indi-

vidual and who is enlarging his group affiliations. These early feelings of prejudice will create many difficult conflict situations for the child in later years.

In her contact with parents and children the nurse who is aware of how prejudice comes into being in primary group situations can utilize every opportunity to alleviate its intensity. Ignorance causes prejudice. The nurse has much to contribute by providing factual information for children and for parents and other adults. She can encourage parents to avoid making disparaging remarks and encourage children to look upon others in the neighborhood as their equals. Many conflicts arise in play groups as a result of prejudice. The nurse will be conscious of deeper and more frequent feelings of prejudice in some areas of the country than in others. She herself may even have some feelings of prejudice. She will realize that feelings of prejudice can never be completely eliminated but she should willingly accept her role in reducing the degree and frequency of such feelings.

MEETING THE CHILD'S NEEDS FOR SEX INFORMATION

Parents may begin sex education for children with simple answers to questions as early in the child's life as he asks them. Parents may continue to build wholesome sex attitudes as the child becomes older. Fortunately the taboos placed on conversation or early explanation of sex have begun to disappear and most parents are finding it easier to answer questions honestly. Children should never be made to feel guilty about sex. Many parents use the child's love for and interest in pets to illustrate birth, and how the mother animal nurses her young. Through such illustrations the parents can make the whole reproductive process seem quite normal.

The nurse can be of great assistance to parents. She can encourage them to accept their obligation in providing the guidance children need during the years between six and twelve. The nurse should help parents understand why sex information is important, and how it contributes to the child's health and happiness in later years. Sexual curiosity is a normal thing for children of this age. Many cultural practices help to create the child's awareness of sex differences: separate toilets, individual sleeping arrangements, etc. The nurse can remind the parents that their own attitudes and behavior will exert more influence upon the child's attitudes than do their explanations. True, facts are important to the child, and there are many things he should learn, but what he sees and feels as a result

of his parents' behavior will predominate in the formation of his attitudes and eventual behavior.

HEALTH NEEDS

The period between the ages of six and twelve is a relatively healthy one. Infectious diseases occur less frequently. Adequate nutrition is as essential as before, and should be supplemented by activity, some of which should be outdoors, and sleep. Good mental health plays as important a role as good physical health. Adequacy of income and home, combined with parental attitudes and interest, influences the manner in which necessary essentials will be provided. Family culture determines practices and food habits, and in these children follow their parents, since eating patterns are established by the parents.

Meal time should be a happy time for the family. The atmosphere should be free from nagging and the practice of good table manners by the parents will afford the child an opportunity to learn socially approved ways which will influence group acceptance of him later. A pleasant atmosphere during meal time promotes mental health for all the family members.

The previously established pattern of regular medical supervision should be continued. The child's vision and hearing should be tested. Poor sight or faulty hearing may influence the child's ability to be part of a group and make him seem peculiar to his schoolmates. The child's environment should be structured with accident prevention in mind. A child of this age is very active and has a limited sense of danger. Accidents, most of them preventable, take a heavy toll of lives in children of this age. Today accidents cause approximately one third of the deaths in the early school age group. This increase has been more marked during the past fifteen years; prior to that time accidents caused only about one fifth of the deaths. The child may survive the accident but be left with a handicap which makes him different and may limit his activities. Education for safe living should be begun by the parents in the home. The child at this age should learn not only about some of the hazards in the environment but also ways of avoiding these hazards. Good health will mean that the child can participate in more group activities and have the feeling that he really belongs to his groups.

REMEDIAL DEFECTS

Correcting remedial defects in children of school age is extremely important. The child is quite conscious of his difference or handicap.

Failure to provide the special help indicated will greatly influence the child's personality development and result in serious complications as he interacts in his social world. He may be teased by members of his group and may develop some deep feelings of inferiority. The nurse is aware of two courses of action, correction of the defect by remedial measures when possible and, when it is not, the advantage of special guidance to assist him in adjusting to his handicap. In either instance the problem should be identified early and immediate steps taken to carry out the best possible plan for solution. Some schools make special provisions for exceptional children; in others it is thought that such children should not be segregated but should begin to adjust to a more normal environment, since it is in such an environment they will have to live and compete when they grow older. Life in a sheltered environment with those of one's own kind will not be possible forever, and adjustment eventually becomes necessary. Teeth can be straightened, crossed eyes respond to surgery, speech defects can be corrected. All these measures improve the child's chances of group acceptance. Available facilities should be utilized on the basis of need and not on the basis of the parents' ability to pay for remedial measures.

HOSPITALIZATION FOR THE OLDER CHILD

When the older child is admitted to the hospital the nurse must secure from him and his parents information that will be helpful in the child's adjustment and reassuring to his parents. How does the child like school? What kind of school does he attend, public or private, and what is his grade in school? How does he get along with children of his own age? If the child works after school, the type of work done may be noted, in addition to his interests and hobbies. It is well to note any nervous habits the child may have. Some mention of his attendance at church or Sunday School and of the religious preference of the parents gives insight into the role of religion in the family and furnishes background information for meeting religious needs while the child is hospitalized. The parents are asked what information the child has had about menstruation, reproduction, and birth.

The older child is better prepared than one younger to understand the necessity for procedures which must be carried out during hospitalization and can accept them as essential for his eventual recovery. Explanation should be provided for each new experience in an attempt to remove fear and apprehension. The hospital personnel and the child's parents must be honest in answering the child's

questions and explaining treatments. If the child can be placed near someone of his own age and sex he can share experiences and time passes more quickly.

Usually there is some type of recreation program in operation in the hospital. This may be a simple one, or a comprehensive one with a full-time staff to promote activities and supply materials. Activities may include games, stories, and handicrafts selected according to the individual child's development and condition. Volunteer workers who are interested and have been instructed in recreation activities are invaluable in meeting children's needs for activity in the hospital. A school teacher may be supplied by the local Board of Education to instruct children who must be hospitalized over a long period of time.

COMMUNITY RESOURCES

Increasing numbers of parents need help in coping with and adjusting to an ever-changing society and the multiplicity of problems encountered in daily living and child rearing. The nurse should be sympathetic to this need and be prepared to suggest sources of help to meet the variety of needs as they occur. There will be diversity in the resources available in any given community but a pattern of similarity does exist. Many of the specific agencies mentioned in earlier chapters have services whose programs are designed to meet parents' needs for this age group. Planned recreational programs, economic assistance, and housing projects are a few of the services that parents may need and utilize. In instances where marital discord may be the basis of difficulty, agencies offering specialized family counseling services may render valuable assistance.

SUMMARY

Each child has his own pattern of growth and development. The child in the early school years has acquired an increasing number of skills and takes responsibility for simple tasks, both for himself and for his family group. He experiences increasing group activity and is learning some of the elementary essentials which are necessary as he performs in an enlarged social world. His awareness of reaction to his behavior helps him to adjust in ways which make him more acceptable in his relationships. He soon learns the gratification of satisfying interaction with family and friends.

School activities consume a large segment of his time and introduce him to many new interactive relationships. New child-adult situations arise as the teacher, nurse, and others become an influential

part of his expanded environment. While the family still retains a predominant role in the every-day life of this age child it is possible to identify influences which result from group participation in the school and other non-family relationships.

The child's feelings about and behavior toward persons with different beliefs and of a different color will reflect family attitudes and feelings. Left to his own resources he would give little consideration to such differences and tend to accept each other child on the merits of his individual attributes.

A healthy attitude toward sex which is based on early explanations and truthful answers to questions should have prepared him to pattern his behavior in an acceptable manner.

When hospitalization becomes necessary he is old enough to understand explanations which acquaint him with methods of treatment and kinds of nursing procedures necessary for his recovery. He may be given an opportunity to make decisions and choices which give him a feeling of importance and accord him status. Unpleasant experiences are easier for him to accept when he has had some voice in deciding the course of action.

The nurse finds working with the child in the early school years very challenging because he is beginning to think, reason, and evaluate.

FOR INVESTIGATION AND DISCUSSION

1. Identify some of the problems which arise when the young child enlarges and increases his group participation.

2. What are some of the cultural influences in the environment which affect the child?

3. What differences in parental attitudes and cultural background can endanger the proper development of children?

4. What techniques can the nurse use to encourage parents to share activities with their children? Why is this important?

5. How can the nurse help the family plan profitable learning experiences for children in the early school years?

6. What is behind a child's sensitivity to a physical handicap?

7. How can the nurse utilize community resources in furthering growth and development?

8. Is it possible for parents with limited economic resources to meet the most essential needs of the child? How?

9. What are some of the major deficiencies in health facilities for adequate services to children?

10. Can you identify the roles that the nurse may occupy, and analyze the effect they have upon the behavior of children in this age group?

11. Observe a group of early school-age children and compare their activities, behavior, and intra-group relationships with those of a preschool group.

12. Does the school system in your community have a plan for sex education in the first years of school? If so, study it and analyze its effectiveness.

13. How can the nurse help the family to foster independence in the child of six or seven years of age?

14. How does the preparation for hospitalization for the child in the six-to-twelve year age group differ from that for the preschool child?

15. What information can the parents give about their sick child which will help the nurse in more adequately meeting this child's needs?

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Chapter 18

NURSING SITUATIONS IN THE TEENS

The period of adolescence is another step in the process of life adjustment toward adult status. The happenings during this period of the individual's development have been predetermined by his previous experiences and, as has been noted, began with the moment of birth and have continued throughout childhood. Chronological age, as such, cannot be used as a criterion for heralding the end of adolescence, since evidence of adolescent behavior frequently exists in the young adult. Considered on an individual basis, each adolescent arrives at this stage of his development through a series of sequential experiences, the result being attained only after certain aspects of the series of events have been lived through. The physical changes of the adolescent are already familiar to the nurse and do not warrant review here.

WHAT IS THE CHILD LIKE IN HIS TEENS?

As is true for all other age groups, if the nurse is to work successfully with adolescents she must have some concept of what this age child is like. The adolescent period has special significance, however, for most student nurses are themselves in this category. The student nurse's position as an adolescent is more complicated, for she has all the problems of this age group and, in addition, those problems inherent in her role as a student nurse. In the former she is considered as an individual who is physically but not emotionally mature, and simultaneously in fulfilling the role of nurse she is expected to think, behave, and function as an adult, employing a mature sense of judgment and intellect. The simultaneous occupation of these two status categories and their resultant roles create many enigmas for the student nurse. Her previous experiences with life have been rather limited, and the business of learning to be a nurse is fraught with many complex and frustrating situations. She soon finds that nursing is not just the acquiring of new skills and knowledge but that the whole environment is filled with people

who have attitudes and set patterns of behavior and that interpersonal relationships run the gamut of possibility from the simple to the intricately complex. Injected into this complex social situation there is the patient, opening up a new horizon of attitudes, behavior patterns, and interpersonal relationships for the student-adolescent.

The adolescent may appear awkward, never knowing quite what to do or what to say. He frequently lacks self-confidence. His degree of self-esteem is markedly diminished by his feelings of inferiority. He is becoming increasingly aware of what society expects of him, how he should behave, how and what he should contribute, and the like. He is in the final stages of his development of self, envisioning himself in his relationship with others, his family members and society. Life experiences have been consistently molding his consciousness of self. He has strong competitive drives and strives for high standards of achievement. He wants to excel, he must prove himself in the eyes of his peer group and of the adults in his environment, his teachers, his parents, his employer, etc. His life becomes a continuous sequence of competing with others.

WHAT ARE SOME OF THE NEEDS OF THE "NORMAL" ADOLESCENT?

First of all, status is very important; he wants to be recognized as an independent individual. He struggles to attain the approval of his groups; each adolescent wants the approval of his own sex and later of the opposite sex. The need for a feeling of belonging is not only very important but very strong. The adolescent needs to be loved; true, the method of expressing affection has changed, but the need is no less powerful. It is necessary for him to feel that he is loved and wanted.

THE ADOLESCENT AND HIS FAMILY

In striving to understand the behavior of the adolescent in his family group relationship, the nurse should be aware of simultaneous drives, one exerted toward and the other away from family, as diagrammatically illustrated in Figure 17. The adolescent seeks independence, but at the same time is quite desirous of maintaining his sense of security within the family constellation. American culture makes transition from adolescence to adulthood extremely difficult, and it is frequently accompanied by a high degree of emotional imbalance. Although he may not heed the advice of his parents, he nevertheless seeks it frequently. He values parental approval of

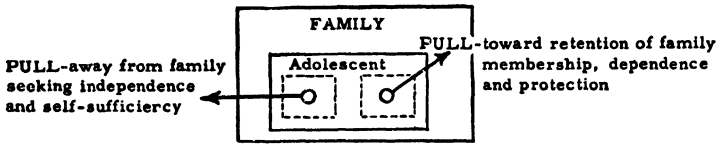


Fig. 17. Opposing drives influencing adolescent in family group relationship.

his behavior and decisions; he needs to feel that his parents have confidence in him.

Intra-family Relationships. It may be necessary for the nurse to analyze the adolescent in terms of his family living experiences. His cultural concepts are quite likely to be identical to those of his family, for it is by way of socialization through participation in family culture that this individual, the adolescent, has become a person. What are the cultural values recognized by his family? Because of group life activities he may be eager and willing to surrender personal desires for family goals. At this stage of maturity he can share cooperatively with other family members in identifying goals and planning action. What pattern of parental discipline influenced his personality development? Are his parents overprotective? Are they reluctant to accord him adult status? The answers will have particular significance to the nurse because of their effect upon her relationships with the adolescent and his family.

Inter-family Relationships. At this age the child develops an increasing sensitivity about the relations of his family to others in the neighborhood and to those in the community as a whole. He begins to compare his family's participation in activities with those of other families and may become quite conscious of their limited number of friends. The class status of his family will have a direct influence upon his social prestige. Chapter 10 has revealed to the nurse why there are class differences in American society. The adolescent may identify certain social disadvantages which stem from his family's economic status, the neighborhood in which they live, and other very evident differences as he compares his family with those of his friends. He may note some interesting differences in marriage patterns, occupational pursuits, material possessions, recreational activities, and educational achievements.

The nurse remembers that the behavior and kinds of problems of children vary greatly in the different social classes. Class status is one measure of social distance, as described in Chapter 10. The important consideration for the nurse is the isolation that results from contrasting folkways rather than spatial distance. Should the adolescent seek to establish a higher social position than that of his

family he is likely to experience frustration and anxiety, proportionately increasing his feeling of insecurity.

GROUPS AND THEIR INFLUENCE

Social groups satisfy an important need of the adolescent and usually come into being as a result of special interests, similarity in age, recreational preferences, and spatial proximity. The adolescent must achieve heterosexual adjustment. Members of each sex want to be attractive, pleasing, and popular to the opposite sex. The adolescent begins to widen his circle of friends and acquaintances, broadens his interests, and constantly seeks new outlets for excessive energy and the ever-present drive for competitiveness. Nursing makes cultivation of friendships with the opposite sex difficult because of living arrangements and restrictions, along with the many abnormal conditions of dormitory facilities in the student's environment. She too is interested in finding a husband, and preparation for her career must compete with this deep desire, which may be of foremost concern.

Group membership acquires new significance and increasing importance to the teen-ager. Being with those of his own age provides opportunity to share problems and experiences which can best be understood by those of one's own kind. Adolescents find real comfort in the knowledge of the similarity of their problems and interests. There is a strong desire to conform to group standards and practices. Dirty, unshined shoes are important because the group wears them. Adoption of unusual manners of dress, hair cuts, etc. enhances the feeling of belonging to the group. Once secure in the feeling of group acceptance, adolescents proceed to gain additional recognition of themselves as individuals.

Gangs Come into Being. Gangs are generally a part of boys' social structure. The nurse needs at least a limited concept of gangs, since in some instances they exert great influence upon adolescent behavior. The expectations of the gang may be in sharp contrast with what parents and society accept as desirable goals and behavior. This conflict is difficult for the young, inexperienced adolescent to resolve. On the one hand he feels honored by membership in the gang, but its standards and roles are not in harmony with demands of society and others. Gangs can be a detrimental influence and frequently result in serious consequences for the individual.

Cliques. The social grouping of individuals in cliques exerts a profound influence upon the behavior of group members, and the

adolescent is frequently involved in this kind of a relationship. Members of the clique are usually accepted as equals and their intimate association typifies primary group relationships. Strong in-group feelings exist in such a social group, with hostility directed toward the out-group. The detrimental effects result because of the exclusion of others from membership, with its resultant frustrations and antagonisms. Cliques are common in the nursing environment.

Youth Organizations. Formal youth organizations vary from one community to another and are too numerous to mention individually. Many are national in scope with local branches in cities and rural areas. However, this type of group activity has a common goal: emphasis upon personal development. The organizations may include health, recreational, and educational activities in their programs. Such organizations serve to promote social activities and provide opportunities for the teen-ager to have fun, make friends, and acquire creative skills. They afford a means for the average adolescent to acquire status which is so important at this period of development. They also permit the adolescent to experience the democratic process in small groups, with participation aimed toward the development of the total personality and a consciousness of home and community responsibility. In play and work activities each has an opportunity to accept and carry responsibility and develop a healthy respect for the diverse opinions of others.

Student Nurse Organizations. Student nurse organizations on local, state, and national levels offer these same opportunities for individual growth and participation. Each school of nursing has some form of student government which is largely responsible for policy-making and group discipline. The policies usually concern dormitory privileges, ethical behavior, disciplinary action, and the like. Thus the students have responsibility for making and carrying out their own rules within the limits set by physical environment, cultural requirements, and social practice. The organization may be composed of students and faculty members or faculty members may be invited only in an ex-officio capacity to give advice and guidance when requested. The organization may be a very simple or a very complex one, but it elects officers, and draws up and administers rules and regulations. Committee activities within the organization may include social and administrative functions.

Minority Groups. Adolescents begin to realize the existence of minority groups within society when they become aware of differential treatment, inequality of facilities available, or of limitations

placed on the use of facilities provided. The first realization may be brought on by observation of unequal opportunities in fields of employment, housing, or education. The nurse should be aware of the physical and cultural differences that occur in religious and ethnic groups but must also realize that recognition of individual worth and contribution should not be influenced by such factors. She should be aware also of the social problems that result from minority group status and strive to promote increasing understanding and acceptance of all individuals. Subordinate status, often a feeling in minority groups, is not conducive to congenial interpersonal or intergroup relationships, so essential to maintenance of good mental health.

SCHOOL AND THE TEEN-AGER

The school as an institution assumes as part of its function the extension of the adolescent's understanding of himself and his complex environment. Functioning as one of the elements in the over-all educative process, the school contributes to the individual's preparation for an active life, attempting to refine the tools for social intercourse. The adolescent's status position in society will correlate to a degree with the amount of schooling he receives, since his earning capacity will be somewhat proportionate to his scholastic attainment. Many statistical tables substantiate this statement. Children in the lower economic groups tend to continue in school for a shorter period of time and as adults usually fill those positions of employment in the unskilled category and at the bottom of the wage scale.

The nurse should be cognizant of some of the factors contributing to the adolescent's failure to continue in school. Frequently his abilities are sufficient to maintain a satisfactory grade average, but financial circumstances at home may force him into early employment to supplement the family income. This same set of circumstances limits the availability of money for his continued school attendance. School environment may be unsatisfying because of his inability to get along with his classmates and teachers. In combination with factors just mentioned, parental attitude frequently exerts a strong influence upon the adolescent. The value placed on education by his parents may be the basis of his attitude that school is a waste of time. The nurse in the role of sympathetic listener may assist in preventing drop-outs.

SEX DEVELOPMENT

Adolescents should possess healthy, wholesome attitudes about sex. They should understand the full significance of their own feelings and, as they develop, should have established acceptable patterns of sex behavior. An awareness of society's expectations should exert marked influence upon attitudes and practices. If parents have guided health development the individual arrives at adolescence without feelings of guilt and is capable of sexual adjustment as designated by the mores of his family group. Accurate information about bodily development, glandular function, and the like lays a sound foundation upon which understanding can be based.

One of the obligations of parents to their children is to give sex guidance throughout the years. The nurse may be called upon to increase the parents' information or work with them in formulating a plan. This continuous approach, if begun early, will prepare the child for the marked changes which occur in the teen-age period of life. Many parents are uncertain about how to proceed. The nurse, with others, may work to improve the parents' attitudes about sex. She may suggest books, pamphlets, and other material which is helpful for parents, giving them information and a proportionate increase in their self-confidence. Study or discussion groups with the nurse as a resource person identify common problems and share experiences in solving them, and through these groups the reticent becomes more confident in talking about sex.

Schools are beginning to offer sex education through some of the subjects in the curriculum. Such classes as personal hygiene, biology, and general science increase students' information and understanding. Regular guest speakers may be utilized to give classes in sex education, conduct panel discussions, and serve as resource specialists in conference groups. The nurse can help both the parents and the adolescent to understand society's attitude toward sex behavior, interpret sexual maturity, and explain such things as the sex urge and the physical changes with the accompanying emotional changes which all teen-agers experience. The adolescent frequently seeks a personal conference with the nurse, during which his individual questions are answered.

DATING AND COURTSHIP

Dating and courtship are two customs which are characteristic of the adolescent period. The patterns of behavior which are expressive of both dating and courtship for American youngsters do not exist

for the same age group in other cultures. Sex attractiveness as the only criterion is ill advised, since it alone cannot insure a lasting, satisfying relationship.

Dating. It is quite a common practice for the teen-ager to begin "steady dating." The adolescent receives a degree of security within the group when there is one individual on whom he can always depend for companionship. Dating furnishes a valuable learning situation for both sexes, since it gives practice in getting along with persons of the opposite sex. Ability to establish and maintain satisfactory heterosexual relationships does much for the adolescent's self-respect and confidence.

Dating is important to the young person's ego and gives him status in his group. If he is not acceptable to members of the opposite sex in his own group, he may have to seek recognition in other groups. The teen-ager who does not date may find himself completely left out of his group and have feelings of embarrassment or antagonism toward his contemporaries. This may be even more acute with the young student nurse who finds herself in a new situation with new friends and acquaintances but no "boy friend" of her own. Fears of being an "old maid" frequently cause young girls to accept dates with boys with whom they have little in common.

Courtship. Courtship as a custom is one of the steps leading eventually to marriage. During this relationship each person tends to evaluate the other in terms of desirability as a mate. Patterns of courtship vary in different cultures. Young nurses frequently seek husbands from the allied professional group of medical students or doctors, feeling it involves a certain prestige and status attainment, but failing to give consideration to the characteristics and habits of the individual.

PREPARING YOUNG PEOPLE TO BE PARENTS

Many teen-agers study marriage and family life as part of the regular school program. Here the future parent begins to see more clearly some of the things which go into a successful marriage and parenthood. Problems are identified and presented by the "case study" method and frequently the sequence of a situation from beginning to end is available for analysis and can be used for discussion to prevent and adjust marital difficulties.

The nurse is frequently asked to serve as a resource person for discussion groups on adolescent problems. The adolescents themselves initiate such discussions. Marriage and home and family life may form the core of these informal group discussions. Students can

be helped to identify the place of the family in a democratic society, bringing to light the many necessary individual contributions basic to successful attainment and satisfying parenthood. What is the student's concept of a socially effective individual-parent? Such a thought-provoking question will divulge much about attitudes toward parental responsibility and individual expectations. The success of his parents' marriage, combined with the childhood experiences of the teen-ager, will have considerable influence upon his establishment of a new family and the success of marriage and parent-child relationships. Probably no other age group is so interested in the "why" of social practices and behavior, and it often falls to the lot of the nurse to supply the information necessary for gaining this insight.

Marriage Counseling. Marriage counseling facilities, available in the community from agencies, churches, etc., are another means that can be utilized to strengthen adolescent ability to assume the role of parent. The inexperienced adolescent very frequently enters the marriage relationship with a limited concept of the responsibilities involved or the adjustment that will be necessary.

Social Hygiene Association. One of the important purposes of this organization is education for family life which fosters sound ideals and practices regarding the role of sex in human life. Public information and education, together with organized community action, provide the means. The public is informed about the need to safeguard family life through laws requiring premarital and prenatal blood tests. The Association provides expert speakers for participation in programs on education for family life and also books, pamphlets, audiovisual aids, and the like, dealing with all aspects of social hygiene, especially sex education.

PREJUDICE

The nurse should be aware of the effects of prejudice, what it does to people who have it, and how to detect it in individuals who possess it. Frequently individuals are denied the fulfillment of their potentials because of prejudice. The nurse herself, as an adolescent, may or may not be aware of prejudice in her own attitudes and behavior. Because of prejudice she may be unwilling to accept other team members, even though they are engaged in providing nursing services. It is highly desirable, as well as essential, for the nurse to make every effort to avoid discrimination against individuals who maintain food habits, religious beliefs, behavior patterns, moral standards, and social customs that differ from her own. The nurse

should never be guilty of differential treatment because of prejudice toward color, economic situations, or social class status.

