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WESTERN JOURNAL OF NURSING RESEARCH is a journal devoted to the dissemination of research studies, book reviews, discussion and debate, and meeting calendars, all directed to a general nursing audience. Contributions are accepted from nurses both within and outside the United States. The views expressed in individual communications are those of the author and not the editorial board, the advisory board, or the publisher.

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January 23-25, 2002
International Conference on Advances in Qualitative Methods, Pretoria, South Africa. Contact: Professor CPH Myburgh and Professor M. Poggenpoel, Advances in Qualitative Methodology, c/o Okhuthele Advertising Agency, P.O. Box 905, Wingate Park, 0153 Pretoria, South Africa (phone and fax: 27 12 345 1070; e-mail: okhuthele@mweb.ca.sa).

March 21-23, 2002
International Conference on Traditions, Evidence and Innovations in Nursing, Phuket, Thailand. Contact: Urai Hatthakit, Faculty of Nursing, Prince of Songkla University, Hat Yai, Songkla 90122, Thailand (phone: 66 74 213059; fax: 66 74 212901; e-mail: convention2002@ratree.psu.ac.th).

April 4-6, 2002
Eighth Annual Qualitative Health Research Conference, Banff, Alberta. Contact: The Offices of the IIQM at qualitative.institute@ualberta.ca.

May 12-15, 2002
World Institute of Health Sixth World Conference on Injury Prevention and Control, Montreal, Quebec. Contact: 6th WHO World Conference, 511 place d’Armes, #600, Montreal, Quebec H2Y 2W7 (phone: 514 848 1133/1 877 213 8368; fax: 514 288 6469; e-mail: trauma@coplanor.qc.ca, Web site: www.trauma2002.com).

June 12-15, 2002
Canadian Conference on Nursing Research, Quebec City, Canada. Contact: General Secretariat, Conference 2002, Faculty of Nursing Science, 4106 Pavilion Paul Comtois, Laval University, Quebec City, QC G1K 7P4, Canada (e-mail: conf2002@fsi.ulaval.ca, Web site: www.fsi.ulaval.ca/conf2002).

September 27-29, 2002
American Association for the History of Nursing 19th Annual Conference, Salt Lake City, Utah. Contact: www.aahn.org.
Editorial
The Grandparents’ Papers

The papers included in this special issue were presented in December 1986 by the founders and early members of the Council on Nursing and Anthropology (CONAA) in an invited symposium at the 85th Annual Meeting of the American Anthropological Association in Philadelphia, Pennsylvania. This issue bears the same title, *The Anthropology of Nurse Anthropologists*, as the symposium and the booklet of the papers originally edited, compiled, and distributed to CONAA members by Evelyn Barbee.

Pamela Brink recently decided that these historical papers should be published in a special issue of the WJNR. When she asked me to edit the issue, I had no idea that by agreeing I would be setting off on such a profound journey. I had read the papers some years ago when I became an active member of CONAA and had long admired the nurse scientist authors for their groundbreaking efforts to forge a synthesis of nursing and anthropology. It seemed an excellent idea to put these historical pieces into print.

Then, as I read the papers again and contemplated the thoughts and experiences described by these sages in the field of nurse-anthropology, I discovered that, rather than “historical,” these commentaries are as pertinent today as they were 15 years ago. I found myself replying aloud to their statements, “Yes, that’s it!” and “Yes, it happened that way for me too.” I am grateful to the CONAA “grandparents” who took me along on their journeys and, in so doing, gave me the opportunity to revisit my own intense trip from nursing into anthropology. I thank them for their wisdom, their humor, and their anger at the status quo. I invite readers of the WJNR to take this same journey.

Although the founders’ journeys commenced from widely varied points of departure, each arrived at a common philosophical destination where they blended nursing with anthropology. They embarked on their journeys by design, inspiration, intention, distress, or simple happenstance. Osborne ventured into both fields by “happy mistakes.” Brink was inspired to become an anthropologist in a course taught by Gustav Carlson. Byerly determined to become a nurse at the age of 4 when an aunt, a nurse, cared for her during an illness. Although she entered anthropology much later, childhood readings about the lifestyles of people from other times and places had intrigued
Byerly early in her life. Kay sought anthropology to explain the behaviors of patients from different cultures.