ATTITUDES TOWARD HEALTH

When it dawns on the teen-ager that good health has some bearing on his physical fitness, his stamina, and his personal attractiveness, he is more willing to exert some effort toward maintaining positive health practices. The same basic essentials of good health, physical and mental, are necessary for the adolescent. Food fads are common, and the girls begin to worry about weight increases. The adolescent may seek information about his growth pattern which may be of particular concern to him when he compares himself with his friends. Regular medical consultation continues to be important.

Safety. Safety should be a serious concern of the teen-ager and others interested in his welfare. A positive approach to decreasing the incidence of accidents might be provided by increasing the adolescent's knowledge about the causes of accidents and ways of eliminating hazards and encouraging individual responsibility for safe living. Thrill-seeking, venturesome youngsters are accident prone. Motor vehicle accidents frequently top the list and usually occur more often among boys. Drowning appears as a leading cause of accidental death, with fires and burns following with a high incidence of occurrence. Health classes, first aid training, and driving instructions are all part of the general community education for safety and usually begin in junior high school. The nurse may give instructions in personal hygiene, home care of the sick, and first aid as part of her contribution to safety. Some information about first aid may serve to prevent fatalities and decrease the severity of injury. Respecting and maintaining good safety habits should be encouraged by the nurse and she should enlist the support of parents and community organizations in promoting safety.

BECOMING AWARE OF PUBLIC OPINION

The adolescent is introduced to a new form of social control: public opinion. As has been stated, "The fear of public opinion which tends to keep a person from violating group standards seems to be the same as the fear that causes him to obey folkways and mores."[1] The opinion of a small segment of the total public may do much to restrain or modify behavior patterns. Public opinion, although not always representative of majority opinion, necessarily

[1] Quinn, J. A., and Repke, A.: *Living in the Social World.* Philadelphia, J. B. Lippincott Company, 1948, p. 224.

becomes an important tool for the nurse in her cooperative efforts with others in attempting to foster better housing, adoption of preventive health practices, and the like. An aroused public, intelligently informed on an issue and in possession of factual data, is frequently in a position to promote the achievement of desirable social goals with prestige, money, and personal effort. In many of the nurse's relationships, she is directly or indirectly formulating public opinion, especially in respect to personal health, medical care, hospitalization, and nursing.

CHILD LABOR LAWS

The nurse should know of some of the requirements with which employers must comply. Both Federal and state laws regulate employment of children. The nurse should familiarize herself with the basic minimum age for employment in the state where she is professionally engaged. She should be prepared to interpret intelligently the benefits of child labor laws. Such laws state the minimum age below which no minor may be employed, regulate maximum daily and weekly hours, and prohibit employment in hazardous occupations. The nurse assists with examination for the employment certificates or work permits which are usually issued in the schools. The child's birth certificate is used to substantiate evidence of age. Employment certificates protect both the child and the employer.

PART-TIME EMPLOYMENT

Teen-agers frequently seek employment, either from necessity or individual desire. Most children have a motivation early to earn money and receive an additional boost to their importance and status by engaging in some form of employment. Work experiences should in no way interfere with continued school attendance, be harmful to the child's health, or introduce him to additional hazards. The variety and number of work opportunities will depend upon the neighborhood in which the child lives and the child's capabilities and skills. If the possibilities are somewhat limited it may be necessary for parents to devise a means for satisfying the child's need to earn money. Work experiences not only broaden the child's environment and increase his contact with people but provide valuable learning situations.

DELINQUENCY

The nurse should recognize that the majority of delinquents are unhappy, insecure children. Delinquent behavior as such is not too

important to her. She should be more interested in the underlying causes of the deviation. She has a two-fold interest in delinquency: one as a citizen, the other as a professional person who, in certain instances, must provide nursing for the delinquent or his family. As a citizen she will be concerned with the causative agents which produce delinquency. These will be found in the home, school, neighborhood, and community. As has been stated earlier, the kind of primary group relationships the child has will be perhaps the greatest determining factor in whether he becomes a well adjusted adolescent or a delinquent. In the nurse-delinquent situation the nurse observes that the delinquent has limited confidence in her or the medical personnel; he tends to doubt the value of treatment and the truth of explanations, and seems skeptical of sincerity. He frequently tries to express nonchalance regarding the seriousness of his condition, medically and socially, and often denies parental interest in him and his activities.

The nurse may first become aware of the child's serious behavior problem and social maladjustment when he becomes truant from school. Staying away from school is one means the delinquent employs to avoid unpleasant situations. The nurse in the school will be asked to determine if absence from school is because of illness. A home visit may reveal the true circumstances, parental attitudes, and other factors. The nurse shares her information about the home situation with school personnel. The nurse should cooperate with the teachers and others in attempting to make the child's experiences satisfying and give him the feeling that he belongs to the group—the school group, recreational groups, and the like. The nurse may work with the family in an effort to improve the child's status in the home and seek to assure him of the feeling that he is wanted and that his parents have a real interest in his welfare. Effort directed toward improving home environment and making school experience and group associations more satisfying will progress gradually toward accomplishment. The delinquent child not only is a problem to his parents, other adults, and society in general, but he is unable to understand himself.

The nurse should possess an awareness of the factors that can be used to predict the occurrence of delinquency. In many situations the mother must work to keep the home together, has little time to spend with her children, and is unable to provide guidance and supervision for their activities. It would be well to remember that not all delinquents come from the lower economic groups of society.

even though these are the ones most frequently involved with juvenile authorities.

The nurse should be familiar with local community programs designed to prevent delinquency and to cope with it when it occurs, and she must have some concept of the extent of the problem. At the moment there seems to be a marked increase in frequency of occurrence and severity of the offenses. Many of the parents of delinquent children need help, and the nurse is in a position to refer them to available facilities from which they can receive guidance or to interpret the worth of institutional services for temporary custodial care of the delinquent.

CHOOSING A CAREER

By the time the child reaches the late teens he must give some thoughtful consideration to choosing a career. He may begin preparation for his choice while still in high school. His social class status, the economic circumstances of his family, as well as his own likes and dislikes, will influence his choice. Perhaps he is not very good in mathematics, or cannot do well in abstract thinking, all such strengths and weaknesses should be carefully evaluated as he attempts to make his choice of a career. If he knows that college is out of the picture, he may choose vocational training that will prepare him to do a job without expenditure of additional time or money. Vocational counseling is available in the majority of high schools. Counselors have access to the student's record and can familiarize the student with the possibilities for which he may be especially adapted and even introduce some possibilities which were unknown.

The student nurse, if she is to enter a collegiate program, must plan courses throughout high school to meet entrance requirements and must have financial resources sufficient to care for her needs through four years at school. In health, intelligence, emotional maturity, group relations, etc., she will have to be above average in order to meet requirements for admission and to progress satisfactorily in her learning experiences.

Each individual must determine where he is in relation to where he hopes to go in pursuit of a career. All the necessities in bridging this gap need evaluation, since success is dependent on a great many factors. The social position of his family may be a determinant in his choice of a career. Family pressure may be exerted, and as a result the teen-ager may embark on a career not particularly to his

own liking. This factor alone may ultimately mean the difference between success and failure. Some high school youngsters feel especially well equipped to do certain things and plan quite adequately to meet the requirements for their chosen careers. Racial and cultural groups may be barred from some occupations or professions. Only recently have many schools of nursing accepted students on merit, irrespective of color or race.

THE TEEN-AGER BECOMES AWARE OF FACTORS THAT LIMIT SOCIAL MOBILITY

By this time of life the young boy or girl is aware of his family standing in the community. Each knows the importance of economic factors in attaining or maintaining social status for the family. In a large number of instances the child will fall into groups of his own kind, occupational, recreational, and the like. These groups provide some security, and moving up in the social strata of society becomes increasingly difficult under ordinary circumstances. If the parents are middle class, the children grow up and pursue middle-class manners, occupations, acquire the usual material aspects consistent with middle-class culture, and marry and continue in the same groups as those of their parents.

Some youngsters will express a desire to be millionaires and, of course, some may attain such heights. School attainment usually correlates with the individual's role in society, his contributions and achievements. The nurse should remember that the movement of individuals from one social group to another is an uncommon phenomenon. It is difficult for one to change social status in any marked degree. Generally speaking, the nurse should expect individuals to function in society at the same status level as the parents did.

CULTURE AND THE TEEN-AGER

Through the years of growth and development many factors have given the teen-ager opportunities to assimilate his cultural heritage. His behavior will be indicative of the degree of assimilation. This whole process of culture assimilation places the teen-ager in a niche in the social structure of society and from here he functions with varying degrees of satisfaction and frustration. An individual's cultural assimilation will determine how he functions and uses his environment to satisfy his needs. Because of cultural change, the pattern of behavior and utilization of resources will not be identical to the parental pattern, but many similarities will exist. The teen-

ager's social life and his roles will emerge and be influenced by culture.

SUMMARY

The period of adolescence brings the nurse into a relationship with individuals who have advanced well along in growth and development toward adulthood. Awareness and appreciation of the needs of the normal adolescent help the nurse structure her relationships with this age group. One of her functions is to contribute in any way she can to help children grow up to become well adjusted mature citizens capable of successful living in a dynamic society. She has many opportunities in various nursing situations to offer guidance as the teen-ager begins to learn his potentialities. The nurse recognizes his strong desire for status of independence, and sees his need to become established and participate as an accepted member in groups. Group interaction is extremely important and provides experiences which help the adolescent become a social being. The nurse should provide any assistance she can to the adolescent in his quest for group affiliations from which he can secure pleasant and profitable associations.

The adolescent is beginning to learn things about his relationship with others and is developing ability to perceive the significance of relationships. Awareness of the effect of his actions on others initiates changes in his behavior which tend to make his conduct more acceptable to others and more gratifying to him.

This period is not without conflict. His need for security within his family group remains strong. Adolescence is a period of moral conflicts. Background experiences and family relationships can be sources of strength in effecting wise decisions. The nurse can contribute to family understanding of adolescent needs and attempt to improve understanding of adolescent behavior since it is so important for each adolescent to feel his parents have confidence in him. Attainment of status is a constant struggle. Strong group affiliations influence behavior and tend to direct interests. Interests broaden to include occupational opportunities, economics, choosing a career, selecting a mate, marriage, and even the establishment of a home.

Study of the community will give the nurse some insight into the special problems of the adolescent in a given area. Delinquency rates will indicate the areas of highest incidence. The school environment gives the nurse opportunity for personal contact and observation in the classroom and other group activities. Familiarity with

the home and family situation enables the nurse to give more effective guidance to the adolescent, the teacher, and others who may be interested. Her role of coordinator between home and school is an important one.

FOR INVESTIGATION AND DISCUSSION

1. Can you explain why the influence of culture varies with different individuals and at different times in the life of the same person?

2. Why does the social environment become such an important determinant in aspects of behavior?

3. How can the nurse cooperate with others in creating and maintaining an environment which promotes mutual respect?

4. How can you explain adolescence as a period of dissatisfaction with things as they are?

5. How can you help youth understand the main elements of American culture?

6. How can social groups so important in meeting a real need of the adolescent be a constructive influence?

7. How can the nurse utilize listening to strengthen her rapport with the adolescent?

8. What are some of the social hazards which may confront the adolescent in a family of low economic status?

9. Should the "teen-ager" begin to evaluate his behavior in terms of effectiveness? Why?

10. How does prejudice interfere with the nurse's relationships?

11. Explain the role of youth organizations and examine their effectiveness in coping with problems of youth. What youth organizations in your community seem to be most effective?

12. What kinds of student organization are in effect in the schools of nursing in your community? What are their purposes? Do you feel that the organizations are fulfilling their purposes?

13. Examine current newspapers and analyze reports of juvenile delinquency in relation to: numbers, age of offenders, causes of behavior, social strata involved, recommended discipline.

14. Visit Juvenile Court and compare types and offenses of defendants with national statistics.

15. Compare the child labor regulations in your state with the national requirements.

16. Secure a brochure from the local Social Hygiene Association and evaluate the program outlined in accordance with community needs. Do nurses participate in the program?

17. Compare the accident statistics for teen-agers in your community with those of the United States as a whole.

18. Is there a Safety Council in your community? If so, what are its objectives and functions? What part does nursing play in the local organization?

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Chapter 19

NURSING SITUATIONS AND THE YOUNG ADULT

Faced with adult responsibilities at this period in their lives, both men and women must make some plan for earning a living. There will be those at the age of twenty years who plan to continue in college. Some will be planning for marriage, while others will already be married and perhaps have one or more children. Still others will be entering the career of their choice. But for all there will be the necessity for adjustments in interpersonal relations, to the opposite sex, to the competition of the employment world, and personal adjustment to a new status, that of an adult. Freedom means responsibility, and this may mean increasing assumption of this responsibility in a variety of new fields, such as community, home, and career.

Adjustments should provide sufficient satisfactions for each individual to continue in the life cycle toward eventual old age. Satisfying adjustments throughout the years make it possible to approach and accept each new phase of life with grace and contentment. Life is an on-going process with many changes, each requiring an adjustment of some sort.

POPULATION CHANGES AND SATISFACTION OF NEEDS

The nurse will be aware of current trends manifested in a diminishing rural population and a growing urban population. She realizes that the alteration in population distribution creates a society characterized by interdependence of family and groups. This contrasts sharply with the earlier pattern in which the family could meet most of its needs without outside assistance or cooperation. All members of society today are dependent upon others for gratification of basic needs and provision of vital resources. All

persons are confronted with the problems of living and must recognize the interdependence necessary for a satisfying life.

For this young adult group the nurse will consider health in terms of people as personalities and as families. She is fully aware of the effect of environment and recognizes that at no time in an individual's existence will environmental factors remain static. The human body is in a continual process of change, and the same is true of the external world.

Nurse–young adult situations provide opportunity for group activities. The nurse may be participating with lay groups whose interest centers around studying problems. An invaluable asset for the nurse will be an ability to work with people as individuals. Her command of scientific information and technical skill will not assure successful performance or satisfying human relationships if she cannot work with people. In the nurse's contacts with young adults she will encourage each to identify purposes and analyze objectives and will give guidance when needed for successful attainment of these ends. In situations where she functions professionally and as a citizen it will be helpful for her to recall that the childhood experiences of the young adult will be the greatest determining factors in how well each functions in making a living, in human relationships, in adjustments, and in career or family life.

SOCIETY'S BENEFITS

Earlier discussion has contributed to the nurse's understanding of society. In order to work constructively with the functioning groups which comprise society the nurse will find it helpful to analyze the expectations which society has for the young adult. Important, too, is what the young adult expects from society in terms of relationships and processes. Up to this time the individual has been primarily a "receiver." But for the young adult the role must encompass another important facet, that of being a "giver." For many there will be a correlation between "giving" and "receiving." Much of the young adult's energy can now be expended in pursuit of creative interests and enterprises which primarily benefit others.

As the youth matures, society's aims and community goals occupy an increasing amount of time and energy. Less and less interest centers around the self, and more and more concern is evidenced for group benefits and environmental improvement. Society benefits immeasurably from the productive and creative talents of young adults.

PERSONAL SATISFACTION FROM LIFE

If society is to realize the maximum benefit from the young adult group, ways must be devised to insure personal satisfaction in life processes and relationships. What does the young adult have a right to expect? He is beginning to discover that his duties and responsibilities are as important as his privileges and rights. The number and complexity of his relationships demand increasing self-reliance. Rapidly changing conditions impel repeated adjustments and this process continues throughout life. It will be comforting as well as useful if the nurse remembers that relationships, attitudes, and values do change. In working with individuals and in understanding herself the nurse will remember, too, that the individual's conception of life is closely related to that of his fellows.

If he is to receive personal satisfaction from life and fulfill his new role as a "giver," W. I. Thomas' four wishes* are just as essential for the young adult as they are for other age groups. Every young adult needs security, he must have recognition and response, and there must be opportunities for new experiences. These expectations are not unreasonable for the young adult, since each needs to feel that he is an integral part of the aggregate—society. Life must be meaningful if personal satisfaction is to be insured.

POSITION IN THE SOCIAL STRUCTURE

In each culture one finds that patterned variations in social structures are determined by class, economic status, and regional and local forces, to mention only a few. Each individual reaching the age of twenty has attained adult status, whether he wishes to accept it or not and regardless of his ability to function in an adult capacity. Each young adult must find his place in the community and assume a variety of roles: citizen, worker, and family member. Some understanding of the meaning of community life will be necessary.

The nurse needs an awareness of the factors which normally separate people into groups within the social structure of a community. Inherent in such a structure are definite status positions. Income and occupation, home conditions, standards of living, club membership, and church affiliations serve to determine categories, affect class standing, and assign status significance. Social group

* "The record also shows that W. I. Thomas, the sociologist, was not far wrong when he wrote of the 'four wishes' of mankind a generation ago. Every individual, he said, needed from his group four things: response, security, recognition, and new experience." Chase, Stuart: *The Proper Study of Mankind*. New York, Harper & Brothers, 1948, p. 84.

activities and community participation seem to be patterned in direct relationship to the young adult's position in the social structure.

PERSONALITY

The emphasis placed upon the importance of personality cannot be too great. It has already been indicated that individually personalities are unique. The nurse may need to help the young adult evaluate learning experiences as a first step in helping him understand himself and the significance of his behavior patterns. The young adult with a personality easily adapted to change is indeed fortunate. Each stage of life brings different responsibilities and provides a variety of opportunities. Good mental health depends upon the young adult's ability to continue growing, developing, and maturing, a process which should continue throughout life. The mature young adult will have a self-confident attitude and will be able to take himself and his capacities for granted. The success of interpersonal relationships is dependent on this process.

> The new personality develops continuously through the incessant interaction between individuals and environment. Because an individual continues to interact with his environment as long as he lives, there is always the possibility of bringing about changes in personality.[1]

In understanding why the young adult behaves as he does the nurse attempts to gain insight into his past life, the childhood experiences and the cultural patterns which have shaped modes of behavior, for as the child behaved then so the adult behaves now. If the nurse understands the meaning of emotional maturity she has the tool for understanding herself and working successfully with people in individual situations, in the family, and in the community. The mature individual can face facts concerning himself and the outside world. His behavior is flexible so that he adjusts his efforts and desires to these facts. He also adapts his needs to the changes in his environment and to the changes within himself which occur in the natural process of growth and decline of aging.

YEARS OF SCHOOL COMPLETED

The nurse in orienting herself to the young adult should utilize available statistical data to ascertain the median number of years of school completed by this age group. A look at statistics will show her that in large urban areas the median years of school completed

[1] Federal Security Agency, *Boys and Girls Study Homemaking and Family Living.* Washington 25, D.C., Superintendent of Documents, U. S. Government Printing Office, p. 46.

by both males and females tend to be somewhat higher than for small incorporated and rural areas. In the urban areas a rough estimate of the median years completed would range from 9.5 to 11.7 years, with very little difference between the sexes, the males completing almost as many years of school as the females. In rural areas, however, the range is lower, with 10.4 the highest median years completed and 8.2 the lowest. On the average, females tend to complete one more grade than males. If the nurse is to begin on the level of the individual's ability and comprehension such information will be necessary, particularly since it should help her to recognize limitations and should indicate what she may expect. The learning that results from her teaching will be partially determined by the usability of such teaching. Teaching which is not individually adapted will have only limited effect on behavior patterns and health practices.

COLLEGE EDUCATION

The social and economic status of the family along with their accepted values will determine whether or not a college education is to be attempted. Some young adults will not possess the capabilities for further education. Those who possess the ability but lack finances sufficient for additional years in school either may seek employment or work their way through school. Some have the advantage of scholarships. The percentage of this segment of the population who go to college is increasing but remains very low in some groups in particular areas.

The creation of the G.I. Bill for those young men and women who served in the armed forces was a means of providing a college education for a greater number of persons who otherwise might not have had such advantages. The cooperative opportunities afforded by an increasing number of colleges, largely in engineering, have made a college education possible for a large number. In many instances the choice of a career will determine the need for higher education, as in medicine, nursing, and teaching.

EMPLOYMENT

Few young adults are so situated as not to have to work for a living. When they enter the field of employment they become increasingly aware of the impact of industrialization on American society. They realize the full meaning of interdependence in satisfying human needs.

The kind of a job the young adult finds will be influenced by his

ability, his preparation, and the availability of jobs. If the young adult is poorly prepared he is quite likely to receive the less desirable kinds of work with associated factors equally undesirable. Parents' choice for this worker may be influential and not always for his best interests. A wise choice would be the selection of a job in which he could make effective use of his abilities.

The community in which the young adult begins his full-time occupational participation will greatly influence job opportunities. This is true of nursing also; for example, the nurse with special preparation and/or experience in industrial nursing would find opportunities for this kind of work very limited in some rural areas.

The motivating factors for the young adult are a secure income and a kind of work from which he can receive satisfaction. Because of youth and inexperience little thought may be given to tenure, but this is an important factor in security. The young adult may find it helpful to consult with local job placement agencies, as such agencies are familiar with job possibilities and minimum requirements for employee placement.

Two new types of experience are encountered by the young adult: occupational orientation and occupational adjustment. In orientation he learns his position in the company, his relation to others, standards of workmanship required, rights and privileges, and responsibilities. Some requirements may mean changes in his behavior patterns, his outlook, etc. Occupational adjustment may mean a change in his daily activities, his concept of values, and the establishment of a satisfactory relationship to afford harmony in his personal and family life.

Union membership may bring new group experiences. In many instances the union may be considered a conflict group and the individual may or may not subscribe to all union practices but frequently he is forced, because of group pressure, to accede to union demands. Some individuals feel that membership improves their status and increases their economic security. The worker views the power of the union as a force for accomplishment quite beyond that possible by individual effort. Many improvements in working conditions have been the outgrowth of union action.

In nursing there are mixed feelings about the merits of union membership and a strong feeling that such activity is not consistent with professional ethics. However, in some areas of the country collective bargaining has been popular and has resulted in shorter hours, improved working conditions, and increased salaries for nurses.

CAREER

In the late adolescent period many individuals will have tentatively chosen a career. The choice will influence the course of the person's life. Usually one thinks of a career as some pursuit which demands special preparation and something that is to be undertaken as a life work. Factors influencing an individual's choice may be socioeconomic, status, race, color, intellectual ability, or family pressure.

HEALTHFUL LIVING

The attitudes of young adults about health will be similar to those of their families. They are acquainted with health needs and become increasingly aware of the environmental factors which are so important in determining over-all health status in the community. The nurse can frequently familiarize young adults with community health problems and indicate possible courses of action for improvement. The nurse is conscious of the effect of social problems on health; she realizes that emotional happiness and satisfactory adjustment in social relations remain important for the young adult group. Many in this group are planning for children of their own and are willing to contribute to programs for improving community health practices from which they can directly benefit. A cooperative enterprise with the nurse and the doctor working closely with other professional groups to achieve improved health status for all is a desirable goal. The trend seems to indicate that people are becoming more concerned about their health and more willing to spend time and money to achieve and maintain good health.

MARRIAGE

One of the most pressing problems for many young adults is marriage. In the past twenty years nursing has progressed from the extreme of not permitting marriage in the student group to allowing it, although many schools do so only during the last part of the educational period. Older students are even permitted to live outside the nurses' residence. Getting married is only part of the aspect of the problem. A happy married life, built on a foundation that will insure permanence, is also essential. All too frequently young adults are so absorbed with the romantic aspects of the relationship that they fail to consider the more fundamental aspects necessary to successful marriage. Impulsive behavior often leads to disappointment and failure, with the marriage terminating in divorce and unhappiness for both persons involved.

INCEPTION OF FAMILY

With marriage as a prelude the young adults will share a new responsibility in the social institution of family. The nurse is aware of the many changes that have taken place in the American family throughout the years. Cultural heritage has no doubt acquainted her with some of the changes in her immediate family group. When she contrasts her family life with that of her parents or grandparents, the changes become more vivid. Contemporary American family structure should be understood by the nurse, particularly in relation to the role of the husband-father. The wife-mother status has heightened, with a proportionate decline in the status of the husband-father. Geoffrey Gorer says:

> The fact that the American mother has arrogated to herself, or has had thrust upon her, the dominant role in the rearing of her children—a role which is held by the father, or shared by both parents, in most other societies—has far-reaching results on the character of the children; and, since this situation is not a novel one, on the character of the adults also.[2]

Some family groups exhibit a closeness that is not evident in others. In those families characterized by a close relationship, one member to another, the affinity will have a direct bearing on the attitudes and behavior of each other person. This is extremely significant to the nurse in illness and disease situations.

Each young adult enters the relationship of marriage with a pattern of behavior and accompanying attitudes developed in the preceding life span. Because of this, adjustment is difficult. The ease and success with which differences are reconciled will be influenced by background experiences, but harmony in this new relationship is paramount. In some instances it will mean acquiescence, redefinition of values, acceptance of new interests, etc. New friendship groups come into being and replace or substitute for earlier relationships with old friends. The nurse may find it helpful to take into consideration some of the early factors which have contributed to the present behavior of the young adult, since her relationship will be so markedly influenced by early life experiences.