By whatever means the founders arrived at their composite careers, each writes about the immanent logic behind their blended roles. Aamodt describes the impetus that role synthesis gave her to search for understanding about “cultural diversity . . . care taking, care receiving, and care eliciting” that has long occupied nurse-anthropologists. Osborne finds in anthropology a “broad field of study” and methods such as field studies that were “peculiarly compatible” with nursing. Brink exalts the opportunity that anthropology gave her to “think in a different way.” Bringing anthropology into nursing, according to Leininger, has helped nurses to expand their worldview and explore the differences and similarities between cultures.

Probably the most compelling theme to emerge from all of these papers focuses on issues surrounding care, what Aamodt describes as the search for links between “care, human response, and quality human experience.” The presenters devoted much of their work to identifying aspects of human care. Leininger claims that “care is the central, dominant, and unique focus” of nursing. As Chrisman points out, the founders embraced anthropology, but this affair did not “recruit them out of nursing.”

Byerly titled her original paper “Betwixt and Between,” an apt description of nurse-anthropologists who march along their clinical, research, and teaching pathways with one foot in nursing and the other in anthropology. This apparent fence straddling has led to considerable misunderstanding over the years. Some of the same miscommunications and misinterpretations that the founders encountered from both nurses and anthropologists in the 1960s and 1970s continue to plague us today in 2001. In one way or another, all the authors reflect on the marginal status of nurses who became “hybrists” when they became “hyphenated.” Kay chose to celebrate her marginality as a means for looking at “both nursing and anthropology from an outsider’s point of view.” Being in the margin is not a bad place to be. If we use it to our advantage, our marginal status can become a powerful tool for leveraging change.

Leininger and Chrisman both remark that nurses have made use of anthropological methods to understand nursing, but anthropologists have not reciprocated. Medicine is given high prestige, but as Aamodt states, nursing care “is not a limited good—if it were pearls . . . or oil, we would know a lot about it.” Nevertheless, the contributions of nurses to anthropology, which derive from both nursing and anthropology according to Barbee, “lie in their emphases on the importance of context and holism.” Osborne suggests putting an “intellectual and action context into future anthropo-
logical and nursing studies.” We need to find ways to make what we learn about nursing care, a vital resource, more accessible and useful to other disciplines and to our patients.

Thank you, Pam Brink, for your timely decision to publish these visionary papers. Your work and that of the other founders provides inspiration and examples of ways nurse-anthropologists can capture and describe the essence of nursing care and practice. The task ahead is to communicate what we have already learned and will learn in the future with our anthropology and nursing colleagues.

Nancy Lois Ruth Anderson

Guest Editor
Introduction

Evelyn L. Barbee

The impetus for the original invited session that produced what became popularly known as the “Founders’ Papers” was the 25th anniversary of the founding of the Council on Nursing and Anthropology (CONAA). At that time, both mission and membership of CONAA had expanded. In fact, 1986, the year that we had our first invited session, was a watershed year for CONAA. Much has changed since that time. Our membership, once at an all time high, has declined steadily since 1988. Our mission, however, remains the same. Perhaps the time has come to evaluate CONAA’s aims. Our goals in 1986 were as follows:

1. Effecting curricular changes in nursing programs to include anthropological concepts crucial to good care;
2. Finding ways to influence and effect improved health care of minorities;
3. Encouraging research that will contribute to the improvement of health care;
4. Recognizing social and political influences on health care institutions that tend to demonstrate little recognition of the health care of persons with different cultural orientations;
5. Assisting nurses and other health care practitioners to become more sensitive to the needs of different ethnic groups;
6. Continuing scholarly research; and
7. Sharing the results of research, teaching, and applied knowledge with other nurse-anthropologists and interested colleagues in the health field.

How well we have been able to affect curricular changes in nursing programs is debatable. Although there is increased talk and publication about multiculturalism in nursing, the theoretical basis for much of what passes for multiculturalism in schools of nursing is lacking. Unfortunately, we are in an era where either interest in the subject or taking a few courses in anthropology has convinced some nurses that they are experts in the subject. In addition, the current governmental emphasis on cultural competence has helped to spawn a number of multicultural or diversity experts in nursing. One result is that nursing is replete with self-styled cultural experts who write books that...
in five pages or less tell you how to deal with this or that culture. Another unfortunate result from this multicultural movement is that complex anthropological concepts are reduced to the level of pop anthropology. Thus, it seems that Hagey’s (1986) question, “How to accurately assess E.T. in five minutes?” has been answered. Of course, a question remains as to the accuracy of these assessments. Nurses now at least think that they know what to do when E.T. comes to the hospital. Because the bases of anthropological concepts are human beings, somehow, we as nurse-anthropologists have failed to communicate the complexity of these concepts (and hence, human beings) to practicing nurses.