Each one of the young adults will contribute to the cultural content of the newly formed family. Each will bring symbolic elements of culture, religious beliefs, a philosophy of living, values, behavior patterns, habits, attitudes, and sentiments. It is hoped that each will have acquired sufficient knowledge and appreciation to enable him to establish satisfying family living. Each nurse has many opportuni-

[2] Gorer, Geoffrey: *The American People.* New York, W. W. Norton & Company, Inc., 1948, p. 55.

ties to encourage individual citizens and the community as a whole to cooperate in constructive planning for improving conditions for family living.

CULTURAL CONFLICTS IN MARRIAGE AND FAMILY LIFE

Husband and wife assume their roles within the institution of family. Their cultural backgrounds have not been identical even though, in some instances, they are from the same neighborhood and have shared activities of the same groups. This means differences not only related to their backgrounds but in social roles, in understanding and knowledge, appreciation, etc., with each possessing a rather unique pattern of behavior. The nurse needs to understand how habits of behavior formed earlier affect marriage relationships and family life.

Through cultural conditioning each partner has formulated a set of values. It is occasionally difficult for the nurse to understand priorities assigned by the husband and wife, particularly when other needs seem so much more urgent to her. She soon learns that motivation is in terms of values. She will find a frame of reference helpful since it will embody the couple's definition of their situation, their concept of personal, social, and family roles in various situations, and the way in which they choose to share their ideas and express their attitudes. Conflict frequently arises because of differences in values. Both husband and wife may concede to a similarity in values but attach different meaning to the same value. In such instances it is not the value itself that is significant but the meaning which becomes the basis of difference. Since cultural conditioning has defined the meaning, difficult problems may be posed.

Closely allied with both values and meaning will be the culturally conditioned mode of livelihood and the subsequent use of income for satisfying needs. If the wife has worked, earned her own money, and spent it as she saw fit for the things she wanted even though some were not essential, she may find it difficult to provide necessities for two or more people on an amount of money frequently less than what she had to spend on herself. A similar situation may exist where marriage occurs between two individuals from different socioeconomic groups, widely separated in earning ability and in definition of values. Open conflict may be avoided during the early part of married life, but when the "honeymoon" is over and return to reality becomes inevitable, adjustments must be made by each person.

AGE AND STATUS IN THE COMMUNITY

Family harmony and individual happiness may be influenced by the age of the individuals who marry. A general statement cannot be made but indications are that those persons near the same age have advantages which speed up and aid adjustment.

Conflict may arise as a result of a desire for improvement in social status in the community. Discussion of the many factors, such as income, education, and the like, involved in the attainment of such a goal is not important here, the intent being only to identify for the nurse some bases for conflict.

A number of factors combine to affect the success of marriage. Such forces as mutual respect and admiration, understanding and tolerance, emotional maturity, common feelings about children, and common interests and religious beliefs are essential to assure permanence and continued growth in this kind of a relationship. If the nurse understands the factors which predispose to conflicts, she can do much through guidance to strengthen husband-wife relationships.

MANIFESTATIONS OF PERSONAL DISORGANIZATION

It will be helpful for the nurse to have some understanding of the origin and consequences of socially unacceptable patterns of behavior. Some individuals dislike conformity, while others lack ability to comply with patterns characteristic of society. In most instances personal disorganization arises as a result of conflict between the individual's own attitudes and behavior and group values. Two types of manifestations may result. The struggle may take place within the individual and result in critical personality changes, or emotional disturbances may lead to mental illness or suicide. If the individual's opinions, interests, etc. are divergent or clash with the social values of his groups, then manifestations of anti-social behavior in the form of prostitution and crime occur. In either instance incompatible desires, aims, and the like cause mental or moral strife. Further examination of some of the specific categories of personal disorganization will serve to broaden the nurse's understanding of social illnesses. Psychiatric nursing will provide the nurse with further information about personal disorganization.

SOCIAL ILLNESSES

The nurse can identify many similarities in the predisposing factors present in persons who seek to escape from the trials and tribulations of reality and the stress of daily life by indulging in drug

addiction, alcoholism, and prostitution. Inclusion of this material in the section on the young adult is not meant to imply that this problem is unique to this age group. It may be necessary for the nurse to consider some of these social illnesses when she works with younger or older age groups. The important fact is for the nurse to be aware of their causes and implications, regardless of the age group in which she encounters the problems. Social maladjustment is a common denominator for each person who succumbs to such deviant types of behavior. Disappointment, frustration, and anxiety are frequently outstanding characteristics which cause individuals to alter their patterns of behavior.

The nurse is interested in the conditions which led to these types of social illness and her contribution in the care of such individuals will be advanced by indications of why the individual felt rejected by his groups and society. For one, loss of prestige through business or marital failure causes the frustration. For another, the background of a broken home with a lifetime of unsatisfactory interpersonal relationships, the absence of any one who really cared for him, and repeated failure in group adjustments comprise the picture that has prevailed. The nurse must have some understanding of the profound influence of these socially unacceptable patterns of behavior on individual and community life.

Drug Addiction. It is estimated that there are about 50,000 narcotic addicts.[3] Some individuals become dependent upon drugs during periods of hospitalization or illness. The nurse is aware of the possibility and cooperates with others in attempting to avoid its occurrence. In many instances, however, a habitual user of drugs will induce others to accept the practice. It is important to note that, in general, those persons who use narcotics have extensive emotional problems which are neither easy to remove nor easy to live with.

Occasionally nurses and doctors become addicted to drugs, but for either there exist social and emotional conflicts which predispose to such acceptance as a method of escape. Some believe that the easy access to narcotics may be the main reason for addiction, but for the majority who can cope with reality in a relatively satisfying way the use of drugs has no appeal. Psychotherapy should be employed in an effort to relieve the emotional conflicts and return the individual to a happy, productive life.

[3] Dysinger, Robert H.: "Mental Health in the United States." *The Annals of the American Academy of Political and Social Science*, Vol. 286, p. 57, March, 1953.

SPECIAL FACILITY. The United States Public Health Service was authorized in 1929 to establish a Narcotics Division to conduct research on drug addiction and operate a hospital for the care of narcotic drug addicts.[4] The Mental Hygiene Division of the United States Public Health Service directs two hospitals for the care and treatment of narcotic drug addicts: one in Lexington, Kentucky, and the other in Fort Worth, Texas. This Division not only conducts research on drug addiction but offers consultation services.

Alcoholism. Although the problem of alcoholism is not exclusively limited to this age group, it seems well to mention it here. The problem is becoming an increasing public responsibility. It is estimated that there are almost 4,000,000 "problem drinkers" in the United States at any time. Of this number about 950,000 are people with severe alcoholism.[5] Many of the necessary facilities to cope with the problem are provided at public expense. Financial assistance to families of habitual drinkers and the increased number of automobile accidents due to drinking are just two examples of the cost to society of alcoholism.

The nurse, in her many contacts in the community, can contribute to the education of the public. She should be familiar with the facilities in the community that offer consultation service for the problem drinkers and their families. Early referral can frequently prevent disastrous results.

The nurse sees many instances in which uncontrolled drinking has a ruinous effect on an individual's life. In America, social drinking is an acceptable part of the culture of many groups. Excessive drinking becomes significant when it interferes with one's productivity or ability to live congenially with others. A mother who drinks excessively may neglect the care of her children. If the father is the problem drinker, his frequent absenteeism and the cost of the liquor will influence his ability to provide adequately for his family. Problem drinkers often become patients in the hospital, either because their excessive drinking has predisposed to accident or injury or because of an illness which is directly related to long-term drinking. The nurse should recognize excessive use of alcohol as a symptom of illness and not as an illness in itself.

Problem drinking is another means employed by individuals to escape responsibility and avoid the requirements of society. In her effort to understand each person the nurse must analyze and study

[4] *Ibid.*, p. 103.
[5] *Ibid.*, p. 57.

the individual's needs, because identical precipitating circumstances will not be found in any two situations. For some, the environmental situation may be the reason for which they seek escape by drinking. Others seek escape because of personal reasons. Some begin drinking because of despondency over illness and inability to continue on the job, or marital difficulties may lead to drinking. Deep feelings of inferiority, physical or social in origin, can be precipitating factors. Unsuccessful business ventures can initiate the recourse to alcohol. For many, drinking begins because of loneliness and dissatisfaction with a dull monotonous life. Since the nurse recognizes alcoholism as a symptom, a form of compensatory behavior, she will look for some serious personality problem.

Treatment will have limited effectiveness if predisposing factors cannot be changed or relieved. Rehabilitation of the problem drinker is slow indeed, and unless the individual involved really wants to stop drinking he soon falls back into his old behavior patterns and again seeks refuge in alcohol.

ALCOHOLICS ANONYMOUS. This voluntary group of people has, in many instances, worked very successfully with the problem drinker. Prerequisite to offering help, however, it is necessary to determine the needs of each individual who seeks assistance. Such groups frequently satisfy the need for close human contact, and within the group the problem drinker can find understanding, and someone who cares, and his affiliation provides an outlet for his behavior. The person who is in need of help for an alcoholic problem finds that Alcoholics Anonymous provides an atmosphere of informal fellowship with persons from many different ways of life and from many religious faiths. For each member alcohol has caused much trouble and unhappiness, and each is eager to pass on to others the help which he has received as a member of the Alcoholics Anonymous group.

Prostitution. Prostitution is one type of behavior which contrasts sharply with ordinary behavior. Such behavior does not have the sanction of American culture. The nurse is aware of standards of acceptable behavior and should avoid any assessment of values to such deviant behavior. Prostitution as a means of increasing the incidence of venereal disease is a concern not to be taken lightly in community health planning. Perhaps the most important factor for the nurse to remember is that prostitution usually occurs for the purpose of obtaining certain cultural necessities, such as money, prestige, or the like, and not primarily for satisfaction of the sex urge.

Suicide. About 17,000 suicides occur among the total popula-

tion each year and an incalculably greater number of persons attempt self-destruction.[6] The nurse has many occasions to be in a situation with a person who has attempted to take his own life. Many attempts prove unsuccessful, and the mere escape from death with subsequent return to living in reality is not sufficient to prevent further attempts at suicide. The unsuccessful victim needs psychiatric consultation and help. Such services may prevent subsequent attempts.

In general, there are multiple causes for suicide. Frequently a person who attempts suicide is very lonely, feels insecure, or suffers from prolonged illness or disability. The nurse must be aware of the social and environmental factors which may give rise to suicide. Suicide seems to occur more frequently in urban than in rural areas. The incidence is found to be higher in those community areas which are typified by disorganization.

In nursing situations involving individuals and families where any of the social illnesses are present, the nurse functions with caution. Close cooperation with the other professional persons assisting in the solution of the problem is advisable. The nurse quite frequently discovers the problem and should attempt to get the individual and/or his family to the most appropriate facility offered by the community. Such facilities may offer diagnosis, consultation, treatment, and social case work. Perhaps one of the most disturbing consequences encountered by the nurse is the privation and suffering which results from social illnesses. Correction of such conditions is a long, slow process. The nurse will attempt to help families use their own resources and strengths so they can again function effectively and comfortably within the framework of society.

SUMMARY

Presumably the accumulated experiences of the early years have prepared the young adult for new roles and increasing responsibilities. The nursing situations may be frequent or infrequent, depending upon the individual situation. The employed adult may be seen by the nurse in his occupational environment. The nurse may visit the home of the young adult, or may see him when she visits in the home of his family. The college environment may include the nurse. Group activities provide opportunity for many nurse–young adult situations.

The young adult accepts life as an on-going process and cherishes his independence of action and thought. He has opportunity to show initiative and takes pride in making plans and carrying them out.

[6] *Ibid.*, p. 57.

Success is a strong motivating factor and mistakes can be profitable learning experiences.

This period is especially significant to some nurses, for they are a part of this age group and it is important for them to know what society expects of the young adult. The nurse becomes aware of some of her own traits and discovers what to expect of young adults in nursing situations. The change from the "receiver" role to that of "giver" is instrumental in patterning behavior and group affiliations. The significance of status should not be forgotten. Personality continues to develop and remains important in group relationships and personal stability. It is well for the nurse to be aware of educational attainment and the intellectual ability of the young adult. Her relationships in nursing situations should be patterned accordingly.

Understanding the factors which motivate young adults strengthens the position of the nurse and gives her some sense of confidence as she attempts to give guidance. Awareness of the characteristics of the community will prepare her to understand some of its assets and recognize the problems which the young adult is likely to encounter. Conflicts which might arise are familiar to her.

The nurse is obligated to contribute in any way she can to strengthening husband-wife relationships for it is in her work with the young adults that she impresses them with the importance of future family life and stability.

Social illnesses like drug addiction, alcoholism, prostitution, and suicide are ways of escaping reality and responsibility. The nurse must recognize these as symptoms and attempt in every way to secure the correct type of help for the individual and his family. The nurse must function in an understanding, objective, tolerant manner so that she may use the tools at her command most effectively.

FOR INVESTIGATION AND DISCUSSION

1. Should the young adult have some understanding of contemporary society? Why?

2. What can the nurse contribute to improvement of understanding of family relationships?

3. How does the young adult contribute to social improvement?

4. What are some of the differences in opportunity which result from variations in social and economic status?

5. Does the nurse have a responsibility to encourage an individual to seek an occupation suited to his abilities and which provides opportunity for personal growth and social usefulness? How does she do this?

6. How can the nurse assist the young adult in making sound judgments?

7. How does the nurse recognize indications of social maladjustment?

8. Can you indicate how folkways enforce sanctions on your behavior? Was this influence good or bad?

9. What tools do you have available for determining family attributes?

10. How does the technic of interview help the nurse evaluate the relationship between husband and wife?

11. How is the social status of individuals determined?

12. Study a current newspaper and analyze the numbers of articles dealing with various types of social illness. What are the underlying causes? How was the person disciplined? What organization was called in to help the individual?

13. Is there a Mental Hygiene Council or Association in your community? What are its objectives, functions? How do nurses fit into the program?

14. Look through the "Help Wanted" section of the newspaper and list the numbers and types of positions available for your adults and note what qualifications are required. Also list the positions being sought by young adults.

15. Find out if there is in your community an agency for marriage counseling and what its program is. How does this fit in with your ideas about such a service?

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Chapter 20

NURSING SITUATIONS IN THE MIDDLE YEARS

Persons between the age of forty and sixty-five are in an effective age group. An increasing number of individuals are experiencing life at middle age. Roughly, there are about forty million people in the United States within this age range, which is frequently referred to as the "prime of life." For many there are increased opportunities for survival and a chance for a long and healthy old age to follow. A majority at this age feel confident of their status, recognize a measure of prestige, and acknowledge a degree of power.

These years can be very satisfying as the middle-aged person looks back on life's accomplishments and pleasures. There may be the pride of having reared a family, provided an education for children, and prepared them to begin a life of their own. For all, this period in life's continuum is a time for reassessment of values and constructive effort toward future planning. The strains and problems associated with maternity and parenthood are now over. Arrival at middle age brings individuals to a new phase of life which offers many opportunities for continued growth and productiveness and unlimited potentialities for social and civic contributions. With a decrease in the many time-consuming responsibilities of early adulthood, time is now available for extension of interests and activities outside the home. Many have gained a wealth of experience through the forty plus years of life, and because of this can make more effective contributions.

THE PATTERN OF FAMILY LIFE CHANGES

For many parents middle years bring about a decrease in family size and a change in responsibilities. At first it may be only temporary as children, one by one, go away from home to attend college. Later marriage or employment in another city brings a permanent separation. Children begin to manage their own lives and become adjusted to their new role of complete independence, and parents are relieved of the financial support of their children. Relationships be-

tween parents and children change with a noticeable diminution of emotional feelings. Simultaneously the parent-dominant child-dependent relationship changes. The relationship becomes one of mutual respect and consideration, with the parents remaining interested in the events in the lives of their children. New roles are created with diverse responsibilities and new families emerge. Parents should accord their children independence and if family life has been designed toward this goal the parental adjustment will be relatively easy.

With the children out of the home and the multiplicity of demands decreased, the parents can utilize the increased opportunities for broadening and deepening their lives. There are many opportunities for self-expression and acquisition of new interests, and more time for social participation and community contributions.

When children marry they provide new roles for their parents, those of in-law relationships. Attitudes and resultant behavior permeate future interaction in this aspect of social relationships. Many will become grandparents and will find the role an unusually satisfying one. It is in this relationship that the grandchild is introduced to the rich cultural heritage which plays such an important part in building an appreciation for the world and the people who have contributed to its general improvement. A keenly felt need, that of a sense of usefulness, is partially satisfied by grandparent-grandchild relationships. Actually, many grandparents really enjoy their grandchildren more than they did their own children, because they do not have all the allied responsibilities for their well-being. Just the element of more available time provides opportunities of enjoyment that were not possible previously.

BASIC NEEDS IN MIDDLE LIFE

Basic needs do not change. The adult of middle life needs to feel wanted, accepted, important, and recognized. He must be allowed to maintain his status. All these elements blend to give him a feeling of worth, competence, and security. His pattern of needs will continue until life ends, the only difference being in the means by which satisfaction is achieved. This being true, the person in middle life needs friends just as do others in the different age categories. Doing things for and with people, contributing to the worthwhile activities of his group, and forming new friendships when the circle becomes small because of death are just some of the factors which add to emotional security for the person in middle life.

The single woman in middle years may seek companionship of

someone in her own age group and with similar interests. Such companionship may include sharing living facilities, joining the same clubs, attending social functions together, and the like. In these ways, unmarried persons or persons who have lost the marriage partner may have many of the satisfactions of family living and remain independent of relatives if they so desire.

Men or women who have lost wives or husbands may remarry in an effort to re-establish satisfactory relationships and avoid loneliness. Sometimes children may object to remarriage of their parents, and the nurse may be called upon to offer help. Her guidance should be understanding and objective as she tries to interpret the needs of middle age to the family. She must allow the persons concerned to make their own choices.

Security, broadly interpreted, presupposes financial resources sufficient to provide for minimum necessities. For most people in middle life some economies are necessary and advisable for a number of reasons. Maturity brings a more quiet life, and individuals find satisfaction in more peaceful pursuits which require less physical energy and are less expensive. The home environment offers many opportunities for quiet and relaxation. Most individuals have an inner acceptance of what life has given them and no longer seek exciting adventures. The rationale of their philosophy of life begins to provide reassuring support for planning the future.

Health Remains a Need. There is a diversity of opinion on the definition of health. An earlier definition covered the term broadly.

> Health is not a condition; it is an adjustment. It is not a state but a process. That process adapts the individual not only to his physical but also to his social environment. Social life or community life is just another name for interpersonal relations. The science of health is a branch of the wider science of human ecology.[1]

It is safe to surmise that the really healthy middle-aged person is wholly adjusted to himself and to his environment. Fundamental prerequisites for healthy living remain unchanged for the middle years. This group can make an important contribution by encouraging wholesome individual and community attitudes toward health promotion and disease prevention.

Early detection of disease followed by proper diagnosis and adequate treatment becomes especially important at this period in life since the degenerative diseases begin to make their appearance.

[1] A Report to the President by the President's Commission on the Health Needs of the Nation, *America's Health Status, Needs and Resources*—Volume 2 Washington 25, D.C., U. S. Government Printing Office, Superintendent of Documents, 1951, p. 130.

Periodic health examinations should continue as a necessary part of the middle years of life. Early attention to minor disorders may prevent disabling conditions and diminish accompanying economic and social consequences which are considered incompatible with happy living. The principal foes of health confronting those in the middle years are heart disease, cancer, kidney disease, high blood pressure, hardened arteries, apoplexy, diabetes, arthritis, and rheumatism.

PHYSICAL AND MENTAL CHANGES

As the continuum of life proceeds changes occur in the body's functions and in mental capacity. In the middle years the individual encounters a variety of difficulties in adjustments to circumstances, people, and events. For some, such adjustments are easy but for others such experiences are fraught with difficulties. The nurse should look for the reasons for behavior that deviates from the usually expected pattern. There is always a reason for behavior which appears to be different, odd, or strange. While the reasons underlying such behavior changes are important, the alert nurse recognizes the possibility that such changes may be the early signs of approaching physical or mental disease. The nurse knows that a healthy personality is just as important as optimum physical health.

The importance of individual differences has been accentuated in the discussion of each age group and individual differences exist in the middle years too. Aging progresses with considerable variation from one person to another. The middle-aged person is what he is because of his previous life experiences. For a complete understanding of the motivations, attitudes, beliefs, and the like, the nurse will find it necessary to take into account some of the factors that have formulated the pattern which produced the middle-aged person. The young nurse will be of another era and not as familiar with society and processes which existed before her birth but which yet form such an important part of the middle-aged person's early life. Individual variation is marked, with subsequent behavior showing the diversity of reactions. There will be those individuals who can accept reverses and limitations with composure, others may become irritated or infuriated, while others may become retiring as a result of experiencing depression and frustration. It is well for the nurse to remember that there are few who accomplish perfect adjustment to all circumstances at all times.

Men and women in middle age must adjust mentally and physically to the termination of the reproductive cycle. The significance of sex life changes and there is a gradual tendency toward diminished

sex activity. Women usually find this period of life more difficult than do men. Women spend much time and money in preserving their attractiveness and attempting to avoid those changes which are indicative of middle age. Men consider maintenance of their physical strength and mental vigor important and frequently look upon these assets as repudiation of other evidences of advancing years. The nurse can be especially helpful by disseminating information about the physical changes that are taking place. She can give individual guidance which will make it easier for the middle-aged person to live with the changes which occur.

THE NATURE OF THE SOCIAL WORLD IN MIDDLE YEARS

It becomes easier for the person of middle age to fit into the social framework as it exists. A person of this age tends to be increasingly realistic and is no longer motivated by ideal concepts. He is disposed to accept the existing practices and patterns of his society. He begins to concentrate on maintaining his status quo. In middle age, the individual can look very realistically at life situations. He tends to adjust his concept of values. He weighs decisions and patterns his behavior in terms of the practicality of the circumstances. Quick judgment and rash action are much less acceptable to him. Thought and consideration prevent his engulfment by situations so frequently encountered in younger age groups. Years of living have provided the middle-aged person with much that gives stability to character and living. Positive attitudes toward aging pay dividends for the middle-aged person.

Each individual must assume responsibility for the major portion of his own happiness. Each is eager to retain useful roles in family, group, and community, and success in creating satisfying social roles for himself will determine partially his well-being. His roles will be numerous and will include those of friend, informed citizen, confidant, and advisor. He should plan for constructive use of his leisure time. Many participate actively as church members. Group activities provide satisfying experiences and should be continued, effort being made to enlarge the scope of group participation. All through life the individual is enmeshed in a web of contacts constantly influenced by other humans in his environment.

EMPLOYMENT

Continued participation in profitable employment is necessary. During this age individuals reach the peak of their work-life and, coincident with this, many attain the height of their financial

achievement. Financial remuneration is only one of the satisfactions of one's occupational pursuit. The work environment unites individuals with others socially. Prestige is attached to many occupations. Certain functional and structural stratifications emerge in the social order as a result of occupational endeavor. Political and economic situations arise within the occupational framework and frequently have broad ramifications for the middle-aged worker. Work remains the primary status-giving role for the middle-aged man.

SUMMARY

Frequently authors have written that "life begins at forty." It is not the intent here to justify this hypothesis, but it should be helpful to the nurse to view some of the considerations which seem generally applicable to those persons who have reached this phase in life. Learning experiences should have provided the nurse with some perception of the attitudes and characteristics which influence behavior. Such experiences will have familiarized her with some of the situations inherent in the aging process. She will recognize the whole process as one of interaction, the components varied and complex with one affecting another.

The nurse's most important contribution is in assisting individuals of middle age to maintain functioning roles which provide recognition and assure self-respect. She may assist in the recognition of needs, relying upon her understanding of the necessity for changes in interest and activities. The nurse will understand the consequence of inevitable physiological changes and alteration in family relationships, and should appreciate an individual's reluctance to accept his chronological age. The emotional impact of relinquishing status-giving roles is inescapable. Mental alertness can be maintained by continued intellectual activity, and the nurse is familiar with opportunities which are available for continued educational experiences.

Recognizing the period of middle age as productive years does not minimize the necessity for growth and in no way reduces the compulsive drives for usefulness, activity, and security. The nurse is obligated to contribute to an environment which makes it possible for those of middle age to lead self-directing, healthy, and emotionally satisfying lives, thus better preparing them for the later years. She will also encourage the older adult to live within his physical means and to view health as an adjustment process. Persons of middle years can find satisfaction in more tranquil pursuits but should be encouraged by the nurse to keep active and make the best of things as they are.

FOR INVESTIGATION AND DISCUSSION

1. How can the nurse have a more understanding approach to individuals who face the normal problems of middle life?

2. Is it possible that dissatisfaction may become a constructive force for social progress? When?

3. Should the nurse encourage personal and avocational interests for individuals in the middle years? Why?

4. What criteria would you use to recognize differences in mental health, emotional stability, and physical well-being?

5. Should the nurse strive to stimulate continued intellectual achievement? Why? How?

6. If the person in middle life seems to have narrow interests, how can the nurse give guidance which will motivate interest in groups and their activities?

7. Discuss the enormous difference that culture can make on an individual's life. On the family. On the larger group—society. How can this knowledge help the nurse?

8. Identify the major phases of growth and development from the young couple without children to the family with children who are grown.

9. How can you tell if a person of middle age meets changes in the environment and changes in himself in a flexible manner?

10. When should one begin to adjust his needs to reality and the continuously changing external and internal conditions? How can this be done?

11. What social and recreational activities in your community are planned largely for the middle-aged person?

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Chapter 21

NURSING SITUATIONS IN THE LATE YEARS OF LIFE

Many factors contribute to the complexity of aging. Insufficient income, inadequate housing, limited opportunity for work, and illness are only a few of the problems involved. The cities and neighborhoods in which old people live, the kind of diet they receive, the kinds of social activities and recreation in which they participate—all obviously will be conditioned to a great extent by the amount of money they have available for these various purposes.

THE NURSE AND THE AGED

To function effectively in her role, the nurse must be cognizant of the characteristics of this segment of the population. In expanding her understanding about elderly human beings it becomes necessary for her to utilize her learning in the field of human relations to meet the needs older persons have for a sense of dignity, a feeling of usefulness, and a desire for recognition. Nurses need to know more about the older worker to better understand him. They need to know his needs, his wants, his drives, his fears, and his ambitions, and should have ability to identify the main problems of later life.

Each nurse has much to contribute in changing people's attitudes toward the aged. Helping people to alter their biases is not easy, but it is necessary. The nurse should not be handicapped by stereotyped attitudes of her own toward elderly persons with whom she works. Her greatest asset will be her skill in understanding older people and knowing how to help them. Their families, too, may need advice or help. What are some of the characteristics of the aged? What are some of the factors which create problems for them?

AMERICA IS FAST BECOMING A SOCIETY OF OLDER PEOPLE

Changes in the population have increased the number of aged in society. The magnitude of the problems encountered by the nurse



Fig. 18. Increase in population over sixty-five from 1860 to 1945, and number estimated in 1970. (From George Lawton and M. S. Stewart: "When You Grow Older," *Public Affairs Pamphlet No. 131.* New York, Public Affairs Committee, Inc., 1947.)

can be more easily understood if she has some concept of population composition with respect to this age group. What are the basic facts about the aged in society? What are the facts in the nurse's immediate community? The similarity of problems will not vary but the frequency with which they are encountered will be partially determined by the number of persons who are sixty-five years of age or over. Cities tend to have an above-average proportion of old folks. Recent population data have revealed a tremendous increase in aged women. The growth in the number of persons over sixty-five is indicated in Figure 18.

LIFE EXPECTANCY IS INCREASING

Life expectancy has risen substantially. The most notable contribution to the increased years of life has been the control of infectious diseases. People are living longer than they formerly did when the incidence of death was higher from these diseases during infancy, childhood, and early adult life. Health education, improved public health facilities, including environmental sanitation; medical research; and early detection and correction of defects now possible because of health insurance and hospital care plans have added

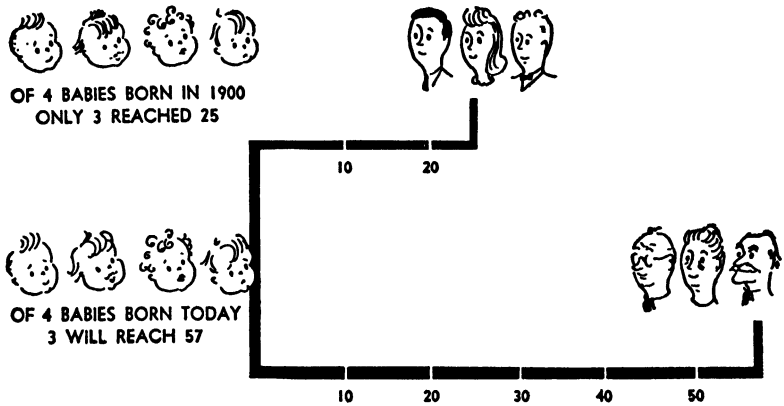


Fig. 19. Increase in life expectancy in this century. (From George Lawton and M. S. Stewart: "When You Grow Older," *Public Affairs Pamphlet No. 131.* New York, Public Affairs Committee, Inc., 1947.)

immeasurable benefits. Individuals have become more health conscious and as a result have adopted more sound hygienic practices and in organized groups have insisted upon improved working conditions.

A baby born in 1901 had an even chance of reaching age 45.6 years; in 1949-50, the expectation of life rose to 64.6 years, an increase of 19 years. Many complex and separate factors are involved in comparison of life expectancy. The Census Bureau shows that life expectancy is generally higher in the agricultural states and lower in industrial states. Lower socio-economic status is undoubtedly important in this comparison. The average expected lifetime at birth now is 71.5 years for white women and almost 65 years for white men. The average life expectancy at birth now is almost 63 years for non-white women and 58.6 years for non-white men. Figure 19 graphically illustrates the increase in life expectancy.

PEOPLE SPEND LONGER YEARS IN RETIREMENT

In 1900 a white male aged forty could anticipate slightly over three years in retirement. By 1940 he could anticipate nearly six years in retirement, that is, the span of retirement had nearly doubled. At age 65 today the average man can expect thirteen more years of life. For the future, a continued widening of this gap between the total life span and the working life span seems likely. It is not unreasonable to expect the time spent in retirement for a forty-year-old male to have risen to 9½ years by 1975.

WHEN IS A PERSON OLD?

Aging is a natural process which ultimately comes to every living individual. Individuals grow old differently. Different organs age at different rates. The number of birthdays one has had is a very unreliable guide to one's age. Chronological age is only one of the factors that can be used in determining how old a person is. The nurse is probably as guilty as others in tending to call all persons who have reached sixty-five years of age or over "old." Such a practice is harmful to the individual and has no foundation in scientific fact. Any assumption that old age starts at a designated chronological age such as sixty-five or seventy years is fallacious.

Beginning with her initial learning experiences and continuing throughout life, great care is taken to impress the nurse with the many aspects of individual variability. In Chapter 15 it was pointed out how the infant begins this lifetime chain of individual variation. There is extreme individual variability in the process of aging, in physical and mental deterioration. There does seem to be some indication that persons in the lower economic groups experience physical and mental decline at an earlier age. Impairment in physical and mental capabilities is highly inconsistent. The nurse is familiar with such phrases as, "You are as old as you feel" and "I'm too old to do that." A person feels old when he believes he has nothing to look forward to. Effort should be made to avoid establishing stereotyped attitudes about persons over a certain age, say sixty-five years. Such attitudes will produce a detrimental effect in any society. The nurse is aware of changes that take place during advancing years, such as decrease in strength with diminution in activity, but the pleasure of living continues for many beyond their seventieth year. It would be well for the nurse to remember that many persons in the older age groups have much to offer society because of a lifetime of valuable experiences.

BASIC NEEDS HAVE NOT CHANGED

It has been pointed out in the discussion of the young child that he must be given an opportunity to do things and that the persons around him must make him feel important. It is generally true that being able to contribute (interaction) and having the feeling of personal satisfaction are just as essential to the older individual. Each still needs to feel that he is needed and wanted and loved. Part of the terror associated with old age is inherent in one's degree of security. Just as for the infant, the need for emotional security is absolutely essential for mental health and happiness and for this the aged, as all

individuals have had to do throughout life, must depend upon others, on children, friends, and associates.

Group affiliations have suffered radical changes for the elderly individual. Death may have taken its toll of friends and relatives. Old friends may be hampered by chronic illness. Group activities give older individuals opportunity to be useful and to keep busy. Participation in groups satisfies their need for emotional sustenance and self-esteem and continues to serve as the medium for satisfying living. In later years they need to meet new people and to make new friends, who become more valuable as time goes on.

Older persons need to acquire new skills or partake in some new activity. They have a definite contribution to make to society. Many communities provide excellent facilities to enable these persons to meet people, have fun, expand their outlook, and expend their energy in some useful pursuit. Living is learning, just as it is for individuals of all ages.

In any stage of life the provision of food, clothing, shelter, and protection remains a necessity. Economic security gives the older individual an assurance that he will not be without these essentials, even though some drastic readjustments in values and standards may be necessary. Sound planning in the earlier years of life is probably the most important factor in future economic security. There still is great need for the feeling of independence.

Elderly persons also need assurance that they will be able to receive adequate hospitalization, as well as medical and nursing care, during the years when they are most likely to need it and least able financially to assume the cost of providing such services for themselves.

PHILOSOPHY FOR LIVING

What are the underlying principles so necessary to the formation of behavior and attitudes which will enable the older person to make the later years of his life happy and satisfying? The basic attitudes of the individual will be the chief determining factor. Preparation for successful living in the later years of life should begin in childhood, since basic attitudes are implanted at this age. Great benefit can come from anticipating the future instead of dwelling on events in the past. Incentive to push ahead, eager for the morrow, minimizes the responsibilities and enlarges the privileges of old age. If the aged have developed a philosophy for living it will be easier for them to keep their morale high and they can more adequately cope with threats to their self-esteem and security. Some persons welcome old

age, some adapt gracefully when it comes, others simply refuse to recognize its reality.

PERSONALITY

Increased years seem to intensify personality maladjustment. It is well for the nurse to remember that crisis situations may precipitate many personality problems. Death of a spouse or friend, retirement, and illness are only a few of the crisis situations which the older person may be unprepared to face when called upon to do so. Age tends to intensify previous behavior patterns. If the individual has been able to make favorable adjustments to his life experiences, modifying his behavior to life's pleasures and disappointments without resentment, he is more likely to take old age and even death as normal phenomena.

SPIRITUAL VALUES

Membership in religious organizations and active participation in church groups are valued activities for many older persons. Periodic visits from clergymen with opportunities for communion, prayers, and other religious consolations afford much comfort to older people. Since this group has more time for contemplation and meditation, thoughts of death and previous life experiences may cause them to re-evaluate their lives and adjust their ideals and goals. The simple act of grace before meals and a daily prayer period may be a new spiritual experience for some. Interest in religion may take the form of discussion with family and friends centering around favorite hymns, scriptures, and the like.

EDUCATION

The median number of years of schooling previously received by men and women now sixty-five years old and over is slightly over eight years. Information of this kind serves to show the nurse where to begin and indicates what she will have to work with. The learning that has resulted from life experiences is not to be discounted, however. The old saying, "You are never too old to learn," may be a strong motivating factor for many of the aged.

Growth is essential to combat regressive tendencies of later years. Many persons in the older age groups are going back to school. For some these years provide the first opportunity they have had to attend school. Their children are grown, responsibilities have lessened, and more free time makes it possible. Adult education courses are enthusiastically received by many. Programs for older people

are designed to teach crafts and hobbies, new vocations and new interests, as well as to refresh earlier interests. Participation in learning activities provides a richer life for many older persons who otherwise would have little opportunity to meet people and enjoy group experiences.

SOCIAL ACTIVITY

Old people need to develop a social life compatible with their income, special interests, and physical and mental capacities. They lose many of their former opportunities for social participation as they sever their occupational ties, eliminate club and organization contacts, lose loved ones, and find family members becoming farther and farther apart in miles and interests. Each of these factors tends to jeopardize the security that stems from service to an association with others, from group participation, from knowing that one is wanted and needed by friends, family, and community, and from continued success in one's interpersonal relationships.

STATUS OF OLDER PERSONS

It is evident that enormous changes in our population have tended to increase the numbers of aged in society and in the labor force, while at the same time reducing their usefulness and status. The older person becomes acutely aware of the uncertainty of his status in the family and in the community. Each tends to constrict his opportunities to be useful, self-supporting, and active. Prejudices exist in culture which places its greatest value on youth. America everywhere glorifies youth. Civilization places great stress on autonomy. As pointed out by Dr. Margaret Mead, culture in America lays stress upon upward gradients, or continuing successes ever spiraling upward; past accomplishments are discounted; it is what you are, not what you were that counts. The older person is often at a disadvantage in this respect. Society places great emphasis in productive activity and status is determined by work and the many benefits that can be purchased by financial remuneration. Work is prestige and status. Work is money. Work is usefulness. Work frequently means companionship. Work dulls the pain of personal strife.

Examination of economic history and national culture further emphasizes the importance of youth and shows the conflicts that arise as the older worker attempts to maintain his status. There is an increasing tendency for the older person to feel left out. This is quite a contrast from the culture in which older individuals hold positions of responsibility, manifest authority, and are accorded a

great deal of respect. Another ever-present threat to their status is the possibility of disabling illness which might result in complete dependency, and removal from home to institutional care and social isolation.

The nurse must cooperate in providing a social environment for persons in the later age group that will keep their morale high and give them reason for living and a deep sense of being wanted. Any threat to the older person's status and security creates a great deal of anxiety. Defenses against all of these things must be built into the individual from childhood.

RECREATION

It has already been stated that one of the basic problems of the persons in this group is that of maintaining the values of self-esteem, social-esteem, and fellowship. Mental health for these persons can be assured only if some means of social intercourse is available and new outlets for creative activity are provided.

Older people usually prefer the more social types of leisure-time activities. Occasions for social intercourse are especially important. Favorite activities which involve almost no social intercourse are gardening and reading. Radio and television are passive forms of recreation enjoyed by older people, especially those who are not ambulatory. The accessibility and use of a telephone to maintain contacts with relatives and old friends also provides pleasant occupation of leisure time. Educational pursuits as mentioned previously and religious activities may serve as recreation, just as a different type of work also provides a form of relaxation which old people welcome and enjoy.

MARITAL STATUS

In the group sixty-five years old and over in the United States, two thirds of the men are married, as compared with slightly more than one third of the women. This difference is explained by the fact that women live longer than men and over half of the women are widowed, while just one fourth of the men fall into this category. In both sexes, 8 per cent have remained single; 2 per cent of the men and 1 per cent of the women are divorced. Marriages among old people are not uncommon, since they provide companionship and restoration of family relationships.

FAMILY STATUS

Slightly more than three fourths of the older population in the United States, both men and women, are living in families. Thirteen

per cent of the men and 22 per cent of the women are living alone or with non-relatives. Six per cent of the men and 3 per cent of the women are living in institutions.

HOUSING AND THE AGED

All too frequently there is a tendency in America to think of housing for the aged in terms of institutional care. This certainly is not the desirable approach, and, although it is necessary for some, institutional care is not compatible with satisfying living for many in this group. Many remain ambulatory and quite able to take care of themselves; however, special consideration should be given to their housing. Decline in income makes housing an economic problem.

In the older age group eight out of ten reside within a family group. The most striking thing about the living arrangements of older families is the high concentration of one- and two-person families. This situation reflects in large measure the combined effect of children leaving home and of the death of a spouse. Among the aging there is a noticeable lack of congestion in their homes. Houses bought to meet the needs of a family with children are frequently retained. Situations in rental housing are usually far worse than those for owned homes. Many older persons are too proud to live with relatives or friends.

There is a need for diversity in types of accommodations provided for older people. The older person's attitude toward housing is based to a considerable extent on his own background and cultural values, his financial resources, the extent of his family and the relationships that exist within the family, his physical capacity, his need for supervision, and the climate and community in which he prefers to live.

The housing needs of older people are of particular significance because maintaining a home has such great meaning in their lives. As other satisfactions tend to decrease in advancing years and many human ties are broken, the home assumes greater significance. Housing can increase the social isolation of the aged in the community. More apartments especially designed for older persons will probably be part of the building program in the future.

Since housing can be harmful to health, living space ideally should be provided on one floor. In such an arrangement there will be no stairs to climb. Consideration should also be given to non-skid floors, automatic heat, electric cooking stoves, and indoor toilet facilities.

HEALTH IN OLD AGE

The older people become, the more concerned they are about their health. Health is a recognized social problem. The health status of

individuals in this age group can be improved considerably by preventive health practices with full utilization of medical science. Preventive medicine has much to contribute. A decline in physical capacities cannot be refuted, but with good health many happy useful years remain for the older person.

Fundamental to the existing attitude toward the ills of old people is the inclination to place a low value on human worth in the declining years. There is an obvious interdependence between social adjustment and physical condition. Counseling on economic and psychological problems can facilitate both social and familial adjustment.

Many problems originate in the field of nutrition. Low income, living alone, little knowledge regarding proper foods, loss of teeth, and resistance to acquiring new food habits are problems related to nutrition which is so vital to the maintenance of health. Properly fitting dentures do much to improve nutrition and digestion.

It is frequently difficult for the person in this age group to maintain social contacts and continue gratifying relationships in the environment. Satisfaction of both of these needs may be limited by such defects as deafness, impaired vision, or crippling conditions. Artificial aids, of which there are many, and physical therapy can be employed to minimize the loss of special senses which reduce social contacts, to increase the margin of safety, and to preserve the individual's mobility.

Accidents and the Older Worker. Important causes of accidents are impaired vision, decreased hearing, slow movements, and unsteady gait. However, older workers tend to have fewer serious accidents than younger workers.

ECONOMIC STATUS

For this aging group there is a constant struggle to find the means to cover increased costs. If economic status is judged on the basis of an individual's wealth or lack of wealth, it can be said that this age group is in the lower brackets of the economic pyramid. Recently it was pointed out by a representative of The Department of Health, Education, and Welfare that two thirds of the people in the United States over sixty-five years of age have annual incomes of less than $1,000. In 1950, of the men aged sixty-five years and over more than 70 per cent had incomes less than $2,000. The income of half the men in this age group was less than $1,000 a year, and a fourth received incomes of less than $500. The median income for men in this age group was $986. The median income was much lower for women

Table 7. Distribution of Persons 14 Years and Over by Total Money Income, Age, and Sex, 1950

TOTAL MONEY INCOME AND SEX	TOTAL*	AGE						
		14–19	20–24	25–34	35–44	45–54	55–64	65 AND OVER
Male								
Total (in thousands)	52,592	5,904	4,886	10,988	10,072	8,550	6,728	5,464
Total with income (in thousands)	47,585	2,476	4,520	10,851	9,935	8,410	6,482	4,911
Percent with income	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Under $500 †	11.3	63.4	11.4	3.3	3.9	6.2	10.8	25.8
$500 –$999	9.4	17.7	13.5	5.8	4.3	6.1	9.3	24.9
$1,000–$1,999	16.4	12.8	27.0	15.3	12.5	14.7	17.3	20.3
$2,000–$2,999	21.6	5.1	29.2	26.7	21.5	20.5	22.4	13.8
$3,000–$3,999	20.9	.7	14.0	27.7	27.0	23.6	20.2	7.2
$4,000–$4,999	9.6	.3	3.5	12.0	14.0	12.4	8.8	2.5
$5,000–$9,999	8.6	...	1.3	8.4	13.9	12.8	8.2	3.6
$10,000 and over	2.0	..	...	.7	2.9	3.7	3.0	2.1
Median income	$2,570	$394	$1,933	$2,961	$3,254	$3,091	$2,494	$986
Female								
Total (in thousands)	56,900	6,280	5,740	12,120	10,780	8,882	6,926	6,172
Total with income (in thousands)	24,651	2,043	3,158	5,083	4,433	3,841	2,765	3,328
Percent with income	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Under $500 †	32.0	63.7	23.6	25.2	25.5	25.2	31.6	47.9
$500 –$999	19.8	16.9	16.0	16.2	17.1	18.5	22.0	34.5
$1,000–$1,999	23.6	15.3	33.5	26.4	24.6	26.5	22.1	11.1
$2,000–$2,999	18.1	4.2	25.3	24.6	22.9	19.2	16.1	3.8
$3,000–$3,999	4.5	...	1 4	6.0	7.5	6.5	4.8	1.2
$4,000–$4,999	1.2	...	.1	1.1	1.5	2.5	2.0	.5
$5,000–$9,999	.6	...	.1	.3	.5	1.2	1.3	.7
$10,000 and over	.2	...	...	.1	.2	.3	.3	.4
Median income	$953	$392	$1,400	$1,355	$1,308	$1,242	$918	$531

* Figures do not necessarily add to total because of rounding.

† Excludes persons with no income and includes those reporting a net loss.

Source: U. S. Bureau of the Census, Series P-60, No. 9, Income of Families and Persons in the United States: 1950.

Table 8. Distribution of Families in the United States by Total Money Income and Age of Head, 1950

TOTAL MONEY INCOME	TOTAL*	AGE OF FAMILY HEAD					
		14–24	25–34	35–44	45–54	55–64	65 AND OVER
All families (in thousands)	39,822	1,852	9,002	9,514	8,322	6,334	4,798
Percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Under $500	5.8	4.9	3.8	4.0	4.7	6.6	14.7
$500 –$999	5.7	7.8	3.5	3.3	4.5	6.1	15.7
$1,000–$1,999	13.2	21.1	11.2	10.3	11.3	14.6	21.2
$2,000–$2,999	17.8	25.0	20.6	16.5	15.7	17.8	15.8
$3,000–$3,999	20.7	20.4	26.3	23.3	19.4	16.8	11.5
$4,000–$4,999	13.6	11.9	15.3	15.5	14.3	13.3	6.4
$5,000–$5,999	9.0	5.8	9.4	11.6	10.3	7.1	4.4
$6,000–$6,999	5.2	2.4	4.8	6.3	6.3	5.4	2.6
$7,000–$9,999	5.8	.7	4.1	5.7	8.3	7.7	4.5
$10,000 and over	3.3	...	1.0	3.6	5.1	4.8	3.2
Median income	$3,319	$2,613	$3,365	$3,644	$3,684	$3,258	$1,903

* Figures do not necessarily add to the total because of rounding.

Source: U. S. Bureau of the Census, Series P-60, No. 9, Income of Families and Persons in the United States: 1950.

than for men. The median income for a family in which the head was sixty-five years of age and over was only $1,900 (Tables 7 and 8).

Regardless of the source of income, practically every older person has to learn to provide necessities and pleasures with less money than he had during the years when he worked. For some this adjustment is difficult because of physical infirmity, decrease in prestige, and the like. The declining value of the dollar has played havoc with pension plans which were to have provided individuals with necessities, and emotional, social, and recreational activities during their declining years.

EMPLOYMENT IN LATER YEARS

Most nurses are familiar with some of the problems encountered by the older worker in the employment field. Work fills many needs of the individual. It provides him with a basis for self-respect, a source of prestige, an opportunity for social participation, a source of enjoyment and creative self-expression, a way to utilize his time, and, last but not least, a means of support. Some companies have a policy that does not permit the hiring of a person over thirty-five years of age. Others arbitrarily set age limits as young as forty years, beyond which they are unwilling to go. There is evidence of reluctance by employers to hire older workers until supplies of younger men are exhausted. It might be well to repeat again that the element of service is necessary to a full and satisfying life. Seeking a job is a very discouraging experience for many older workers. The nurse sees that here is a man or woman who has worked for a certain length of time, has created and has been a productive member of society, then suddenly, for want of employment, the individual finds himself a social outcast. Part-time employment would do much to prevent the older person's loss of identity and of his values as a personality.

A number of industrial and occupational trends contribute to the long-term decline in employment opportunities for older men. These trends reflect the social and economic forces which have led to increased employment of women outside the home. The trend among aged women in work activity has been upward. In general, the trend has been toward a continuing decline in the relative number of older persons with income from employment. Rehabilitation of the older person is assuming greater and greater importance today, as the numbers in this age group continue to rise. Employment in some form is one of the most effective means of rehabilitation, and efforts

are being made by many groups to provide gainful work for old people. Baby-sitting with its many facets of setting up machinery for selection, preparation, delivering, and calling for persons has been highly recommended by eminent physicians. The resources available in old people have not been sufficiently tapped to date.

RETIREMENT

The individual's adjustment to oncoming old age, all of the psychological changes which he must make as time for his retirement nears and arrives, will likewise be conditioned to a very great extent by the financial provisions which he has made, or which have been made for him. If his financial resources are fairly adequate he will have little to worry about, but if the contrary is true, then old age will loom as a threat.

Retirement today for the majority of older people means retirement without honor, for even the advantages of social security programs, pension plans, and accumulated life savings are not sufficient to maintain an individual at a decent standard of living once income from employment ceases. The trauma brought on by sudden retirement cannot be underestimated. For those persons fortunate enough to have developed a wide latitude of interests and pursuits early in life, the traumatic effects are less. Retirement which severs the older worker from his occupational pursuit makes the individual feel that he has lost his social status, his independence, his earning power, and his participation in community life. An aging population means that the labor force is aging too. The loss of employment and lack of jobs are basic problems of older people.