How well we can encourage research that will contribute to the improvement of health care is largely dependent on how many graduate students, particularly doctoral students, we teach or can influence. Given that less research is being done at the master’s level makes it very difficult for some of us to meet this aim. Although some of us may not have graduate students, we can still influence students in other programs. For example, in addition to working with master’s students at the Massachusetts College of Pharmacy and Health Sciences (MCPHS), I have and continue to advise graduate students who are not at MCPHS. Our record in recognizing social and political influences on health care institutions that tend to demonstrate little recognition of the health care of persons with different cultural orientations is uneven at best. Much of our research continues to focus on discrete groups with little social or political analysis. We have not done as much as we should have in exploring social and political influences on health care institutions at any level. A fruitful area would be a social and political exploration of nursing. Perhaps this is because too few of us are prepared to do critical political economy analysis.

The nation’s progress with regard to minority health is uneven as noted in both Healthy People 2000 and Healthy People 2010. The latter, with its emphasis on health disparities, provides excellent opportunities for CONAA members to showcase their work. Our progress with regard to Aims 6 and 7 is much easier to evaluate. We have cosponsored or sponsored sessions at every American Anthropological Association (AAA) and Society for Applied Anthropology (SFAA) meeting since 1986. In 1986, we cosponsored with the Transcultural Nursing Society our first international conference, “International Nursing: The Cross Cultural Context” in Edmonton, Alberta, Canada. And in 1997, we cosponsored the SFAA meetings in Seattle, Washington. In 1993, I guest edited the December 1993 special issue, “Racism, Gender, Class and Health,” of Medical Anthropology Quarterly (MAQ). Three of the four articles in this special issue were adapted from
papers presented at the CONAA session at 1991 AAA meetings. In addition to the four main articles, the March 1994 issue of *MAQ* included six guest commentaries on “Racism, Gender, Class and Health” from anthropologists, nurses, and a psychologist. The success of that special issue is measured by the number of requested reprints and the fact that at least one of the articles was reprinted in a medical anthropology anthology.

Despite our success, the biggest challenges lie ahead. Foremost among our challenges is how to continue to reproduce our numbers. The proliferation of doctoral programs in nursing is both a curse and a blessing. Although more nurses are getting doctoral preparation in nursing, we have to ask if this means that fewer nurses will be seeking doctoral preparation in anthropology. How will we effect the kind of curricular changes in schools of nursing and make anthropological concepts and theories the foundation for these changes? Last, but not least, as we encourage more nurses to become anthropologists, we need to make sure that some of them are trained in critical political economy so that we will be better prepared to explicate the social and political processes that affect health care.

**REFERENCE**

Betwixt and Between

Elizabeth Lee Byerly

Conducting anthropological studies in one’s own culture, as I have on two dissimilar occasions, is difficult enough without the challenge to meet the “anthropology” of my own self as a nurse-anthropologist. That challenge is to blend some show of self at this stage of formal retirement from teaching and research with my wish to share what I think of as the more relevant contributions of my rather belated assumption of such a career.

I early thought I wanted to become a nurse. A favorite aunt was an army nurse during World War I. When I was hospitalized with pneumonia at age 4, she cared for me, and so I began at that early age talking about becoming a nurse myself.

On reflection, perhaps it was only the more formal training and acquisition of knowledge about anthropology that came later in life. Beginning with the days of my engrossed reading as a child, I was intrigued by lifestyles of peoples from other places and other times. My subsequent choice of retirement in a semi-isolated mountain valley in north-central Washington may have been a not-unexpected outgrowth of my rural Iowa background and childhood reading of everything I could possibly find about lives of settlers and Native Americans in early America. These interests were augmented by an introductory course in anthropology in high school and another later in my master’s program.

It was not until I entered nursing school at Michael Reese Hospital in Chicago (a socialization shock of some magnitude) that I actually experienced contact with persons different from those of the Anglo-German-Czech region of my younger years. My years at Reese, located in what was the heart of the city’s “black belt,” and the largest Jewish hospital in the region, widened my horizons.

I was born in 1926 to parents of “Old American” stock. Many of our ancestors arrived in this country in the early 1700s. My father’s family were from Alsace-Lorraine and intermarried with German and Scots-Irish families; my mother’s ancestors were Scots-Irish. Both branches of the family
traveled the usual migration routes to Iowa by the mid-1800s, my father’s from Virginia, Pennsylvania, and Ohio, my mother’s from the Carolinas through Kentucky and Tennessee.

Both parents were college graduates. My father was also, as were the generations before him, a farmer and dairymen. My mother had been an English teacher before marriage. Higher education was valued in both parents’ families during their generation and mine, so it is not too surprising that both my sister and I have graduate college degrees. When I was 4, we moved in the midst of the Depression to Monticello, a town of 2,500 in eastern Iowa, where I received all my K-12 schooling in the same brick building.

I received my nursing diploma from Michael Reese Hospital School of Nursing (1947), B.S.N. from the University of Iowa (1955), and M.N. in nursing administration (1958) and Ph.D. in anthropology (1970) from the University of Washington, Seattle. I received a Division of Nursing (DHEW, PHS) Nurse Scientist grant for the doctoral study.

I held various staff and administrative positions in both community and research/teaching hospitals and taught at the University of Washington School of Nursing (Seattle) and at the Intercollegiate Center for Nursing Education (Spokane). I taught courses in nursing administration, cross-cultural/transcultural nursing, graduate and undergraduate research, and theory development and evaluation. I held an adjunct appointment in the Department of Anthropology, University of Washington, and a courtesy appointment (collaborative status) with the Department of Anthropology, Washington State University (Pullman). In 1975, I spent a few weeks in Kenya as consultant to the ACTION/Peace Corps Health Education Project. From 1977 to 1980, I was project director and principal investigator for a Division of Nursing migrant health research project in north-central Washington state. I have taught nursing workshops and spoken to other health care groups about the importance of recognizing cultural variations in caregiving. Retirement from my professorship at the ICNE occurred in May 1986.

Research and Writings

Although my early research interests focused on nursing and hospitals as subcultures, over time my interests expanded to include transcultural and healing systems as relevant to rural and migrant farm workers. From these interests came writings in several areas, including application of anthropological concepts to nursing administration, education, and practice; research methods (participant observation, ethnoscience, nondiscrete category
analysis, research in one’s own culture); health-seeking choices among standard and nonstandard care/cure options by a multiethnic group of migrant farm workers (New Age, Anglo, American Indian, and Spanish-speaking); public health implications of the migrant/transient lifestyle; and control behavior in stress management.

Other writings were concerned with integrating anthropological content in teaching of cross-cultural nursing practices and health care delivery; cultural components in the basic nursing curriculum, philosophy, goals, and processes (Byerly, 1977); and commentaries on two transcultural nursing conference papers (Byerly, 1979a, 1979b). Pamela Brink and I coauthored a model course that was published by the Society for Medical Anthropology (Byerly & Brink, 1979). As an early guide, this model provided a flexible and pragmatic approach for the teaching of introductory transcultural nursing at undergraduate and graduate levels.

My doctoral study of the hospital nurse roles provided a basis for an article on the role of the nurse-researcher as participant in the study of one’s own culture (Byerly, 1969). This paper was substantially revised for inclusion in Brink’s book of readings (Byerly, 1976). The revised version discussed application and relevance of the participant observation role, technique, and method in nursing research and clinical practice. The dilemma in the research role, that of ethical considerations in the study of American subcultures, was later dealt with in the work with New Age migrant farm workers (Molgaard & Byerly, 1981).

The Hospital Study: A Systems Approach

My dissertation research (Byerly, 1970) involved 13 months of field study and employed concepts from general systems theory in the analysis of role behavior among nurses in a large urban community general hospital. As ethnographer of the subsystem of nursing within the larger, complex, sociocultural system of the hospital, I took the position that sociocultural systems may be conceived of as “controlled feedback systems.” Thereby, I explored the place of control systems as corrective feedback to maintain a “steady state.” The major aims of the study were as follows: (a) to determine how nurses handled potential and actual disruptions in the work milieu, and (b) to examine what effects these control behaviors had on the hospital system. Specifically, the research was an attempt to discover how nurses, because of their central role in furnishing and coordinating patient care services, may exert direct or indirect influence on the equilibrium of the organizational processes and structure of the hospital. The study employed concepts
of “ideal” and “real” structure, and observed control behavior in a nine-category system on perceptual-cognitive and actional-conative levels.