Compulsory retirement is still prevalent in many areas, but an increasing number of concerns are increasing their age limits for compulsory retirement while others grant extensions which permit the worker to continue in his job after he has reached the stated age. Others may offer opportunity for less strenuous activity or a job that does not require speed. There are many things to be said in favor of and against compulsory retirement, but from a sociological point of view it destroys the older worker's sense of security and utility, is costly, and lowers the standard of living.

SOCIAL INSURANCE PROGRAMS

Some degree of financial security is extremely essential to most persons in this older age group. It has already been pointed out that the ratio of older to younger people in the population is constantly increasing, therefore the burden of support for older persons, either

through personal aid or higher taxes, will rest on those in the younger age brackets.

Role and Function of Social Security Programs. The primary function of such programs is to provide continuing income for persons and the families of persons who are no longer wage earners and give some degree of protection to the family if the insured wage earner should die. The nurse should be familiar with the two most common programs.

OLD-AGE AND SURVIVORS INSURANCE PROGRAM. The Old Age and Survivors Insurance program was established under the Social Security Act of 1935, and is operated entirely by the Federal government. The fund from which these benefits are paid is made up of the social security tax, contributions of employees, employers, and the self-employed. Those persons who have worked in employment covered by the social security law are entitled to a monthly retirement check.

The kinds of payments made to the aged, the factors determining eligibility, and other provisions will not be discussed here. This information is readily available to the nurse from many sources. At present, monthly retirement benefits are payable at age sixty-five. The highest amounts paid to retired workers without dependents average from $55.00 to $68.50 per month, but for many who are receiving benefits the monthly average for men is $43.50 and for women $33.60.

OLD AGE ASSISTANCE. Another public program designed to assure older people of income is known as Old Age Assistance. Both Federal and state governments contribute financially to this program, but state governments are solely responsible for its administration. Old Age Assistance is not given unless an individual's income is insufficient to provide for his needs for food, shelter, clothing, and medical attention. Persons sixty-five years of age and over may qualify for Old Age Assistance payments provided they meet all the other rather rigid qualifications. The average of these payments varies from state to state and depends upon whether only an individual or a family is involved. Payments are usually a little more adequate in the latter. In any instance, however, the amount received is insufficient to provide necessities and falls far short of providing economic security for the aged.

INDIGENCY IN THE AGED

Indigency in the aged is a socio-economic ailment of society. No single factor produces it, but the causes are varied and intertwined.

The fears, hopelessness, and despair endured by an increasing number of the impoverished aged cannot be clearly shown by utilizing statistical techniques. If the nurse is to understand persons who fall into the category of indigent she must have some concept of the adequacy of old age assistance programs, how these people live, and what the basic reasons were that led to their impoverishment, and from this information gain some clues which may prevent such circumstances in old persons in the future. The old person who is no longer ambulatory is faced with a multitude of problems. An elderly person living on the top floor of a slum tenement cannot carry coal to heat his one room. For nearly all of these people life has been a grim journey. Some have known few comforts in their lives; some have worked hard and reared families, but have suffered misfortune. To the nurse each is a human being, entitled to understanding care and personal recognition.

During their entire lifetime only a few of the impoverished aged may have earned a decent wage. This reflects the close relationship between poverty and the handicaps of lack of social status and education, difficulties in home environment, lack of special skills, submission to alcohol, and sickness of self or family. A study of causes will show the nurse that indigency can be predicted with a relative degree of accuracy since certain causes predetermine it to some extent.

What does all of this mean? Why be concerned? The increasing financial burden carried by an ever-decreasing proportion of younger persons in the population will eventually weaken the very roots of society and threaten its stability. The nurse may ferret out the causes of dependency and suggest methods of preventing it.

CUSTODIAL CARE FOR SENILE PERSONS

Senility has a tremendous impact on society and can be considered as a serious social problem. The tax burden that must be borne by the public to provide for custodial care is tremendous. Consequently there are too few facilities available to meet the increasing demand for care. Few in this older group remain socially independent. Family life is disrupted, and social stigma is frequently present because of lack of understanding. The nurse often needs to help families accept custodial care for the aged individual who has become senile. She may do this herself or refer the family to a social case worker. Interpreting the functions of a mental institution and attempting to destroy the attitude that all people who go to such institutions are "crazy" does much to encourage family acceptance.

THE ROLE OF THE COMMUNITY

The role of the community in relation to its aged should be characterized by progressive leadership. There should be genuine concern about meeting the needs that exist. In some instances guidance may be sought from experts who are asked to evaluate the situation objectively and offer recommendations for community planning. Financial assistance programs are not sufficient to provide more than bare necessities and in themselves are not enough. Public interest in problems of housing the aging should not be confined to the infirm or chronically ill. It is a real challenge to any community to provide satisfactory housing for aging individuals and families. Low cost housing accommodations help solve the problem, but there are too few of them. Education helps in enlisting the public's acceptance of the responsibility for providing basic necessities and helpful services for the aged who formerly could provide for themselves.

Each community should feel obligated to provide recreational programs and facilities for the older groups. Community adjustment to the phenomenon of a rapidly increasing older population is quite individual. Provision for health, housing, employment, education, and other necessities of later life will be possible, however, only through community action. These facilities vary according to type of community in which the person resides, urban or rural.

SUMMARY

Performing in nursing situations in the late years of life calls for insight into the involved process of aging. Unfortunately, the chronological age does not provide a valid criterion for determining how old a person is. Population changes have increased the number of aged persons, and predictions indicate a continued increase for some time in the future. Augmenting this is the increase in life expectancy. This means that more people are spending longer years in retirement. However, the basic needs of individuals in the later years of life remain unchanged. The nurse will find an individual's philosophy of living helpful to her in analyzing behavior and attitudes she encounters in nursing situations with the aging. The evaluation of the effect of life experiences on personality may offer important clues. The nurse will take advantage of every opportunity to motivate the older person to continue growth through educational pursuits, increased social activity, and recreation. Imparting a feeling of usefulness and importance will help the older individual maintain a position of status which is so important, since many circumstances rob or threaten this basic need. Special problems that must receive

consideration from the nurse are housing, economic resources, and health. All environmental factors make their influence felt, and she cannot isolate one from another because of their interrelatedness. The nurse should attach substantial importance to the need for employment in later years. Financial remuneration is perhaps the least significant factor, when contrasted with the opportunity afforded for social participation, prestige, and self-respect. The nurse may have many opportunities to interpret the meaning of retirement to individuals, families, and community. Active support in opposition to compulsory retirement should be encouraged.

Programs designed to offer increased economic security are social measures with a variety of benefits. Expanded needs may tax the ability of society to meet the demand, however. The ultimate solution seems to be in the direction of improved health status with emphasis on preventive practices, early diagnosis and treatment of disease, and gainful employment determined on an individual basis. The community should continue to assume the role of leadership in providing an environment more suitable and satisfying to persons in the late years of life.

The following outline summarizes the appreciations which the nurse should have for individuals in the late years of life:

1. The increasing numbers of aging individuals.
2. The multiplicity of problems associated with this age group:
   (a) financial resources,
   (b) housing,
   (c) employment and leisure,
   (d) fixed habit problems,
   (e) physical decline.
3. The necessity for the feeling of belongingness, usefulness.
4. The changing concept relative to responsibility for care, family vs. community.
5. The importance of reminiscence in this period.
6. The increased importance of spiritual values.
7. The pleasures, satisfactions, and values of senescence result from the mental hygiene practiced through life.[1]

FOR INVESTIGATION AND DISCUSSION

1. How can the nurse utilize information about an older person's leisure-time activities to determine what he is really like?

2. What important community problems have arisen because of the increasing number of older people?

3. How can educational programs aid in shifting the responsibility for care of the aged from the community to the family?

[1] As developed for the curriculum plan by the College of Nursing and Health, University of Cincinnati.

4. Discuss the different types of plans for more adequately satisfying the needs of the aging.

5. What opportunities does the nurse have to improve the outlook of the normal individual in the declining years?

6. What is being done to assure adequate medical and nursing services for a rapidly increasing population over sixty-five years of age?

7. What is the function of culture in human adjustment?

8. How do in-group relationships determine conduct and occasion behavior consistent with cultural norms?

9. Would you expect to find individuals and families in the late years of life who have health problems but no social problems? Identify them.

10. What are some of the factors which make the difference between dependency and independence in the late years of life?

11. What facilities have been set up in your community for aged persons? Are they satisfactory and adequate?

12. Compare the age ratios of persons in your community with those of the nation.

13. What are Adult Education organizations doing about education and recreation for older persons in your community?

14. Find out the retirement policies of several large industrial and business organizations in your community and evaluate them in relation to effects on older persons.

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Chapter 22

NURSING SITUATIONS IN ACUTE ILLNESS

In developing nursing situations in illness, acute and chronic, consideration will be given first to those factors which are similar in all nursing situations in illness. In many instances a period of hospitalization is necessary, which means certain experiences are involved. These include admission to the hospital; contacts with strangers—the many individuals representing the various groups concerned with hospital care; completely new environment with its specific equipment designed for care of sick persons; hospital regulations and policies that are new and often misunderstood by the patient and his family; separation from home and family, and perhaps relinquishment of personal identity because of hospital clothing and furniture; hospital routines and procedures, and diagnostic and therapeutic procedures which are strange and sometimes unpleasant or actually painful.

In some situations illness may have an acute onset, followed by rapid recovery, as is true in pneumonia. Recovery may be gradual with temporary or permanent functional damage, as in rheumatic heart disease. In the latter, however, some degree of optimum living may be realized after certain adjustments have been made. Other illnesses are characterized by a slow or gradual onset followed by slow recovery eventually resulting in normal living, as in tuberculosis. An acute illness will be considered as one which usually lasts for only a few days or weeks. It may be helpful for the nurse to think of acute illness as a crisis situation, one that is severe or critical. Because of the severity of the patient's condition it is frequently impossible for the nurse to work jointly with him in evaluating his needs in the early phase of an acute illness.

APPLICATION OF SOCIOLOGICAL CONCEPTS CAN STRENGTHEN COMPREHENSIVE NURSING

The nurse is only one of the persons contributing to the care of the patient. Each member of the health team has a specific contribution

to make, and final recovery from illness is always the result of this combined effort, with the patient making the greatest effort in many instances. When illness occurs and the individual becomes a patient, the nurse will find her knowledge of the sociological concepts an invaluable asset as she begins to make a plan for comprehensive nursing specifically adapted to "Mr. Jones." The factors of group, culture, and personality, and associated experiences have made "Mr. Jones" what he is. His attitudes and behavior and his many unique qualities that make him "Mr. Jones" will be extremely important in his acceptance of his illness, his cooperation, and his desire to recover and return to his former role.

Essentially, textbooks for nurses are disease centered in their content and are primarily concerned with the disease condition as such. Until rather recently nursing was likewise disease centered and still remains so in some areas as well as in the behavior of some nurses today. The intent here is not to minimize the importance of this information, for it is essential, but concurrently with this knowledge the nurse must learn and have the opportunity to apply the sociological concepts. Unless this is true she cannot do comprehensive nursing or consider the "whole person," which is so frequently advanced as the desirable approach to patient care. It is just as important for the nurse to find out what makes the patient behave as he does, what his feelings are, what he thinks, etc., as it is for her to know that in a specific disease certain changes are occurring, some organs are becoming permanently damaged, and that recovery is not likely. To be comprehensive, nursing must be family centered within the confines of a neighborhood in a community as well as individually patient centered. In order to be aware of *all* the implications inherent in the care of a patient the nurse must apply her knowledge of sociology along with her knowledge of other basic sciences.

It will be necessary for the nurse to recognize illness as an interactive process in which an aspect existing in fact or in thought causes an action by or a change in another factor. Primary concern here is on the sociological components of this interactive process and not on those of the disease process. The nurse recognizes that the social components in many instances do affect the course of the disease, recovery, etc. The reverse may be true, i.e., the disease process affects the immediate and subsequent social components of the interactive process.

Sociology helps the nurse evaluate the influence of the cultural background which each individual brings into his illness situation when he becomes a patient. The nurse may begin her inquiry by

directing conversation in a way that will reveal the patient's social environment, his relationships in groups, and the meaning such contacts have for him. The patient's behavior may indicate that he is extremely anxious about his sudden illness. In some instances his illness will be so acute that he is in coma or unresponsive to his immediate environment. Such circumstances as these challenge the understanding and ingenuity of the nurse as she provides nursing care. The nurse can take for granted that in the illness situation each patient usually follows his customary patterns of behavior.

What effects have the cultural forces of his groups had upon this patient and on his family? Are there social problems in the community which have contributed to this illness situation? Is there an attitude prevalent in society regarding the disease which the patient has? Will the disease condition result in ostracism or stigma for the patient's family? Will return to his old job be impossible because of his illness? Will former group affiliations be jeopardized? Such questions are only a few that may occur to the nurse as she establishes her relationship with the patient and individualizes his care. A thorough understanding of sociology will help her understand and accept the patient as he is, permitting her to function competently in a friendly, nonjudgmental manner. It should help her visualize the effect of traumatic experiences, gain insight into problems, and understand how the patient feels and why he feels as he does. The nurse cannot secure and maintain mutually satisfying interpersonal relationships in the complex environment of the hospital and the community without understanding and applying sociological concepts.

Continuity of Care. The location of the hospital in relation to the geographical area which it serves determines the effectiveness of plans designed to provide continuity of care for patients. The proximity of a family's place of residence to the available hospital facilities influences the position of the patient as he attempts to maintain close family relationships during his hospitalization. Perhaps the most important component of continuity of care will be the nurse's understanding of her role which has previously been described as one of responsibility for prevention of illness and care during the phase of illness, extending into the home and continuing until the patient is again functioning at his optimum capacity in daily life.

One of the most helpful tools in providing continuity of care is some form for recording pertinent information. Such a form as the Kardex will provide a running record of the nursing care as planned for an individual patient. This tool makes team nursing care more effective as each team member cooperates in the comprehensive plan.

It is necessary to revise the plan from time to time so that it is consistent with the patient's progress and his changing needs. Such a plan adds considerably to the patient's feeling of security and limits the number of "strangers" in his environment. It is quite reassuring to the patient to have the night nurse comment on his mastery of a difficult situation which occurred in the morning. The patient has more confidence in the informed nurse. Such a tool makes it unnecessary for the patient to repeat the same thing over and over, and he will not have occasion to say, "You are the fourth nurse who has asked me that same question today."

Interagency referral is another tool which can be utilized by the nurse in providing continuity of care. The nurse in the hospital can share her information about the patient, his reaction to illness and degree of recovery, and can make recommendations for further care to the nurse who is to visit in the home. The return of the referral to the hospital gives the nurse who initiated it an opportunity to evaluate her care and realize satisfaction from her role in the patient's improvement or recovery.

CONTRASTING PHYSICAL ENVIRONMENTS IN HOME AND HOSPITAL

It is difficult to generalize and say which is more significant or traumatic to the patient, contrasts in his physical environment or in his social environment. Individual differences are a strong element in determining the results of the contrasts, but it should be quite evident that for every individual there are some similarities which have a far reaching effect upon the course of the illness, return to normal activity and a routine life, and the degree of permanent recovery or adjustment. It is well for the nurse to give careful consideration to both aspects and weigh the benefits carefully as she plans her contribution toward the patient's care and help for the family.

Regardless of the economic or social status of the patient, his abode, whether sumptuous or meager in material wealth, provides him with necessities essential to his general well-being. He takes pride in or feels an inner security in his home. He finds comfort in his "easy chair," and finds his life made more pleasant or more enjoyable by his possessions; he prefers an old hat or coat long past usefulness, and savors food that he is accustomed to.

A person gains prestige in his group from certain necessary articles of clothing or insignia—the policeman from his uniform, the union member from his identification badge, the plumber from his tools. Some feel independent and self-sufficient, have a sense of accomplish-

ment, and enjoy group, neighborhood, and community approval. Some take pride in jewelry, hair dress, or articles necessary for their business, such as a brief case, a camera, or the like. All these things are symbols of success, power, prestige, and economic standing. What happens when illness occurs and the individual must abandon them on entering the hospital?

Hospital Admission. The majority of hospitals provide an admission department through which all patients must pass. Here an employee takes a brief history and, depending on the nature of the illness, the time spent on this procedure varies. On reaching the unit he is to occupy, the patient is undressed, and he may or may not be permitted to wear his own pajamas, robe, or the like. All his possessions except the bare necessities for personal hygiene are checked in the clothes room or turned over to the family for return home. If the patient is in a critical condition there is less immediate trauma, for many of the routines are delayed until his condition has improved sufficiently for him to become aware of what has actually happened. Without benefit of the history, which is frequently not too revealing, it is difficult for the nurse and others to determine social or economic status of the patient when he is in bed in the hospital. In the hospital he appears to be similar to others who may actually be quite different in prestige, social standing, and material wealth. The patient not only has his illness to battle, but often must meet this difficult task without the aid of things which have formerly given him a sense of security and competence.

In health his freedom of movement depended largely upon his own desires. In the hospital he becomes aware of restrictions from the moment of his admission. "You must stay in bed." "You are not permitted to go to the bathroom." "You are to be flat on your back." The patient's every movement is planned, and he may be transported from one department to another for tests, examinations, and consultations.

The quiet, familiar atmosphere of his home may be replaced with the bustling, strange environment of the hospital; or the active, stimulating noises of his home may be replaced with a subdued hush. Each of these changes increases his fear and anxiety, and consequently his apprehension. Sleep may be impossible without the aid of a sedative.

His bed is narrow and high, and often seems uncomfortable. His gown is short and partially open in the back. He is quickly absorbed into hospital routine. He gets wash water at the same hour, usually very early in the morning, is served food in the same manner and at

the same time as other patients. Indeed, all this is in sharp contrast to his familiar home environment where he could, within limits, eat what he pleased and when he pleased. Unpleasant medications and painful treatments are necessary for recovery, so he is told. He may not be permitted to have a radio and, because of his physical condition, he may not be allowed to read or indulge in other activities which would shorten the slow passage of time and give him diversional interests.

A patient suffering from a coronary thrombosis complained to his attending physician about his state of total helplessness and "nothing to do." "You should remain quiet and concentrate on getting well" was the reply. This is small solace for a man who has formerly led a very active, busy life. Since the outcome of the patient's illness may well depend upon him, it is important for the nurse to understand the full significance and meaning of the contrast between the home and hospital environment for each patient.

It may be well to mention the person who has not had a home but has lived in a cheap rooming house or small hotel. The nurse may be inclined to reason, "This is so much better than he is used to. Here he is warm, clean, has regular meals, etc." But for this individual the contrast is just as severe and no more palatable. Maintenance of life within the hospital environment is difficult for every patient.

CONTRASTING SOCIAL ENVIRONMENTS IN HEALTH AND ILLNESS

Many books have been written about the "patient as a person." Some authors have included chapters with this approach in texts related to other fields. It would seem more appropriate to give consideration to the person as a patient with an acute or chronic illness. In illness the daily routine of the individual, his customary pattern of living, has been interrupted, if not changed. Just what does this mean to the person? What was he like when he was well? He will have an established pattern of behavior, certain attitudes and values—all of these he brings with him in illness. How has he handled previous crisis situations? Many factors will influence his success in his new role as a patient.

Prior to his illness the patient has been an independent person capable of planning his own activities, determining when and how to achieve certain desires and goals. In contrast, with illness, he becomes dependent, incapable of satisfying his own needs. He is in a position to be told when and what he can do. He may be told he can or cannot eat. Fluids may be restricted or forced, or in some instances withheld

completely. It may be necessary for the nurse to feed him and assist him in the use of the bed pan. His doctor will write the "orders" and this word means regulation or command. In the hospital environment the patient finds his life completely regimented by rules and regulations with which he is expected to comply. Many of these rules apply not only to him but to his family as well. The cultural environment of the hospital contributes to his apprehension.

His friends and his family have played an important part in his daily life. His associates at work, his group activities, all are important, and now illness has severed some of the contacts and limited others. During visiting hours the number of persons permitted in his room or on the ward at any one time may be limited to two. His children may not be permitted to visit him. The lack of permissiveness of the hospital environment contrasts sharply with the independence which he formerly enjoyed.

As a patient he finds himself in a strange human world—new faces, new people, all with special functions with which he is unfamiliar. Some are friendly and sincere and seem interested in him, while others are impersonal, very matter-of-fact, and intent upon accomplishing certain tasks. Things that had little value and were insignificant when he was well become very important and quite dear to him during illness. He misses his friends and family and may feel lost without someone to confide in and to whom he can express his feelings, fears, and anxieties. Illness has produced sharp contrasts in his social environment.

Illness is a definite threat to an individual's security. Regardless of the kind of disease or illness the patient has, he is a person with feelings. He has fears and is uneasy, perturbed, uncertain about the outcome of his illness and his recovery. Frequently the nurse finds a correlation between the severity of the illness and the degree of fear and anxiety shown by the patient and his family. Because of the inclination to stress nursing care for the patient instead of for the disease, the nurse recognizes each individual's personality characteristics. His illness brings him to the hospital, but many of the problems of his life accompany him. Some of his life problems are more acute because of his illness and additional problems constantly present themselves.

From the nurse-patient situation the nurse learns much about people. How does personality affect this relationship? Each nurse has experienced a variety of relationships with patients. Some patients she feels she can "get along with" very well, while there are others whom she feels she cannot understand and she finds it difficult

to solicit their cooperation. The nurse may realize that her own personality exerts a great deal of influence upon the patient; it may modify his behavior and may produce constructive or destructive effects. If the nurse accepts the belief that the patient's personality is the sum total of his experiences as he interacts with his environment she can begin to gain some insight into the etiology of his personality. How does he handle his role in illness? How does he react to the disruption in his daily life? Illness will have some effect upon his personality, and conversely his personality will have some effect upon his illness. It is uncommon for the nurse to encounter a person in illness whose behavior, attitudes, and values are not influenced by his illness situation. It is well to remember that illness creates many problems in interpersonal and social relationships.

ACUTE ILLNESS THREATENS FAMILY SECURITY

Acute illness is difficult for the patient, but what of his family? Few families are prepared for acute illness. If illness occurs suddenly it is extremely disrupting to family routine and the effects of it are far reaching. Other relatives may have to come into the home to help in the emergency, or some members of the family may have to go into relatives' homes for the duration of the illness.

Hospitalization means at least a temporary break in the family circle and in family solidarity. Critical adjustments are frequently necessary, and because of the suddenness with which they must be made are frequently not well thought out or efficiently planned. A close family friend, less involved emotionally, is often a tremendous help in constructive planning and arranging temporary modifications in family practices.

The security of the family may be threatened economically because of loss of income and increased expenses. Few families, even those with some kind of prepayment hospital insurance, can face the high cost of medical care and hospitalization without some marked adjustment in spending.

Acute illness not only interferes with the security derived from primary group associations and produces economic burdens but also results in severe emotional strain which threatens security for the family. Visiting the ill person may prove a hardship because of disruption of routine and the time element involved. Fear, dread of the outcome, anxiety over slow progress toward recovery, and other associated factors add to the family's general feeling of insecurity. This insecurity may be heightened if the family is unable to understand the reason for or the value of treatments, operative procedures,

and the like. Should the illness be an infectious one, there is the added burden of preventing its occurrence in other members of the family, as well as care of the room where the patient had been confined prior to hospitalization. An infectious illness may also interfere with community activities for other members of the family and may restrict social contacts temporarily. In illness family life becomes very different and may be extremely difficult, with the effects lasting well beyond the patient's recovery.

THE NURSE-PATIENT RELATIONSHIP IN ACUTE ILLNESS

The usual person confronted with an acute illness becomes dependent. Behavior patterns remain individual and each person has his own ideas about his new role of patient. Some patients regress to earlier patterns of behavior and look upon the nurse as a mother figure. In this kind of a relationship the nurse may find it difficult to solicit and secure self-help from the patient, if such is compatible with the illness. Because of the security derived from regression the patient may be reluctant to cope with the more complex aspects associated with improvement, recovery, and eventual hospital dismissal.

Patients and their families from the various social and economic groups of society view the nurse differently, and as a result the nurse-patient relationship may be patterned accordingly. Those persons in the upper economic and social groups strive to maintain or continue their feeling of superiority and may think of and act toward the nurse as a servant, with the relationship being one of inferiority-superiority and submission-dominance. In contrast, the nurse is likely to find those patients who are part of the middle and lower economic and social groups more willing to accept recommended treatment and appropriate care. Frequently, since members of these groups are not used to services, doing things for themselves is a natural way of life. Patients permitted small privileges are appreciative and take pride in assuming some responsibility for their own care. Often these groups feel closer to and are more friendly with the non-professional personnel who give them care. This may be due partly to the "awe" in which they hold the nurse or to the patient's feeling that the nurse does not have time to bother with "minor details" and "problems." It seems easier for the ancillary workers to accept the patient as he is and through their behavior indicate to him that his beliefs and ideas are important. Ancillary workers in a close team relationship with the nurse can contribute pertinent information to enhance the un-

derstanding of the nurse. Because of the limited time that the nurse can spend at the bedside she should solicit and utilize this shared information so that she may learn more about the person as a patient and thus improve his care.