Because of the need to protect participant privacy, results of the study, with one exception (see Byerly, 1969), were not published. However, I did use these data when teaching in both research and transcultural nursing courses. Students noted similar behaviors still occurring in hospitals of their own experience. Anthropological definitions of adaptation, which identify institutions as instruments of adaptation, were useful for examining nurse control behaviors in cultural and interactional domains as nurses attempted to reconcile discrepancies in the workplace. Further study using values and beliefs of the “subculture of nursing” as factors in choices nurses make to manage stress could also be useful in examining reasons for today’s nurses leaving the profession or choosing other careers.

Rural Health Research Project: An Ethnoscience Approach

In 1977, I received a 3-year grant from the Division of Nursing, USPHS, to study health care alternatives of the multiethnic group of migrant and seasonal agricultural workers who harvested orchard and field crops in a four-county area of north-central Washington state. An ethnoscientific study, it was the first one to be funded by the Division. As project director and principal investigator, I was assisted by two other sociocultural anthropologists, a bilingual and bicultural program assistant, and later, a cross-cultural nursing graduate. Groups studied were American Indian, Mexican/Mexican American, New Age counterculture, and non-New Age Anglo.

Seventeen published and/or conference papers came from this research, 12 of which I was author or coauthor. The full report, published on microfilm (Byerly, 1981), addressed the major domain, Health and Healing, by presenting taxonomies in five subdomains: Sicknesses, Causes, Curers/Healers, Therapies/Remedies, and Preventions/Prophylactics. In-depth interviews with three healers (two Hispanic and one New Age) were summarized using Irwin Press’s 11-part Curer Stylistic Inventory (1977). Other sections of the report included descriptions by Hispanic informants of 14 ethno-illnesses, persistence of humoral beliefs among Spanish-speakers, use of the Coast Salish spirit song in coping with stress and illness, and examples of decision making during illness episodes. A glossary of New Age lexicon is also included; although not inclusive in nature, it lists 199 terms identified from the New Age data.

Five publications (Byerly, 1979c; Byerly & Molgaard, 1982a; Byerly, Molgaard, & Snow, 1979a, 1979b; Molgaard & Byerly, 1981) focus on
ethnographic information from the New Age interviews. Each briefly communicates the fundamental concern of New Age people with holistic health and healing. The New Age eclectic medical philosophy (of Ayurvedic, Chinese, Native American, chiropractic, naturopathic, and homeopathic origins), with emphasis on service to others, self-healing, and enlightenment, differs from that of the usual Western biomedical model. There is, however, a subcultural locus in biomedicine and other non-oral sources of New Age medical beliefs that leads to the conclusion that these constitute a “lay” rather than a “folk” medical system.

Public health implications of the migrant/transient lifestyle were identified in the subjects, concerns about the physical, mental, and physiological health hazards faced while living on the road and working in agriculture. The data demonstrated the relevance of anthropological analysis for epidemiological issues in public health, the relationship between a New Age social institution (the value placed on mobility) and transmission of illness during an episode of hepatitis A (Byerly & Molgaard, 1982a).

Other papers focused on factors influencing decisions between standard and nonstandard options in choice of health care. Migrant workers’ decisions to seek health care significantly reflected coping strategies developed in response to perceived stigmatization in encounters in biomedical care settings (Byerly & Molgaard, 1982b). As low-income, transient, and other-cultural groups, they were and still are particularly vulnerable to such stigmatization and were seen to employ strategies during encounters with health professionals to avoid labeling as deviants and to obviate stigma. Among the multiethnic groups studied, use of standard and nonstandard options in health care varied both cross-culturally and intra-culturally. Persons operated in more than one system simultaneously, or else in tandem, with movement in and out of systems occurring as circumstances seemed to dictate. Through a comparison of the coping styles of three migrant women (Hilliard & Byerly, 1983; Byerly & Hilliard, 1983), we identified representative cultural means of stress management: the Coast Salish spirit song and dance, New Age meditation, and the Mexican ethno-illness susto. In the latter, susto was examined as a physiological adaptation to stress, a culturally specific way of handling internally experienced stress through illness.

Ethnoscientific Analysis

In the Rural Health Research study (Byerly, 1981; Molgaard & Byerly, 1981), techniques of both standard ethnography and ethnoscience proved
valuable in identifying and analyzing ethnomedical beliefs, practices, and decision making among a multicultural group of farm workers.

The ethnoscience method, however variously interpreted by its users, has been a useful means of collecting and organizing accumulations of ethnographic data in the domains of interest. Originally used as a system of discrete categorization and, thereby, for ease in analysis of components, some recent investigators recognized a need for further expansion of analysis. In Molgaard and Byerly (1981), we suggested that one solution to the questions of taxonomic analysis in this continually developing field was examination of internal category structures as revealed by the data.

Analysis of the highly variable sociocultural and cognitive milieu within which health seeking occurs required several methods. We found field techniques and taxonomic analysis useful to varying degrees. During construction of the latter, we noted that not only did some categories have discrete boundaries but informants located some lexemes (taxons) in more than one position within a taxonomy, giving qualifying reasons for doing so. We needed more accurate means to explain our “fuzzy sets” (Molgaard & Byerly, 1981).

As a theory of cognition, nondiscrete category analysis has the advantage of not only focusing on the structural interrelations of categories but also formalizing the common-sense intuition that categories do not have sharp boundaries, but graded ones that overlap (Molgaard, Byerly, & Golbeck, 1979). Examination of the internal structure of categories (i.e., the criteria for and the gradations in set membership) allowed us to consider the fuzzy areas of medical beliefs, where overlap between Western biomedical concepts and lay/folk concepts could be seen to influence decision making and health seeking. This form of analysis not only supported the ethnographic data but also further supported the contention that categories do have internal structure and are not discretely bound. I found it interesting, some years after completion of the study of hospital nurses’ role behavior, that although I noted category overlap in 1970, I had not yet had the additional experience with ethnoscience methods nor with nondiscrete category analysis to make use of the concepts. Knowledge does tend to be accumulative.

NOTE

1. This paper is a revision and update of the original paper as presented at the CONAA Symposium, “The Anthropology of Nurse Anthropologists,” in Philadelphia in 1986.
REFERENCES


issues in the study of one’s own society (pp. 153-166). Cambridge, MA: Cambridge University Press.


Addendum

Fifteen years after this paper was presented at the CONAA symposium in Philadelphia, it seems to me that my research of hospital nurse role behavior and of health-seeking behaviors of migrant farm workers carries much relevance in the current chaotic state of health care in our increasingly multicultural society. Problems of access to health care have prompted health seekers to look at alternative methods of meeting their needs. My New Age informants in the 1960s may not have been so far out. And this trend certainly reflects actions seen with the migrants where lay and folk medicine choices have long served as a substitute for or a supplement to established biomedical practices.

Control—Isn’t that what all of us are seeking? Does a person choose to be a nurse, when there are so many other things he or she could do? Can nurses control their own personal investment in caring for others—how and where and when? What about those seeking health care? How can they control their needs for care and treatment?

An understanding of what a person brings to the decision-making process is inherent in transcultural nursing, which has an important role in delivery of relevant and fair health care. Nursing has always been eclectic in the development of concepts and theories. It must continue to do so if the growing emphasis on holism in nursing is to have a sound scientific base.

The importance of research at both the master’s and doctoral levels in nursing cannot be overemphasized. The most stimulating portions of my career as a nurse-anthropologist were those of my two major research efforts. I enjoyed the process of structured and unstructured discovery of the beliefs and actions of other persons, and the gaining of more insight into my own feelings and beliefs.

Most rewarding was the sharing of knowledge with students and colleagues, when I could see the excitement of their awareness and beginning understanding of the influence of the clients’ cultural values, beliefs, and behaviors on nursing efforts to provide appropriate care. Least rewarding
were the circumstances of my teaching positions where I had little or no contact with other nurse-anthropologists with whom to share and expand ideas on a regular basis.

Anthropology “at home,” in my own society, was an opportunity to increase knowledge of selected aspects of health care by means of two different approaches for anthropology and nursing research: (a) general systems theory (the hospital study), and (b) standard ethnography with ethnoscien-
tific analysis (the rural health research).