In each nurse-patient relationship the nurse should understand the reasons for the patient's feeling of insecurity. If it is the patient's first experience with hospitalization, as contrasted to one who has had repeated experiences of hospital care, the nurse notices the difference in adjustment and attitudes. Some insecurity is evident even for those who have had earlier experiences, but the nurse can sense a familiarity with routines and environment. The kind of a reaction that patients have will be influenced somewhat by previous experiences.

It is well for the nurse to remember that the suddenness of acute illness will not have afforded the patient and his family opportunity for adjustment. "If we had just had time to plan . . . ." is a frequent comment to the nurse. In many instances the family can do a great deal to lessen the patient's feelings of insecurity and increase his confidence in necessary treatment and in the personnel responsible for providing care. The nurse should make an effort to meet the immediate family and learn from them about the person who is the patient. A short conversation can be very revealing and may contribute to a more profitable nurse-patient relationship.

HEALTH EDUCATION AS THE MOST EFFECTIVE TOOL FOR AVOIDING ILLNESS

In the last analysis the individual is largely responsible for his own health. This being true, health education offers perhaps the most effective tool for preventing illness. Through health education individuals and families can become better informed about their health needs and how they can provide for these needs as well as become familiar with the many resources available for health promotion and disease prevention.

If the nurse is to use the tool, health education, effectively and contribute to the over-all improvement of health practices, it will be necessary for her to recall the basic fundamentals of learning and apply these. Knowledge alone will not be enough, for she must have insight into motivating factors which will result in the understanding and use of good health practices. Modern science and medical advances have made rapid strides and have given many new concepts about disease prevention and control, but unless these discoveries are accepted and utilized by the general public little can be accomplished in improving daily living and in avoiding illness.

It may be well to mention early ambulation in relation to health education. Early ambulation for all patients hospitalized for various conditions has limited the nurse's opportunity for teaching. There is not sufficient time to provide occasion for the nurse to really learn to know the individual-patient. This is perhaps the greatest handicap in beginning the teaching where the patient is and adapting it to individual needs. Other members of the team contribute much of the nursing care, further limiting the contact which the nurse has. A solution is difficult, but the nurse should strive to increase the time available within the limits of possibility, assign priority to pertinent content, organizing the teaching content to include the most essential aspects. She should also give some thought to the most effective manner of presentation, such as demonstration, conversation, and the like. The readiness of the patient for teaching will frequently influence the speed with which the nurse can proceed.

SOCIO-ECONOMIC STATUS AND INCIDENCE OF DISEASE

Some diseases are found more frequently in certain groups. Studies have indicated a correlation between socio-economic status and disease incidence. Tuberculosis is a good example, for it occurs more frequently and death rates are higher in the lower economic groups. Limited financial resources and associated circumstances can be considered predisposing factors and relate directly to increased incidence. Consequences of poor housing, crowding, and similar factors probably contribute to the increase of communicable diseases in the lower economic group. Environmental sanitation, more difficult to maintain in crowded congested areas, is also an important factor to consider in relation to disease incidence.

The nurse will find an occasional review of morbidity and mortality statistics helpful in providing information about the current problems which she may expect because of disease incidence. Those tables which indicate incidence in relation to such factors as income and the like will show significant relationships between the various socio-economic groups.

RESOURCES WHICH MAY BE UTILIZED TO COVER COST OF ILLNESS

The whole problem of cost of illness and payment for care is one of which the nurse is constantly aware. Many families resist regular medical and dental supervision, which may result in oppressive costs and extended care later. The nurse is aware of the merits of pre-

ventive practices and finds the attitude just described disheartening and detrimental to health status. She may see low-income families spend their limited funds for television sets, automobiles, gadgets, and the like, instead of planning to meet medical expenses. Although such practices are regrettable they are frequent and some solution must be sought. She may see middle-income families struggle to meet costs of illness by sacrificing many of the minimum essentials for daily living. The families with higher income can provide for the best available services. It is well to consider what facilities are available to cover the cost of illness.

Workmen's Compensation. Most states have adopted some form of workmen's compensation. These programs vary widely in the kind of coverage offered, as well as in the kinds of employment covered and the amount of benefits paid. It is well for the nurse to know some of the benefits of these programs, most of which are designed for payment of workers who are injured on the job. The worker may receive his salary while he is off work because of injury; medical care and hospital expenses may be partially provided or covered by total payment; and cash settlements may be made in case of loss of an eye, hand, foot, or other permanent injury. Some provide payment for survivors in the event of a fatal injury.

Prepayment Plans. Many large insurance companies offer policies for health and accident coverage, although most of these fail to cover the entire cost of illness and hospital care. Maximum benefits are designated and certain diseases are not covered by benefits of the policy. These policies are expensive and the cost of premiums prevent many persons from taking advantage of this kind of protection.

The most popular prepayment plans are the Blue Cross, for hospital care, and Blue Shield, for medical and surgical care. These group insurance plans can be secured for a small monthly payment which many families in the middle and lower economic groups can afford to pay. Benefits vary from one area to another but the services provided are rather comprehensive and are being extended. Some thought is being given to provision of long-term care and nursing service in the home. Most families find these two plans of great assistance in meeting costs for hospital care, surgery, and medical services. The increasing popularity of these plans should insure coverage for an increasing proportion of the population.

Other Sources. Almost all hospitals offer some free services to persons who cannot pay. The hospital may receive help from Community Chest, taxes, church affiliations, etc., for the purpose of pro-

viding essential services to indigent individuals, and staff physicians may offer their time and skill without charge. Hospitals usually make efforts to collect some small sum from all patients since this fosters independence and self-esteem.

Local welfare organizations, particularly county welfare, negotiate with hospitals for services to county residents who cannot finance their own illness and consequent hospitalization.

The nurse must know the policies of these organizations in order to secure necessary assistance for patients and their families. The medical social worker and the social case worker are valuable allies in helping the nurse and family make arrangements for medical and hospital care.

SUMMARY

Nurses need to learn early what it means to consider the patient as a human being. When the individual enters the hospital he brings a disease condition with him. The nurse must give consideration to the pathological process but simultaneously must be aware of the problems which the patient also brought along. In comprehensive nursing, both the person and his illness will receive attention, for the nurse must find means of aiding the patient and his family in overcoming family problems, including social and emotional factors as well as physical factors. It is difficult, if not impossible in some instances, to decide if the problems have caused the disease or the disease has caused the problems. In either event, the nurse recognizes that success in the alleviation of one depends upon the progress made in mitigating the other.

The individual as a patient has many sides to his personality. The nurse is aware of the patient as he thinks of himself, which may differ considerably from others' opinions of him: there is the patient as the nursing team sees him, and the individual as his family sees him. There may be similar personality characteristics in each of these "individuals," and facets of each will be important to the nurse as she gives care. She must be capable of accepting the idiosyncrasies of the patient if she is to provide support which is to help strengthen his feeling of security.

The nurse must have some conception of the importance of culture with respect to illness. The individual has been molded by his cultural background and brings, in sickness as in health, a collection of characteristics and value concepts which will pattern his behavior in the nurse-patient situation.

There is a distressing contrast between the permissive environment

in which the patient functioned prior to admission and the role of dependence which he must assume on entry into the hospital. The patient felt a degree of security in his home with his family, but the hospital environment creates deep feelings of fear and apprehension. The nurse's efforts to aid the patient in recognizing his role and in accepting responsibility for his contributions toward successful treatment help the patient feel he is a member of the team striving to accomplish the goal of recovery.

It is important for the nurse to recognize that each individual adjusts to disease in his own particular way. The family also reacts in its own manner to an illness experience. Visualizing the family in its social-cultural setting will help the nurse comprehend family behavior in illness situations. The nurse must also remember that illness and hospitalization may prove very expensive, particularly if the family has neither hospital nor medical care insurance. This may influence the behavior of the patient and his family, producing fears, worries, and even temporary changes in personality. The nurse is in a position to reassure and support the patient and his family through her knowledge of the proper agencies to contact should any outside financial assistance be necessary.

FOR INVESTIGATION AND DISCUSSION

1. Can you list ways in which the behavior of the family will affect the behavior of the patient?

2. How does illness affect the behavior of an individual? Does this have any implication on nursing situations?

3. Is there any relationship between biological and cultural factors in a disease condition?

4. What techniques might the nurse employ to secure cooperation from the patient?

5. How may the patient's past and his family history contribute to his hospital adjustment?

6. How does it help provide better nursing care to analyze the individual patient in terms of:

   (a) health, mental and physical;
   (b) family and family life;
   (c) interests and activities;
   (d) understanding and appreciation of cultural heritage;
   (e) intellectual status;
   (f) personality;
   (g) philosophy and ideals;
   (h) occupational habits.

7. Why is it important for the nurse to have some understanding of family attitudes about health and toward illness?

8. What is the relationship between economic resources and procurement of early diagnosis? Would you say the factor of money heads the list as the main determinant in seeking early adequate care?

9. What potentialities does your community have for prevention and control of disease? Are any of these strictly social factors?

10. What indications have you had that families are interested in participating in programs designed to maintain health? In programs designed to cope with social problems?

11. Find out the per diem cost in a local hospital and compare this with national cost. What percentage of patients in the local hospital have hospital insurance of some kind?

12. Review a hospital insurance policy and evaluate its benefits: diseases and conditions covered, amount of payment allowed, types of treatments paid for, length of hospitalization covered by policy.

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Chapter 23

NURSING SITUATIONS IN LONG-TERM ILLNESS

Various definitions have been given for chronic diseases, and the number of pathological conditions falling into this category are numerous. Consideration of the disease condition as such is not the prime object here. The social consequences of the various chronic pathological conditions constitute the more appropriate topic. It is in this realm that the nurse frequently lacks knowledge, appreciation, and skills. She usually is aware of the degree of dysfunction, has some understanding of the changes which have occurred in the body, and can recognize symptoms, but she has difficulty in organizing her contribution consistent with the broad ramifications of chronic illness.

As a point of departure it seems sufficient to consider long-term illness as the result of a chronic condition. Long-term illness will be considered as one which has existed for at least six months or one which, because of the degree of evident disability, shows promise of continuing for an indefinite period of time. In either instance the illness is destined to infringe upon every aspect of the individual's life: himself, his family, their neighborhood, and the community, and to affect his economic status, his occupation, and his social life, to say nothing of his physical condition. Although the nurse is concerned with many aspects of the problem of long-term illness she has some special needs which must be met to qualify her to work effectively with others and to coordinate her services with the over-all community program. Since long-term illness can create far-reaching problems it will be necessary for the nurse to recognize early and cope intelligently with the sociological aspects inherent in each individual situation in order to make her most effective contribution.

IDENTIFICATION OF THE MAJOR DISABLING DISEASES

Those diseases or conditions most frequently categorized as chronic diseases are cancer, heart and blood vessel ailments, arthritis, rheu-

matism, post-poliomyelitis, multiple sclerosis, cerebral palsy, epilepsy, diabetes, blindness, deafness, tuberculosis, muscular dystrophy, syphilis, and mental disability. The kind and incidence does not warrant detailed consideration here. In each long-term illness the individual involved and the constellation of factors in him and the life about him will vary, but even so there are some general circumstances which can be considered profitably.

The one item that tells most about a given illness and also about the nature and the burden of the case load in a given population is the diagnosis of the disease. The diagnosis usually gives a general idea of the expected duration of the disease, whether recovery is probable, and, if so, whether it will be complete or whether the patient will be permanently impaired.

MAGNITUDE OF THE PROBLEM OF CHRONICITY

Examination of statistical data substantiates the assumption that illnesses of long duration are increasing steadily. Concurrently with the increased incidence there seems to be evidence of greater awareness and interest on the part of the public in general. The nurse can be expected to cooperate in disseminating accurate information about the magnitude of the problem as a step in stimulating further public interest and support for improved and more adequate facilities for meeting the needs of persons with long-term illness.

The number of persons 14 to 64 years of age with a disabling illness or condition in September 1950 was estimated to be 3,605,000. Had the population of resident institutions been included an additional total of roughly 750,000 disabled persons would probably be added to the number above.[1]

Various authors indicate the total number of the population actually suffering from a long-term illness may be from 26,000,000 to 30,000,000. These figures, however, include many conditions of a relatively minor nature not included in the earlier list. In some instances the conditions included were of short duration, and this, no doubt, accounts for the excessively large number. Figure 20 will further emphasize the magnitude of the problem of long-term illness.

AGE SELECTIVITY

Long-term illness is no respector of age, and has no special affinity for any particular age group. However, the probability of some kind

[1] Federal Security Agency, "Estimates of Disabling Illness Prevalence in the United States." *Public Health Monograph No. 4*, 1952, p. 11.

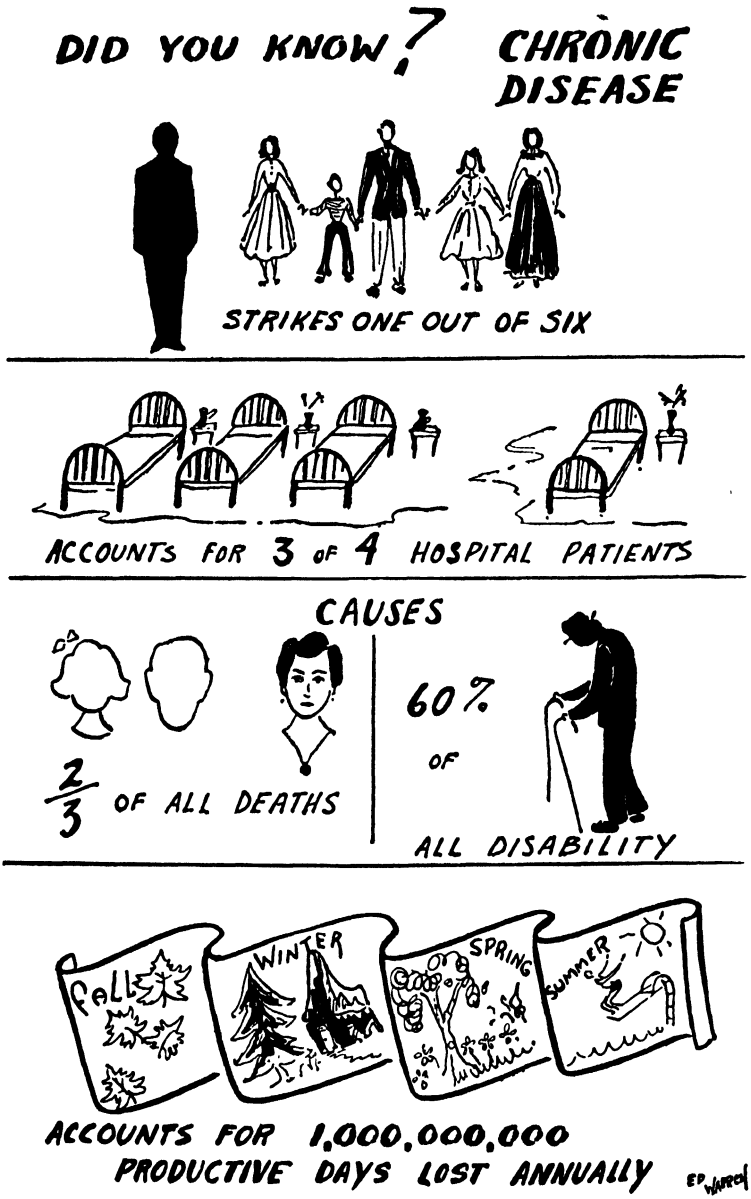


Fig. 20. The magnitude of the problem of long-term illness. (From Herbert Yahraes: "Something Can Be Done About Chronic Illness," *Public Affairs Pamphlet No. 176.* New York, Public Affairs Committee, Inc., 1952.)

Table 9. Estimated Percentage of Persons with a Disabling Illness or Condition in the Civilian Non-Institutional Population by Age: United States, September, 1950

Years	14–64	14–19	20–24	25–34	35–44	45–54	55–64
Both Sexes	3.67	1.81	2.34	2.31	2.98	4.65	8.63

Source: Federal Security Agency, "Estimates of Disabling Illness Prevalence in the United States," *Public Health Monograph No. 4*, 1952, p. 2.

of long-term illness increases with advancing years. Table 9 sheds some enlightenment on the age distribution.

The age at which long-term illness appears influences the life adjustment for the individual involved. If the illness begins shortly after birth or during childhood or adolescence it produces an effect upon normal growth and development: social, mental, and emotional, as well as physical. The effects from this early beginning may be so far reaching as to extend throughout adult life. The best hope for decreasing the devastation resulting from long-term illness seems to lie in prevention.

PREVENTION

Most people fail to appreciate the value of good health until they do not have it. Only recently have public health programs encompassed the control of chronic disease. Many of the diseases which precede long-term illness can be prevented. For some there are specific preventive measures; for others modified nutritional practices, safe habits, avoidance of predisposing conditions, and healthful living in general produce results.

Another factor which enters the picture here is early diagnosis and proper treatment. Many physicians believe that early discovery of the disease condition is the most influential single factor in minimizing the extent of long-term illness and determining the degree to which the individual can return to optimum living. To the extent that prevention fails to accomplish the desired results the nurse must cooperate with others in decreasing the effects of the illness or disability.

The likelihood of an ever-increasing number of persons afflicted with long-term illness makes the preventive approach basic. The staggering economic consequences seem overwhelming. Concentration should begin with the promotion of optimum health for all throughout the life span, as this is the most important factor in attaining prevention. Providing the people with facts enabling them

to meet the current and long-range health needs is an important function of the nurse. Additional study and research should provide needed information about the influence of social factors as predisposing to specific disease conditions resulting in long-term illness.

LENGTH OF DISABILITY PERIOD

Although the average duration of disability varies with the kind and extent of the disease condition, age also seems to be a factor which influences the length of the disability period. Studies have shown that the days of disability tend to be less in the younger age groups, while a steady increase in days of disability can be noted as age increases. Part of the explanation may lie in the fact that occurrence of acute illnesses is more common in the younger age groups, while, in contrast, the long-term illnesses seem to dominate in older age groups. For persons who have reached sixty-five years and over, the disability period is much longer than it is for the population as a whole. The period of disability affects many areas in the over-all picture of long-term illness. The loss of productive activity is greater, the costs to the individual and the community are increased, and problems of social adjustment and return to optimum living are all intensified by duration of the disability. The length of time that the ill person is disabled is probably of greater importance to him than to the community.

PERSONALITY

Repeated emphasis has been placed upon the importance of the nurse's respecting the individual's personality. Each person, regardless of his condition, is deserving of recognition indicating that he has personal worth and, in almost all instances, a contribution to make. In some situations his own care of personal needs may be the extent of his contribution, but he will feel that he is being helpful and becoming less dependent.

Emotional maturity is an important component in nurse-patient relationships. There will be those persons who can realistically evaluate their limitations and with a surprising degree of calmness philosophically accept the facts which confront them. Some individuals, facing the facts, can adjust work patterns, living habits, goals, and the like and receive satisfaction within the limits established by the type or extent of the disability. Limits may become necessary, too, because of environmental factors, for not all are intrinsic to the personality. The nurse knows that her contributions will be effective to the degree to which she is cognizant of the individual's social environment and relationships: past, present, and future. The patient's

personality will determine his acceptance and his willingness and ability to cope with the critical situation of long-term illness and, last but not least, to profit from the experience and relationships established. Personality is one of the interactive factors constantly influencing the course to be taken and the results to be obtained. Ability to identify and evaluate the etiology of sociological forces involved in each long-term illness situation is as important to the nurse as knowledge of the disease process.

There are personality patterns which favor acceptance of long-term illness as a means of deriving satisfying experiences. For individuals in this category ill health provides an excellent opportunity for them to justify their inability to perform or accept responsibilities logically theirs. In extreme cases it is evident that illness justifies escape from normal social relationships, personal obligations, and assumption of roles which are considered essential in society. In such situations the nurse must exercise great skill in helping the individual to accept a more realistic approach to his problems. Long-term illness and severe disability may predispose to personality changes which justify the oft-heard comment, "He has certainly changed."

What kind of a person was the patient before his illness? On the surface it may appear that the adult is adjusting satisfactorily to extrinsic environmental factors, but he is much more adept than the child at concealing intrinsic factors, i.e., his real feelings. His overt behavior is quite significant and may denote conflicts, frustrations, and feelings of insecurity and inferiority. Impatience may be indicative of a firm, unyielding personality. Such behavior must be understood and receive attention as indicated, if self-esteem is to be maintained and return to optimum living is to be realized. The nurse should take advantage of the fact that she is in an ideal position to help the person gain a better understanding of himself, assign new values, and accept his limitations.

HOUSING FACILITIES

There seems little doubt about two things: first, long-term illness is widespread to the point that most families have it to contend with; second, it is more desirable socially and economically to care for the person in the home. A common denominator makes this practically impossible: modern homes are smaller. Physical arrangement and limited space present real obstacles. Just the addition of a wheelchair which is too large to move through doorways may isolate the person from other family members or mean a complete rearrangement of the interior of the household. When space is at a premium privacy may

be impossible and unreasonable adjustments may have to be made for the sake of the ill person. A one-story house with enough rooms to provide one for the patient does lend to the possibility of satisfying the needs of both the family members and the ill person.

INFLUENCE ON FAMILY LIVING

The problems associated with long-term illness reach into the lives and homes of many. Even in the most ideal family some adjustments are necessary, for long-term illness prohibits normal living. Family relationships may become quite complicated, intolerance may result, and family stability may be threatened. Continued stress over a long period of time may even result in such critical circumstances as separation or divorce. For some families the only solution to the problem is the exclusion of the ill person from the family circle. This rather drastic course of action is easier to follow if the patient is not a member of the immediate family group. A wife may be more willing to provide care elsewhere for her ill father-in-law or distant relative than for her ill husband. Not infrequently serious family difficulties arise over the care of an older relative in the home. Yet some families are capable of maintaining relatively high morale, thus minimizing the effect of long-term illness which requires care from the family group.

The degree of disruption depends upon which family member suffers from long-term illness. Should it be the mother, maintenance of the household becomes a problem. If the father succumbs to long-term illness, it may be necessary for the mother to leave the home to work. Children are affected by the changes which necessarily occur within the home. In some households all adult family members work and this means the disabled person is left unattended throughout the day. In many instances, homemaker service may perform an important social function for such families. It enables the family to live together as a unit and permits the ill person to remain at home in his familiar environment. The homemaker performs the essential household activities, and sustains the atmosphere of the home and the comfort of the family. If nursing service in the home is available, it, too, may make home care for the patient with long-term illness possible and relieve family members of some of the physical and mental care.

It is rare to find a family which does not evidence insecurity. In acute illness situations the insecurity is greater in degree but shorter in duration. It is easier for families to accord special concessions because of illness when it is acute, but on a long-term basis such con-

siderations may strain relationships. Over a long period of time it seems difficult for many families to gain the security so essential to successful interpersonal relationships.

SOCIAL IMPLICATIONS OF LONG-TERM ILLNESS

The individual who has experienced long-term illness finds it extremely difficult to resume responsibility. His degree of self-confidence is influenced by the extent of his dependency. If interest in things outside himself and his illness diminishes, assumption of former roles may result only after his attitudes have been modified and he again gains status and prestige in what he can contribute. It does seem possible to limit the traumatic effects of limitations imposed by long-term illness if the individual is made aware of the potentialities early in his illness. The possibility of regaining economic independence strongly motivates individuals to make necessary emotional and social adjustments. The way an individual accepts his limitations reflects his social adjustment. Friends and family can provide many important items, but self-esteem seems to be the impelling power driving the individual to take advantage of his potential capabilities.

When it becomes possible for husband and father to return to his job, his wage-earning status is restored and he regains his role of provider for his family. If the long-term illness forced his wife into employment outside the home, she now can return to her role of homemaker for the family. Again the family feels proud as its usual life is re-established and the members again take their place in the neighborhood and community.

ECONOMIC LOSSES

In considering the economic implications of long-term illness it becomes necessary for the nurse to give attention to aspects beyond those of the patient and his family. The loss of regular income is not to be minimized, however. Many families almost completely remodel their living patterns to bring them more realistically in line with a lower income or to make their available savings go further. A lower standard of living is the result. When long-term illness renders the patient unfit for work, other economic factors emerge for society. What of the community.?