Now, in 2001, many of my acquaintances look puzzled when I describe myself as a nurse-anthropologist. The general public apparently has little understanding of the relevance of anthropology to health care in American society.

Contributions of nurse-anthropologists, such as those projected for an upcoming CONAA symposium highlighting current and future health care issues, will certainly emphasize the important contributions made by integrating cultural aspects and health care. As Chrisman noted at the 1986 CONAA presentation of the “grandparents” contributions, nurses in the “betwixt and between” position should remember that “being pivotal is being powerful.” We can be.
The title of this symposium, “The Anthropology of Nurse Anthropologists,” is ambiguous. One interpretation of the title could be that its intent is to center on the nurses who are anthropologists. What are their social structure, social organization, physical characteristics, language, modal personality, and so on?

I have chosen to interpret the purpose of this symposium to be “What kind of anthropology do nurses do?” This afternoon we are the key informants, demonstrating intracultural variation among “founding parents.” This variation comes from individual psychohistories and cultural history. As in other cultures, we informants are likely to be marginal to our particular groups, nursing, anthropology, and nursing science. The anthropologist who is a nurse may be bicultural in knowledge of the content of two separate systems, biomedicine and anthropology, bilingual in the ideolecs of these systems, but marginal to both fields. Despite the criterial attribute of the anthropology Ph.D., the nurse who teaches nursing may also be perceived as marginal to anthropology. Finally, the nurse who is an anthropologist is evaluated as marginal to other nurse scientists. Numbers, which come from subjective decisions in perception, interpretation, and categorization, are reified in the sciences that are favored by funds. Today, I will celebrate our marginality.

Anthropology has been described as the most humane of the sciences and the most scientific of the humanities. The purpose of this paper is to demonstrate how basic humanities research can help to describe and predict the care that women give to themselves and their families. It narrates a personal journey. As a nurse, I have been interested in what women do to take care of their families and themselves. As an anthropologist, I learned to ask questions that could reveal this domestic care.

I first saw the potential for applying anthropology to health care before ever undertaking graduate work. As a student in public health nursing in San Francisco, and afterward as a visiting nurse in New York City, I learned that...
most health care was lay care, given at home. Biomedical health care advice could not be imposed successfully on the polyethnic populations of these cities. Later, I had further demonstration that even in the closed culture of the hospital, knowledge of lay care was important. The key event occurred when I was a clinical instructor in maternity nursing and found that a young Mexican woman, newly delivered of her first child, had been isolated in the unit’s hall, separated by screens, because she was following a cultural dictate of her mother: no bathing until 40 days after childbirth. This episode, upsetting to all involved, led to those first courses in anthropology at Cal (UC Berkeley) when I was starting work on my master’s degree in nursing at UCSF.

It was later that two fields of anthropology assisted me in understanding lay care. These are ethnohistory and linguistics. To some extent, my choice of these fields is an accident of history: I received my training (this word is honorable in anthropology, pejorative in nursing) in a department that required “the” four fields of archeology, cultural anthropology, physical anthropology, and linguistics. Few nurses include all these when studying anthropology, to their disadvantage, I feel. As Robert Frost said, “I took the road less traveled by, and that has made all the difference” (Frost, 1972, p. 51).

General archeology proved to have value. For example, we learned how to use material data as does the archeologist to infer behavior. So much later, when I asked an informant to show me the medicinal herbs that she had told me about, I could get a much clearer idea of frequency and distribution of these items in domestic care. I had learned to ask for such individual demonstrations when I was a public health nurse, but not how to organize the data to uncover principles by which people took care of themselves.

The archeological requirement could be completed by courses in ethnohistory, a choice that I made. The ethnohistorical approach is crucial to a study of care, for care is a singularly undescribed domain in the anthropological literature. Even the Human Relations Area Files have no such category. Those who give care are “People Without History” (Wolf, 1982).