Loss of productive activity has broad community ramifications. Long-term illness is the greatest factor in terms of days lost from work, particularly since the incidence is continuing to increase. For one individual such productive losses may not be too significant, but for the population in general it becomes a major factor in goods and

services so vital to the American way of life. The interdependence of the population makes it necessary to weigh the effects of the lost time very objectively. Prevention, mentioned earlier, is receiving increasing support from employers, since production is the key to society's well-being.

The nurse must recognize the inability of most families to withstand the overwhelming financial burden of long-term illness. Planning to meet such economic needs is desirable but for many even systematic savings prove insufficient. When individual and family financial resources have been exhausted and further treatment and care are necessary, who pays the bill?

The needed services for long-term illness become the responsibility of the local community. For a disease condition like tuberculosis this factor is so frequently present that special institutions are provided for such patients. Another illustration is the care of the mentally ill. Although for many years this has been primarily the responsibility of the community, on a humanitarian basis the quality of care could be questioned.

The Federal government is vitally concerned in the extent of long-term illness. Increasing amounts of money must be appropriated for care and research. These sums must come from taxes which may be reduced in amount if ill persons are not wage earners and hence not personal income tax payers. Long-term illness greatly influences American economy.

LONG-TERM HOSPITALIZATION

The lack of adequate facilities for the care of patients with long-term illness results in the utilization of hospital beds so vitally needed for other services. Hospitals are unsuited to the care of persons with long-term illness, since most of them are planned and administered for the care of the acutely ill. Shortage of hospital beds and trained personnel is not the whole picture, however. Many individuals with long-term illness do not need such expensive services and accommodations for adequate care. The average patient with long-term illness requires less costly care than that provided in the hospital, where the care is not only expensive but is often unsuited to meet the patient's requirements.

Prolonged hospitalization seriously hinders the individual in other ways. The physical and social environment predispose to increased anxiety and may delay return to optimum functioning. Continued exposure to acutely ill patients has its effect upon the mental stability of the person with long-term illness. The routinized practices deemed

necessary for efficient ward administration leave much to be desired. Diversional therapy is often limited. Hospitals also lack adequate departments for physical therapy, occupational therapy, rehabilitation, and recreational facilities. The latter is especially important for children.

Patients with long-term illness are limited to the ward environment, and are not permitted to dress as they might if adequate convalescent care were available. The personnel frequently lacks understanding of the social and psychological needs of patients with long-term illness. It is the expert nurse indeed who can elicit self-help from the person confined for long periods of time in the hospital environment.

The American Hospital Association has indicated that the average stay in general hospitals of individuals over sixty-five years of age is 22.5 days, compared with the average of 10.1 days for all hospital admissions.

Recently there has been considerable interest in home medical care plans and a number of hospitals have set up programs to meet the problem of long-term utilization of hospital beds by patients with prolonged illness. Not only does the plan release hospital beds for patients who are acutely ill, but it allows the person to remain at home in familiar surroundings with his family and friends while he is also receiving skillful medical and nursing care. The extension of hospital services into the home, with continued supervision by the hospital staff, reduces appreciably the cost of the patient's care. These services, although designed primarily to meet the health needs of indigents, can be utilized for persons who can pay nominal fees.

Boston has been utilizing home care for a number of years, and in 1949 the New York City Hospital System adopted the plan. These are just two large cities which have found these services effective and economical. The nurse will be familiar with the facilities for extended care in her community, and if they are available can reassure the patient and his family regarding hospital dismissal and the quality and effectiveness of his medical supervision at home.

HOSPITALIZATION FOR THE CHILD WITH LONG-TERM ILLNESS

Fortunately the trend seems to be toward permitting the child with long-term illness to remain at home if at all possible. From an economic standpoint, care costs much less in the home. Various agencies are attempting to devise some plan whereby parents caring for a child with long-term illness at home can receive some financial

assistance. From a community point of view this plan deserves support, not only because it is economically sound, but because it is more conducive to the child's mental health.

At home he is surrounded with all the things in his world which have meaning for him. Home care, when possible, permits him to avoid long periods of separation from his parents, siblings, and others, increases his security, and makes it possible for him to remain very much a part of his family group. Since most hospitals limit visitors to those of sixteen years of age or above, the sick child's friends and playmates cannot visit him there, whereas in the home they frequently provide his only contact with his group and brighten the days and weeks involved in long-term illness.

MEDICALLY INDIGENT

It may be well to mention those persons who under normal circumstances can meet the economic demands of daily life and who can provide for their own needs. This group remains self-sufficient until an experience of acute or chronic illness occurs. Contrary to the usual opinion, not all of these persons are in the lower economic group; medical costs are a severe burden for many in the middle economic group as well. Savings and other accumulated assets frequently are insufficient to pay the high costs incurred during illness. Consequently it is necessary for persons to seek temporary public assistance. If illness has occurred to the wage earner, assistance may be necessary for daily living expenses as well as for medical costs.

The nurse will need to interpret this financial assistance to the patient and his family and dispel his thought that it is charity. This is extremely difficult for some individuals to accept, and may even hinder recovery. Inability to meet the cost of medical care should not be interpreted by the patient as a failure in personal responsibility. It may help the patient if he can see that adequate medical care may prevent chronic illness later or modify the degree of recovery, increasing the possibility of his return to a productive life. If the patient can understand this help as a community service, one to which he has previously contributed, available in time of need, much anxiety can be prevented. Perhaps an interpretation of help in a time of illness facilitating return to a productive, self-sufficient life later encourages patients to accept financial assistance. The loss of prestige is one of the basic factors involved in the patient's feeling of acceptance. Many wish to keep information relative to outside financial aid from their friends and neighbors.

Similar attitudes may result from hospitalization in a city or county institution. Special therapy and advanced procedures perfected through research may be available in such hospitals but the patient feels the stigma of "free service" more acutely than the advantages of superior care. One patient, critically injured in an automobile accident, wished to keep his hospitalization from his friends, saying, "What will they think of me being in a charity hospital?" Fortunately such attitudes are frequently changed before dismissal, and the patient has only praise for the quality of his care.

CONTRASTS BETWEEN ACUTE AND LONG-TERM ILLNESS

It should be evident that there are many differences between acute and long-term illness. Acute illnesses occur more frequently and in greater numbers, and last shorter periods of time. In most instances the individual suffering from acute illness benefits by complete recovery from the disease condition and can return to normal living in a relatively short time. In contrast, long-term illness occurs less often than acute illness and persists over a much longer period of time, even for many years. Permanent disability frequently results and prolonged incapacitation prevents a return to the usual way of life. The acute illnesses most frequently occur in younger age groups, while long-term illnesses predominate in the older age groups. Those individuals in the later years of life are in much more unfavorable circumstances to bear the financial burden of long periods of hospital care and medical treatment. Long-term illness presents almost insurmountable difficulties for the afflicted individual, in contrast to the temporary encumbrances resulting from acute illness.

CHRONIC DISEASES WHICH RESULT IN NON-DISABLING CONDITIONS

Some disease conditions interfere relatively little with the routine life activities of the individual. Diabetes is a disease in point. Many individuals can continue in the same job and enjoy life almost as usual. Marked dietary variations requiring time for weighing food and calculating nutritional requirements are no longer necessary. Nurses encourage continuation of usual activities and, with the exception of a few precautionary health practices, the individual suffers little inconvenience. Radical changes and marked adjustments in family routine are seldom necessary for the diabetic person today.

Permanent disability is quite different. Pain and discomfort may never completely disappear; the degree of deformity and extent of dysfunction may gradually become more evident.

SEX DIFFERENCES IN DISABILITY

Some disease conditions occur more consistently in males than in females. Such sex-linked differences in incidence can be noted in the higher rate of ulcer, coronary heart disease, and the like in men,

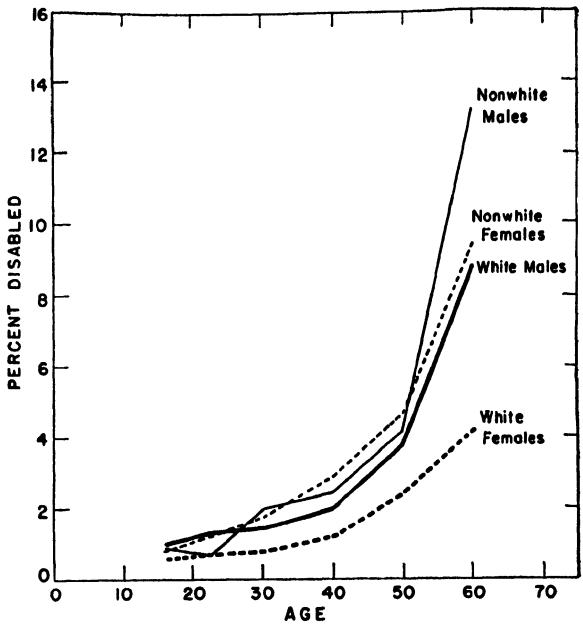


Fig. 21. Percentage of surveyed population with a disabling illness or condition of over 3 months' prior duration, by age, sex, and race: February, 1949, and September, 1950, surveys combined. (From Federal Security Agency: "Estimates of Disabling Illness Prevalence in the United States," *Public Health Monograph No. 4*, 1952.)

whereas women seem to have a higher frequency of such diseases as nervous and liver disorders. The results of a limited survey as shown in Figure 21 indicate that the incidence of disabling illness is greater in males than in females.

MENTAL ILLNESS

Today mental illnesses present one of the most serious problems in the field of health. It seems justifiable to single out mental illness

for separate consideration because of the great number of persons afflicted and because of the serious long-term personal and social consequences.

Mental Illness as a Problem. Mentally ill persons in the United States numerically exceed patients with any other type of illness. Public funds are used for providing facilities and care for the majority of persons with mental illness. The cost is colossal. Because the number of professional personnel prepared in this specialty is limited, much of the care must be provided by ancillary workers. Community mental health programs need to be developed. Much needs to be done in removing the social stigma and encouraging a more realistic acceptance of mental illness. Rehabilitation services should be improved and expanded, affording greater opportunity for more persons to return to a socially useful life. Early diagnosis and treatment lead to a more hopeful prognosis. Increased public recognition of the importance of promoting preventive programs and increasing available facilities for care would stimulate further action to overcome the problem.

The broad spectrum of mental illnesses ranges from the milder forms of psychoneurosis to the more serious disorders such as psychoses. Psychosomatic illness is seen in individuals who have difficult life situations and who are not personally equipped to handle problems resulting from adversity. In some instances the illness is acute, while in others it is considered long-term. Patients with some disease conditions require hospitalization and treatment for a short period of time, but others may be institutionalized for years or even for life.

Personality disorders are also considered in the category of mental illness. Many persons manifest personality disorders with varying degrees of social maladjustment. Drug addiction and alcoholism are behavior patterns which may emerge. Other disorders are evidenced in failures in interpersonal relationships, in school, at work, or in marriage.

In examining the statistics showing the ten leading causes of death, one does not see mental illnesses listed. The assumption, then, must be that the death rate from mental illness is low. Indirectly, however, many deaths in the form of suicide and homicide can be attributed to mental illness.

Increasing Need for Institutional Facilities. The demand for more facilities for the care of patients with mental illness seems reasonable in light of Figure 22. This graphic illustration shows the need, consistently increasing year by year, not only for greater num-

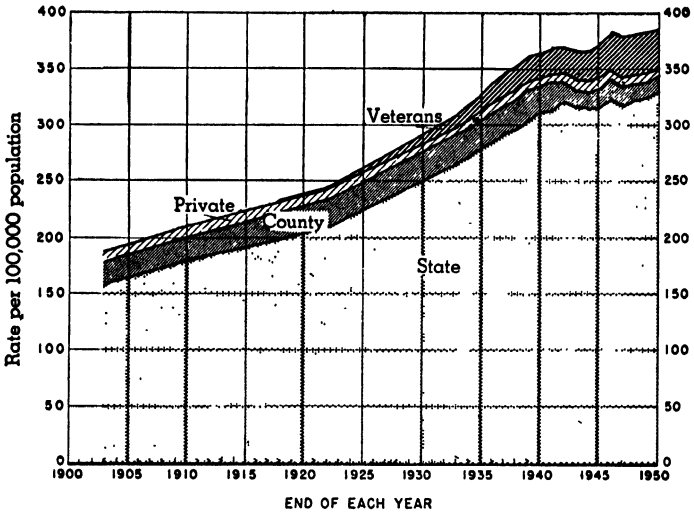


Fig. 22. Resident patients in mental hospitals per 100,000 population, United States, 1903–1950. (From Robert H. Dysinger: "Mental Health in the United States," *The Annals of the American Academy of Political and Social Science*, Vol. 286, p. 9, March, 1953.)

bers of available beds and accompanying services but for improvement in quality of medical treatment. When these factors are considered, the full significance of the preventive approach to the problem becomes more understandable.

Environmental Factors in Mental Illness. Certain environmental conditions warrant consideration as predisposing or contributing factors in mental illness. Statistical analysis indicates that the incidence is higher in urban than in rural areas, and in larger cities than in smaller cities. The highly competitive existence of the urban dweller constantly functioning in a more complex environment may be instrumental in increasing the rate of mental illness. Emotional stress created by environmental factors such as occupation, housing, and material possessions cannot be overlooked.

Family Strengths and Weaknesses. The whole process of socialization may distort the individual's personality to the extent that functioning in society is restricted. Interaction, individual and family, with society may produce tension and frustration. Many factors in present-day society tend to increase anxiety and limit security. The complex interactional pattern of daily life frequently proves to

be a greater burden than some individuals are prepared to accept. Cultural conflicts make adaptation to changing environmental circumstances difficult for many.

The Nurse and Mental Illness. Many professional persons, such as physicians, teachers, health educators, social workers, and nutritionists, come in contact with great numbers of persons and are in a strategic position to influence mental health of the population. The nurse as one member of the professional team recognizes mental health and mental illness as social problems. Her responsibilities are manifold. She is obligated to contribute toward increasing public interest in the problems associated with mental illness. Progress depends upon public awareness and assumption of responsibility rightly within the jurisdiction of the community. The nurse herself may need to cultivate a more understanding acceptance of persons who suffer from mental illness. Along with members of other professions, she must accept and promote prevention as the most economical and humane approach. She should utilize every opportunity to foster and encourage healthy personalities. She must recognize how vitally human behavior is influenced by attitudes and how the emotional climate of the home affects the individual. She should remember that every phase of the individual's life, his relationships with fellow men, and his concept of self create the personality, the human being. The depth of her understanding will be proportionate to her insight into the factors causing the condition.

The nurse must learn to recognize behavior which may be indicative of mental illness. Early symptoms may become evident in emotional disturbances varying in depth and frequency. She will find her knowledge of essential components of healthy personality development helpful in identifying early symptoms of illness or evaluating deviant behavior. It may be necessary for her to give some thought to the manner in which mental illness develops in an individual. In health and illness situations the nurse is closely associated with the results of conditions of life which have impinged upon an individual's attempt to satisfy his basic needs. Environmental circumstances may make it practically impossible for the individual to acquire such satisfaction in a manner acceptable to the society in which he lives and must function. His failure to adjust or his inability to adapt may only accentuate his problems.

The nurse is aware of the problems associated with institutional care: serious overcrowding, insufficient professional personnel, inadequate facilities, lack of supportive therapy, inability to meet

individual needs, and failure to provide continuity of care after dismissal from the institution. She should be familiar with the variety of services provided in the community for prevention, diagnosis, treatment, and rehabilitation.

SOCIAL CONSEQUENCES OF DEFORMITIES

Physical deformities cover a wide range of conditions which set a person apart from others. Some deformities may be present at birth and come in the category of congenital anomalies, a number of conditions may be the result of injury, while still others arise because of destruction of tissue by some disease process. Because there are so many deformities it would be impractical to discuss each one here. However, there are similarities in attitudes toward self, in social consequences, and in group interaction which should be considered in a general way.

For the child who begins a healthy adjustment to a deformity early in life and whose family accepts the deformity in the same way, the extent of trauma and social isolation, imposed or from choice, is minimal in comparison to that which results when the deformity or disfiguration occurs in later life. The handicap presenting the greatest problem for the individual, and often his family, is one which is visible to others. If the handicap is one that can be concealed or minimized by prosthetic devices the individual can continue living in his usual manner among those persons who know and understand him.

In choosing a situation for elaboration it seems possible to include all the necessary considerations in a discussion of an individual who has cancer of the face. Very frequently cancerous conditions of the face require radical surgical procedures to remove diseased tissue. Often persons are left without a lip, jaw, or other part of the face. The social consequences to such a person can be listed under two headings: first, those resulting from fear of the disease condition itself, primarily in terms of infectiousness, and second, those which result from the severe disfigurement caused by surgical interference. The latter is more significant.

The individual involved will probably never be completely able to forget the probability of death, but his attitude of himself and the attitudes of other people will present his most persistent and most frequent obstacles. The individual may suffer from no physical or mental handicap in the sense of disability. The social handicap and associated restrictions in financial status present the traumatic situations in his life. He will have difficulty in maintaining his self-

esteem and in assessing his individual worth. He may find it more comfortable to avoid people, even old friends. Their inquisitiveness and curiosity make him constantly aware of his disfigurement. He may find steady employment limited, and even returning to a familiar work environment may be emotionally impractical.

Social distance resulting from attitudes of members of his groups may further isolate him. Even changes in family life may increase the extent of his social isolation. A serious inferiority complex may develop to deepen his feeling of inadequacy. His interaction with his human environment may reach the point where he actually avoids contact with people. It may be impossible for him to escape the psychological trauma of his handicap, even if he can adjust to his social world. Personality changes may gradually appear.

Society will continue to create barriers for the handicapped as long as present attitudes about the desirability of differences in appearance exist. Plastic surgery can perform miracles in terms of remodeling, but the long period of time which must necessarily elapse before the remedial precedures are completed affords opportunity for permanent damage in the form of social interaction. Group acceptance will be slow and the individual may never again have the feeling of belonging which is basic for his social security.

THE ROLE OF THE SOCIAL CASE WORKER

Many profitable services are provided by the social case worker in long-term illness. Because of her skill and feelings for people she contributes a constructive force in the services provided. She is a member of the team carrying the diverse responsibilities in long-term illness. The social case worker's skill in listening to the patient, in obtaining information, and in understanding the meaning of illness permits her to make valuable contributions. Her information, based partially upon first-hand observations made in a variety of environments, is shared with the nurse when the need arises. Her evaluation of each situation is based upon medical, social, and economic factors. She is consulted for an opinion on rehabilitation possibilities and her ability to provide an objective evaluation of each individual situation is most helpful.

THE ROLE OF THE PRACTICAL NURSE

A very important contribution to the nursing service in long-term illness is given by the practical nurse. The following definition of a practical nurse has been agreed upon:

> The practical nurse is a person trained to care for the subacute, convalescent, and chronic patient requiring nursing service at home or in institutions, who

works under the direction of a licensed physician or a registered professional nurse, and who is prepared to give household assistance when necessary. A practical nurse may be employed by physicians, hospitals, custodial homes, public health agencies, industries, or by the lay public.[2]

Practical nurse care is economical not only financially but also in conservation of the time of professional nurses, yet the professional nurse must be available for competent guidance and supervision. The practical nurse may function in the hospital and public health agency as a staff member or in the home as an employee of the family. Professional supervision must be provided because the patient with long-term illness may be receiving the same types of treatment as the one with acute illness. An analysis of the treatment, procedures, and patient's temperament must be made both in the hospital and in the home in order to determine the type of care he needs and the person best qualified to give it. The team plan will be quite effective in providing comprehensive care for patients as well as in utilizing the skills of all workers: professional nurse, practical nurse, attendant, etc. In the hospital the practical nurse may have more opportunity to know the patient as she cares for him, sees him with visitors, and observes his reactions to hospital personnel and regulations as well as to treatments and his own condition. The practical nurse will share the knowledge with the professional nurse so that the plan of care may be improved, modified, or changed according to the patient's needs. In the home situation the practical nurse may be under supervision of the public health nurse or family physician, but she still functions as a team member, consulting the professional person and sharing her observations. As greater numbers of practical nurses are graduated from approved programs and licensed to practice, they will be utilized in hospital, home, and community in order to participate in the extension of total services for care of patients with long-term illness.

REHABILITATION

The placement of rehabilitation within the chapter on long-term illness does not deny the need for it in acute illness. Inclusion here seems more appropriate since it is more frequently utilized in connection with long-term illness. A broad concept of rehabilitation, which begins at the time the diagnosis is made and continues until the individual is again re-established in his community, should be a part of each nurse's philosophy.

[2] Federal Security Agency, Office of Education: *Practical Nursing Curriculum*. Washington D.C., U. S. Government Printing Office, 1950.

The nurse recognizes her contribution to rehabilitation as a part of the team relationship. This concept accords the family an important role, since their cooperation and understanding are so essential for goal attainment. Many individuals and agencies may participate in formulating, utilizing, and supporting the plan for the individual. Each plan must start with the individual. His needs and capacities are unique, and the environment in which he is to function is different from that of any other person. The available community facilities will determine the course of action that can be taken. Wise planning will make full use of facilities and include any adjustments that must be made. It is common practice for the nurse to consider her contribution toward the patient's adjustment to hospital life one of her most important responsibilities. She must realize that her efforts must also include aspects of rehabilitation which will continue after the patient is discharged and until he has again become a functioning member of society.

Rehabilitation means restoring the individual, irrespective of the type or degree of his handicap, to optimum social, physical, psychological, and vocational functioning. Rehabilitation is frequently thought of as re-training designed to prepare the individual to return to productive employment and regain a degree of financial independence. The nurse should consider not only the vocational guidance programs and physical rehabilitation for the handicapped person but also creation of new interests and activities which will make new friends. Any contribution to full utilization of the individual's capacity can be considered rehabilitation. Self-care may be the limit of possibility, but this will give a substantial boost to the individual's morale and should secure recognition for accomplishment. The handicapped person should be helped to identify himself with his group and feel a part of group activities. Helpful suggestions from the nurse often promote this inclusion by family and friends. No one factor is as important as the feeling of belonging.

Occupational Therapy as One of the Components of Rehabilitation. Only recently has the significance of occupational therapy been fully realized. Some institutions like sanatoria have utilized the occupational therapist in their programs of rehabilitation for a number of years. However, wide acceptance of occupational therapy is still a goal. The occupational therapist should become a vital member of the professional team. There are not adequate numbers of trained personnel for this type of therapy, but as interest increases and recognition of the need becomes more acute, more qualified persons may prepare themselves for this important phase of rehabilitation.

Occupational therapy is prescribed by the physician with the selection of the special project left up to the therapist and the patient. The purpose of occupational therapy is to aid the patient in recovery from disease or illness. This recovery is not always physical in nature. If full recovery is not possible, then the aim becomes one of helping him to adjust to the residual effects of disease or illness. Two aspects frequently go on at the same time, engagement in some constructive pursuit and guidance in self-help activities. Some of the projects are specifically selected to encourage activities with others. Old interests may be revived, and new interests created. Resumption of hobbies provides the individual with therapeutic as well as pleasurable activities. Each plan is different, because each individual is different, and needs vary from one to another. The nurse can participate in the program by familiarizing herself with it, by sharing information about the patients with the therapist, by encouraging patients in their work on various projects, and by observing changes in patients' behavior as a result of new interests.

Physical Therapy. Physical therapy has long been recognized as a vital part of the treatment of patients with crippling conditions. A physical therapy department is usually a service offered by every large hospital and provides treatment for both acutely ill and chronically ill patients. In rehabilitation this type of treatment is essential, since it helps the patient combat the crippling condition, either through re-learning motor activities or through modifying motor activities in order to function as effectively as possible in modern society. The nurse must be familiar with the aims of physical therapy, and must cooperate with the patient and therapist in the program outlined and administered by the physical therapist.

THE COMMUNITY

Perhaps the most serious disadvantage imposed on adequate care and treatment of those with long-term illness is the shortage of adequate community facilities to meet their needs. Community planning is diversified, but the responsibility for services for those with long-term illness probably should be borne by the general public through tax-supported programs. It seems clear that the voluntary agencies and private philanthropy cannot bear the cost or the total responsibility for long-term illness. The stress lies in the fact that persons with long-term illness must be cared for over long periods of time and require specialized services for rehabilitation. Communities are experimenting on how to meet this constantly

increasing need and yet keep within the limits of available financial resources. There is a possibility that certain basic developments in the field of public health and public welfare will finally determine the range and scope of services for persons with long-term illness.

Various types of programs have been considered and can be reduced to two main categories: institutional, which includes general hospitals, nursing homes, rehabilitation units, and homes for the aged; and care in the community environment, which includes home medical care plans, housekeeping services, boarding care, nursing services, rehabilitation, and employment. The need for careful planning and integration of the services of the different agencies in the community is evident. All agencies in the community should cooperate in the development of a community-wide, broad-range program.

SUMMARY

The purpose of this chapter has been to enlighten the nurse on the complexity of the problems of long-term illness, control of which is one of the most important health and social problems confronting society today. One of the nurse's most important functions is to encourage and support the person with long-term illness. She can frequently convince individuals that they are able to lead comparatively normal lives despite their disabilities. The nurse must acquire an understanding of and an interest in treatment and care of persons with long-term illness. She must have knowledge about the social factors involved in serving the chronically ill. She will realize that the social situation in many instances is such that the care of patients with long-term illness in the home is impossible.

It is frequently necessary for the nurse to ascertain the individual's own resources for meeting some of his needs and consider the resources available to him through friends, family, and community. Her cooperation with the allied personnel concerned is especially valuable, for she usually knows the circumstances in the home, knows the individual well, and is aware of his previous experiences. She is familiar with the family's attitudes, and usually understands the financial circumstances. She will recognize the strengths which the individual brings into the new situation of long-term illness, as well as the difficulties there may be in it for him. Only by knowing the person can the nurse really understand the individual and identify other needs.

Much remains to be done in the field of mental illness. The most glaring deficiencies in the program are in adequate care and in

effectual supportive therapy. Since mental illness ranks so high in the list of health problems it seems necessary for all members of the prefessional team to encourage and contribute to improved care. Adequate facilities must be provided by the various State governments, with specially designed programs to interest professionally trained persons in this field of specialization. More emphasis on mental health is desirable as the most effective means of preventing mental illness. Nurses are aware of conditions—environmental, social, physical, and the like—which if not corrected or treated early may predispose to later mental illness.

It is very encouraging to note the increased interest of the members of the professional team in the handicapped person as a member of society. This means he is envisioned as a human being, functioning in various relationships with the same desires, needs, and aspirations as any other person. Rehabilitation is designed to get the highest possible "functioning" for each person who has a handicap. Rehabilitation offers encouraging opportunity for many to return to a profitable life, to society, and to themselves.

A workable knowledge of the sources of financial assistance and special services is also essential. The nurse will need to review agency policy, eligibility for care, and the like, in order to keep her information in line with frequent changes. The nurse's changed concepts, increased understanding, and breadth of knowledge have prepared her to assume increasing responsibility to function more effectively in nursing situations in long-term illness.

FOR INVESTIGATION AND DISCUSSION

1. How could you determine the extent to which pre-existing factors may influence an individual's acceptance of a disabling illness?

2. How may specific disease conditions alter an individual's relationship to his family? His friends? The community? Society?

3. How can the nurse utilize community resources in improving nursing care?

4. How can the nurse become familiar with resources which the community provides for long-term care?

5. Why is it so important to strive for some degree of return to optimum functioning?

6. What are some of the social problems which result from long-term illness?

7. What are some of the problems of the child with long-term illness or handicaps, and of his family, which might be encountered?

8. How can you help individuals compensate for extreme disabilities?

9. How might a child's handicap or illness influence the way in which he has grown and developed and established his basic relationships with his family and others?

10. Do families with numerous health problems also have corresponding frequency of social problems? Which ones?

11. How can the nurse assist the individual and his family to adjust to long-term illness?

12. What is the relationship between socio-economic status of the family and prevalence of long-term illness within the family group?

13. How do population changes affect existing health programs? Chronic disease?

14. From the point of view of the community, what is the socio-economic toll of disability?

15. What factors contribute to the nurse's success or lack of success in helping the individual and his family with their problems in long-term illness?

16. How could the nurse utilize other members of the team in helping a family face problems resulting from long-term illness?

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Chapter 24

IN THE PROCESS OF TIME . . .

This final chapter is a departure from the structure of the preceding chapters, as it is really in the nature of a summary. It will include aspects of the total environment in which the nurse functions, and types of relationships which are essential for effective human interaction. It will enumerate indications of progress and note some of the strengths and problems which exist in the nurse's environment in health and illness. The strengths and problems are neither complete nor arranged in order of importance. These strengths and problems are proposed with the knowledge that some will have direct influence, while others will have indirect influence on the nurse in her various roles. No suggestions for maintaining and improving the strengths or remedying the problems have been proposed, since each situation is different, and the individual's reaction to the situation frequently changes. Furthermore, the nurse with others in her community should examine the local strengths and problems unique to the immediate environment and make concerted effort to improve and remedy the situations with which they are concerned. The problems, for which some solution must be found, will serve to direct the efforts of the nurse and others into productive channels of thought and action. A better nurse, more adequately prepared to assume her obligations and responsibilities in society, will be realized only if conditions for giving opportunities suitable for personal growth and future goal attainment are improved.

THE FRAMEWORK WITHIN WHICH THE NURSE WILL FUNCTION

The nurse's ability to function effectively in any nursing situation will be based upon her understanding of comprehensive nursing and her awareness of role and responsibilities. The following definition has been endorsed by the boards of trustees of the American Med-

ical Association, American Hospital Association, National League for Nursing, and American Nurses' Association.

> Comprehensive nursing includes physical and emotional care of the patient; care of his immediate environment; carrying out treatments prescribed by the physician; teaching the patient and his family the essentials of nursing care which they may have to perform; participation in activities for the prevention of disease and the promotion of health, and delegating to other workers activities which they can perform for specified patients.[1]

The authors would like to expand the definition to include the following facets of care: attention to spiritual needs of the individual; sociological implications in relationships; broader interpretation of environment to include influence of factors outside the home or hospital; appreciation of individual which implies a greater depth of understanding; and perhaps by stating it earlier in the definition to place greater emphasis upon promotion of health because of the trend toward the preventive approach.

In attempting to indicate the framework within which the nurse will function it may be helpful to consider another concept of nursing:

> Nursing is a significant, therapeutic, interpersonal process. It functions cooperatively with other human processes that make health possible for individuals in communities. In specific situations in which a professional health team offers health services, nurses participate in the organization of conditions that facilitate natural ongoing tendencies in human organisms. Nursing is an educative instrument, a maturing force, that aims to promote forward movement of personality in the direction of creative, constructive, productive, personal, and community living.[2]

This definition emphasizes relationships and personality development. It is very broad in scope, encompassing in a general way the variety of responsibilities which are significant in nursing.

The nurse may accept either or both of the definitions stated, but each individual's interpretation of the definition and her application to each nursing situation will be different from that of another person. It may be well for the nurse to compose her own definition of comprehensive nursing, and, so long as this definition embodies the essential principles, it will be acceptable. It is of utmost importance that there be some stated concept of comprehensive nursing, so that each individual concerned may recognize her particular role, so that group effort will be unified, so that there will be increased

[1] "Tentative Statement on Nursing Education." *Nursing Outlook*, Vol. 2, p. 83, February, 1954.

[2] Peplau, Hildegard E.: *Interpersonal Relations in Nursing*. New York, G. P. Putnam's Sons, 1952, p. 16.

understanding of a common purpose, and so that all activities will be directed toward attainment of the goal. The definition will also create the framework within which the nurse may function more effectively.

RESPONSIBILITIES OF LEADERS IN NURSING

Much of what is to be said here will be appropriate for any nurse in a position of leadership. The intent, however, is to focus on those individuals who have direct responsibility for the education of student nurses since they are to become participants in nursing in the future. Student nurses learn behavior patterns from those nurses, particularly those in roles of leadership, who compose the particular social group in nursing. The inclination of "followers" to imitate leaders increases the gravity of the leaders' responsibility to maintain attitudes and behavior consistent with a truly democratic philosophy. Two things become essential, change and truly democratic living.

Change. Perpetuation of certain customs and ideals, important in the philosophy of nursing, is desirable. However, many beliefs and practices are no longer consistent with trends or compatible with a dynamic society. This means, then, that many nurses must change their concepts about nursing and people. They must also change their own behavior. It may be helpful to recall that change, even though essential, is gradual. Adapting to change is a learning process, and one which is continuous. The basic problem in reality in today's nursing is one of relationships. Current publications emphasize the theme of relationships and, while not proposing anything essentially new, do give insight into the increasing importance of this aspect of nursing. This leads into the second important consideration, a democratic way of living. All the essential facets of democratic living will not be identified but it may be worth while to investigate a few of the more important components which have special significance for nursing and nurses.

Respect for the individual is basic. Much has been said in earlier chapters about the importance of respect in relation to status. All persons involved in nursing need to be constantly aware of the need for respect. Cooperative relationships so essential to successful team functioning, accomplishment, and personal satisfaction emerge most profitably in an environment where mutual respect is the basis for all interaction.

Democracy. New patterns of group life and new problems in human relations will continue as a part of maturing democracy in

nursing. Increasing consideration must be given by those individuals in positions of leadership for the general well-being and personal happiness of the nurses, student and graduate alike. Each functions most effectively in an environment where consistent standards of behavior are maintained. Young students who have been exposed to the democratic way of life will find the autocratic practices and behavior still found in many nursing environments very thwarting and confusing. Written evidence of democratic belief and talk about democratic practice will not be enough. Leaders whose behavior actually embodies democratic principles will be essential for satisfying participation of all who contribute to nursing. This means that drastic steps must be taken by many to implement the principles which are recognized as democratic. Unfortunately there is no consistency in the concept of democracy. Principles proposed in theory must be adopted in daily living and applied in all phases of interpersonal relationships. The dignity of every human being must be respected, each can be expected to assume responsibility when the right of sharing fully in society is accepted. It will be necessary for leaders in nursing to emphasize the full meaning of relationships if the nursing environment for which they are primarily responsible is to mesh effectively with reality.

TEAM RELATIONSHIPS AND GROUP ACTION

Repeated emphasis on team function in nursing should convince even the most skeptical of the importance of cooperative effort. Several excellent pamphlets and articles have been written about the team concept in nursing. Each author has emphasized repeatedly the necessity of group understanding and concerted action. Each member of the group should be aware of the goal or goals. Each should understand the reason for or the course of action desired for successful attainment, and each should be accepted as an equal member of the group. Group unity of purpose and action will demand congenial relationships among individual members and will result in productive accomplishment. Here the nurse will find the sociological concept of group especially helpful in patterning her own behavior and in understanding and accepting the behavior of other group members. Within the framework of the group each member must find satisfaction for his basic needs. The group pattern of social relations has this satisfaction as one of its functions. In addition to consideration of the group the nurse, as leader of the team, must keep before her colleagues and herself the individual as a patient with basic needs which must be understood and satisfied if optimum-benefit team care is to be given.

COMMUNICATION

The nurse needs to develop skill in communication. Earlier chapters have shown why people communicate with one another and have given examples of how communication may be accomplished. Nurses frequently find it difficult to make use of their accumulated knowledge because of their inability to share this information successfully. It is necessary for the nurse to be able to express her thoughts and ideas effectively. This is a requisite of a good nurse. The effectiveness of her skill in communication will have a direct relationship to the adequacy of her teaching. It should be possible for the nurse to transmit information in such a way that only one interpretation is possible. This eliminates doubt and mistakes which result from faulty understanding of the meaning of words. Skillful communication also helps improve relationships, especially when specific action is required, and is one of the most effective means of winning cooperation of individuals and groups. Efficiency also can be improved by expert communication. The nurse must also be capable of using the language of the other members of the health team, the patient, the family, etc. Much still remains to be done in acquainting the nurse with the techniques of communication and in developing her practical skill.

There are still many areas in nursing in which a two-way system of communication does not exist. Not only should information be passed down the line, but there should also be a direct channel up the line if coordination of effort and skill of all personnel is to be effected. This vertical system is also essential for improving relationships between the individuals in authority and the workers. There is a horizontal method whereby persons on the same job level share information. Too often nurses fail to appreciate the value of communication and make little effort to participate wholeheartedly in transmitting information.

WORKING WITH PEOPLE

Today, nurses work with people just as they always have. However, it becomes increasingly clear that the nurse of the future will need greater knowledge, understanding, techniques, and skills in her personal contacts than were considered essential in the past. Skill in understanding individual and family reactions will be one of her most valuable assets.

Whether the nurse thinks about it or not, she and the persons with whom she comes in contact are daily influencing and modifying each other's personality and behavior. When the nurse understands the people with whom she works and has established her

status she should function more effectively in groups. Environment should be structured in such a manner that sustained cooperative relationships can be achieved.

The quality of the nurse's person-to-person relationship with the individual-patient and with her co-workers is perhaps the most important aspect of any situation in which she is involved. For this reason it seems likely that the sociological concepts may well form the basis for improving relationships and exceed the importance of disease-centered learning experiences. Technical competence alone will not insure success in her work with people or in her relationships with others.

UNDERSTANDING OTHERS

Ability to understand others is one of the fundamental steps in getting along with people. The nurse's relationship with others will be advanced if she can determine why individuals act the way they do. This information becomes especially important as she endeavors to get along with individuals who are different from her, economically, socially, culturally, racially, etc. Individuals differ in many ways, but basically their needs are the same: each wants to be liked by others, to receive recognition, to win approval, and to feel important. This does not mean that it will be necessary for the nurse to like every individual or be liked by every person with whom she functions in the various situations, but if she understands each individual it should be possible for her to get along in a satisfying relationship even with those for whom she has no special liking. As she begins to understand a person better she will find she is more reluctant to criticize differences and will also find it easier to be at ease in his presence. Getting along with others is a skill which the nurse will have to develop most as she learns other skills needed to perform intricate procedures. It may be helpful for her to start with her own family and friends in improving her skill in analyzing the feelings and behavior of others. Ability to understand others and get along with them is a skill which, when once acquired, cannot be considered a permanent accomplishment. Improvement is necessary, and the skill of understanding people is a process which should develop continuously.

RESPONSIBILITY TO STUDENTS

Improved curricula, enriched learning experiences, advanced teaching skills and techniques, and change in emphasis from disease to the individual are commendable achievements from which the

student receives numerous benefits. These are not enough, however. It is essential to increase understanding of the student and her needs. Here again it will be helpful for all concerned with instruction and supervision of students to utilize sociological concepts as each student is considered as an individual. The student's understanding can be increased by knowledge of her social values, previous experiences, attitudes toward people in health and illness, need for which she will seek satisfaction in human interaction, and her concepts of culture and society. Her feelings about the rights of others and respect for individuals will strongly influence her behavior. She must be guided toward understanding the importance of responsibility and be provided with learning experiences which give opportunity for the assumption of responsibility.

Experiences must be realistic and practical in order to prepare her to practice effective nursing. From the day she enters the school she is required to function within a framework of human relations that may be quite different from those to which she has been accustomed. This area is one in which there should be unlimited understanding, because it will be necessary for the student to develop a pattern of social interaction which will be conducive to good mental health, perpetuate the desire for growth, insure personal satisfaction, and guarantee quality performance.

EVIDENCE OF PROGRESS

There are encouraging indications of progress in health services, particularly those in which nurses function to a high degree. Reviewing this evidence of progress should provide stimulus for more deliberate planning and purposeful action toward further accomplishment and should make possible an attack on some of the problems which will be mentioned later. Concerted action by everyone concerned, with some degree of continuity, should favorably encourage progress. Among a few of the strengths that are fundamental are improved environmental circumstances, the status accorded to nursing as a profession, the greater desirability of nursing as a pursuit, which makes it attractive to prospective students. Other items which appear on the credit side of the ledger are:

Less lethargy and ignorance on part of the public, with increasing awareness of health needs.

Increased demand for medical, nursing, and hospital services, indicating increasing confidence in health services and acceptance of preventive concept.

Health and welfare planning not only on local, state, and national level, but on international level.

Widespread hospital construction throughout the United States, with better geographic distribution of physicians, nurses, and hospitals.

Research within hospitals and other health agencies designed to make objective analysis of what is being done, who is doing it, determining its necessity for welfare of individual-patient, economy of performance, etc.

Better use of personnel.

Development of the team approach in many areas, including nursing team.

Recognition of the full significance of cooperative effort.

In-service educational programs for all personnel.

Willingness on the part of administration to accept techniques and personnel practices long successful in industry.

Time-motion studies.

Opportunities for growth on the job.

Exploration of the role of the nurse.

Special emphasis being placed on the role of the nurse as a teacher.

Education designed to increase understanding as well as knowledge.

More frequent study and implementation of nursing curriculum with corresponding improvement in nursing education.

Practical learning experiences in human relations.

Increased stress on the importance of human relations in nursing situations.

Recognition that the nurse is dealing with people, not diseases.

Comprehensive approach in nursing which includes family approach, use of sociological concepts, and consideration in various nursing situations.

Appreciation of family needs in health and illness.

Better understanding of the contribution of social agencies.

Utilizing more opportunities for the promotion of health and

prevention of disease, with particular emphasis upon health teaching.

Improved community services.

Evaluation of needs and planning to meet future needs.

Recruitment as a personal and community responsibility.

Encouraging more active participation of students in planning their own learning experiences and in meeting their needs.

More guidance for students in learning experiences.

Improved orientation for the young student.

Awareness of the importance of background experiences and influence on human behavior.

The educational soundness of guided learning experiences and the provision of better guidance for students.

Growth through research, particularly in nursing.

National accreditation of schools of nursing.

Revision of the code for professional nurses.

Continued emphasis on the importance of further education for nurses.

Decreasing resistance to change.

Plans to enrich the background of the graduate nurse.

Wider use of referral.

VITAL ATTRIBUTES FOR THE NURSE

During an Institute on Nursing Education, Dr. Margaret Gerard said, "the quality of what you do for other people as nurses depends on what kind of a person you are as well as on what kind of knowledge you have." This statement could be even more meaningful if considered in light of what the nurse does with people, since this thought seems to be more consistent with the concept of self-directed activity. If the nurse is to realize deep personal satisfaction, to continue in growth and development, and to function effectively in each nursing situation, she should:

Know herself and understand her peer group.

Be able to relate herself to people.

Increase her knowledge of the basic human motivations.

Exercise discriminatory judgment.

Appreciate the increasing complexity of modern American culture.

Recognize the significance of a constantly changing environment.

Develop a degree of flexibility in her behavior which will assure ease of adaptability in nursing situations, interpersonal relationships, and group participation.

Gain insight into the reasons for resistance to change.

Understand the role of emotions in human relations and recognize the effect of her feelings upon her relationship with others.

Accept the concept of team as a means for the most effective utilization of human resources.

Realize the abundant potential of individuals.

Develop a consciousness of total community welfare.

Contribute to the improvement of established community services and encourage those services which are lacking.

Increase her awareness of what happens to families and individuals.

Focus attention on the family in any nursing situation.

Broaden her concept of nursing, making it more comprehensive.

Utilize each individual in the nursing situation, including the individual-patient, in the most advantageous way.

Teach self-help activities as a means to an end, especially in relation to early ambulation and rehabilitation.

Endeavor to develop leadership skills and make the follower role more satisfying.

Scrutinize her attitude toward her job.

Feel justified in the desire for a job with prestige.

Relate social and health aspects to daily living.

Become familiar with the prevalent religious beliefs and practices in the community and respect these beliefs in nursing situations.

Have knowledge and understanding of contemporary society.

Be qualified to consider important social goals for the future.

Expand her outlook to the national and world scene.

Utilize research in the solution of problems.

Respect and encourage individual differences.

Provide opportunity for discussion of controversial issues, as an effective means of resolving conflicts and decreasing tension.

Recognize the responsibilities inherent in freedom of action.

Understand her role in the program of positive health.

Appreciate the way of life and cultural values of other people.

Make an effort to understand the viewpoint of others.

Possess a wholesome attitude about life and have a philosophy of living.

Recognize prejudice as an indication of insecurity.

Apply the sociological concepts to the hospital as a social-cultural phenomenon.

Be prepared to function more adequately in increasingly complex nursing situations by utilizing the sociological concepts of group, culture, and person.

Place special emphasis on individualized nursing care.

Analyze social needs and plan nursing care which will meet those needs.

Be prepared to do group teaching.

Have the ability to evaluate the influence of past experiences on interpersonal relationships.

Increase her satisfaction and improve care by frequent evaluation of performance.

Understand the factors which contribute to productive group effort.

Emphasize the importance of community resources for health maintenance and in prevention and control of disease.

Apply the problem-solving method to nursing situations.

Have ability to identify social factors as causative agents in illness and disease.

Accept the fact that her educational preparation is never quite finished.

Be prepared to assume additional functions relinquished by other members of the health team.

Increase participation in professional and non-professional activities.

PROBLEMS

Nearly every problem in a sense is related to change. Identifying problems which exist in the environment does not imply ignorance of the desirability of taking a positive approach. However, the enumeration of problems related to nursing should point up some of the difficulties for which solutions must be found. If a solution is not forthcoming, then it will be necessary for the nurse to adjust her behavior in such a way as to function without irritation, frustration, defeat, and pessimism. It would seem that some of the problems call for immediate attention, with improvement of circumstances in lieu of solution. Others call for group interest and application of group effort. Many will defy solution by any single individual or small group but must be recognized for their influence upon the development and experiences of individuals. It would be impossible to identify all the problems, and the purpose here is simply to suggest some of them. Problems are considered to be:

Withdrawal of students from educational programs.

Increasing competition for women in all fields, and the effect of this on nurse recruitment.

Lack of financial resources for student education.

More objective methods of grading student performance, also of evaluating performance of all nursing personnel.

Limited interest of nurses in professional organizations.

Individual's unwillingness to work under conditions which exist in some hospitals.

Nurses' reluctance to relinquish former roles to others.

Personal aspirations for increased power and prestige.

Nurses' inability to use problem-solving methods.

Dual role of many nurses—family and job.

Critical analysis of why nurses leave nursing.

Ways of improving nurse-doctor relationships to include increased cooperation and recognition of the nurse as a colleague.

Doctors' unawareness of the nurse as a personality.

Authoritarian pattern of behavior and its detrimental effect on morale.

Antiquated techniques and ineffective utilization of personnel in an era of increased demands for nursing services.

Number and variety of persons involved in nursing care.

Increase in complexity of relationships.

Need for improved communication, both vertical and horizontal, also up and down the line.

More adequate job descriptions for all personnel.

A guide for defining the responsibilities of the nurse as she functions in various positions.

Failure of doctors, nurses, administrators, and others to appreciate the social revolution which has taken place.

Reluctance of management to consult with individuals about matters directly affecting them.

Need for improving understanding of others' jobs, organizational policies, etc.

Simpler and easier ways of carrying out nurses' duties.

Better utilization of nurses' specialized skills.

Overcoming of organizational inertia.

Utilization of non-professional personnel.

Economical utilization of supplies.

Lack of understanding of function of the nurse.

Ineffectual manipulation of human resources in nursing situations.

Increasing rapidity of change in the structure of nursing situations.

Increased demand on hospital services.

Assembly-line techniques in nursing care.

Critical shortage of nurses and other health service personnel.

Morale and its effect upon productivity of employees.

Job satisfaction.

Low salary scales in view of required preparation.

Uniqueness of the hospital in the need for service around the clock, day and night.

Undesirable working hours and rotating shifts.

Unmet needs in hospital services.

Decrease in average length of stay in the hospital.

Increased complexities in medical treatment and associated nursing care.

Utilization of basic sociological concepts in human relations.

Existence of prejudice.

Ineffective leadership.

Insufficient understanding of and insight into human behavior.

Individual differences in beliefs and opinions.

Lack of foresight.

Nurses' limited analytical ability.

Little provision for individual and group status.

Lack of motivation for self-directed activity.

Lack of permissive environments structured to encourage independent thought and action.

Teaching done in hospital not adaptable to home environment.

Much more effort and study will be needed to help the nurse improve her ability to work with people. Interpersonal relationships and successful participation with others toward the attainment of a common goal are aspects of nursing the significance of which can no longer be ignored. Gratifying interpersonal relationships are essential in the promotion of good mental health. The potentialities of improved human relations hold great promise for the future of nursing.

FOR INVESTIGATION AND DISCUSSION

1. What are attitudes, and how are they developed? How do attitudes influence behavior? What is the relationship between attitudes and values?

2. Do you have any evidence of the effect of your personality or attitudes upon the interpersonal relationships of the group with which you are now working?

3. What traditional practices are nurses attempting to preserve? Determine their effect upon individual and group behavior?

4. Can you identify a caste system in your hospital? How does it affect relationships?

5. What are the factors in the hospital environment which justify its classification as a social institution?

6. What factors contribute to the improvement of morale?

7. How does one contribute to the creation and maintenance of a permissive atmosphere?

8. How can sociology help the nurse develop an ability to understand the feelings of the group?

9. How does the nurse acquire the ability to be a good listener, one who is objective in her attitude?

10. List the characteristics of a successful nursing leader.

11. How does one learn the meaning of respect for the individual?

12. How can the nurse help people with their interpersonal relationships? Is there any correlation between her ability to give this assistance and her understanding of herself?

13. Discuss the impact on nurses of the changing status of the profession.

14. How can a group transform plans into action?

15. How does one's feeling of security affect cooperative behavior?

16. How does an understanding of the basic human needs help you work more effectively with people?

17. Illustrate some specific nursing situations in which you found your knowledge of and skill in human relations especially helpful.

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