At Arizona, we had the opportunity to study from anthropologists who had made rich contributions in the field of ethnohistory—the late Edward Spicer, Edward Dozier, and Thomas Hinton (Kay, 1996). None had investigated the ethnohistory of care, but they showed us how to interpret the past from a study of contemporary cultures. Spicer (1980) said,

I have relied on what I consider the most vital element in the modern discipline of ethnohistory. This consists in the interpretation of documented events of the past by means of the knowledge of situations in which anthropologists have gained through direct study of living societies. Just as geologists assume that
processes which currently affect the earth’s crust may be regarded as having done so in the same manner in the past, anthropologists may assume uniformities running through the whole experience of humans—past, present, and future. (p. xii)

Spicer, Dozier, and Hinton exposed us to early historical documents and the classical interpretations of these writings. Such readings helped us learn how critique is culturally bound in time and space. One course in history of anthropological theory and another in history of physical anthropology reinforced the idea that neither science nor its evaluation is pure but must be relative to its cultural ecology. Assigned readings in anthropology also helped in a way not provided in other sciences. We saw good writing, characterized by concrete examples. We were not mystified by abstractions untied to real people, things, or events. As a graduate student, I was determined to make my work relevant to the new field of medical anthropology, a field not then taught at Arizona. I read primary and secondary sources of “folk medicine” for every paper for which the topic could possibly be used. For a course in the archeology of Mesoamerica, I wrote a paper on pre-scientific medicine, comparing two systems of medicine, pre-Cortesian Mexico with pre-Renaissance England. I read the observations made by Sahagun, Landa, and Hernandez during the first century of the conquest and secondary sources of pre-conquest medicine such as Ocaranza and Leon. For England, I read (in translation) Anglo-Saxon leechbooks, the Lacnunga, various medieval herb books, and tertiary sources such as Chaucer. The primary sources were Greek writers of the beginning of the Christian era, Galen, Soranus, and Dioscorides, whose theories based medicine for 19 centuries, theories that filtered down to contemporary lay care.

The next course for which I researched lay care was Ethnology of Northwest Mexico, land known as northwestern New Spain from the 16th to the 19th centuries, when the space was relabeled Northwest Mexico, Southwest USA. Renaming was accomplished in 1821 by the Mexican revolution from Spain, the Mexican-American War of 1836, and the Gadsden Purchase (1848). Perhaps I was drawn to this culture area because it was peopled by mestizos, Mexicans whose gene pool as well as whose culture reflected various intermarrying Indians and Mexicans inhabiting an area once thinly populated by a few scattered tribes. I am genetically, culturally, and by discipline also a mestizo, although a different kind.

What was northwestern New Spain is now referred to as the Greater Southwest by ethnocentric American anthropologists. Although this area has been the subject of much fine research, little had been done on matters of health and illness. Medical anthropology has been a well-developed topic
for Central and Southern Mexico, but not in the Northwest, “so far from God, and so near to the United States.” Where then to learn the domestic medicine of the Greater Southwest? The answer was found by searching out the writings of lay workers who were known throughout history to add care of the sick to the regular duties for which they had been trained. Religious missionaries today often offer health care to those they would convert. Might this be a “uniformity running through the whole experience of humans”?

Northwestern New Spain was missionized by Jesuits from 1570 until their expulsion in 1767. They were followed by Franciscans. These Fathers were ordered once a year to send to their general or his provincial officer an account of what passed in their missions. Such accounts were collected in the writings of 17th-century Jesuits such as Perez de Ribas or their 18th-century counterparts after non-Spanish were permitted to come (Donohue, 1969). These included Ignatz Pfefferkorn, Johann Nentuig, Bernard Middendorf, Joseph Och, and Felipe Segesser. All reported activities in the care of the sick. Later, I was to find the works of Miguel del Barco and Francisco Clavijero, who included discussions of illnesses and herbs to treat them. I was also introduced to secondary sources, writings of the Jesuit historians Alegre and Decorme, and more recent, Peter Marsten Dunne. They eventually led me to the work of Johann Steinhofer, or Juan de Esteyneffer, as he was called in Mexico, when I was doing postdoctoral reading.

Esteyneffer was a lay brother in the Jesuit order who was sent to Mexico in 1693 to care for the old and ailing missionaries. He was also concerned with the care of the Indians in the missions. To assist the priests, who had neither doctor nor pharmacist to help, he wrote the *Florilegio Medicinal de Todas las Enfermedades*. The 522-page book was first published in 1712 and again five more times, and there is evidence that it is still in use today (Anzuñes & Bolanos, 1978). Discovering the work of Esteyneffer proved to be the most consequential event in my study of lay healing. It is a valuable source for the contents of contemporary domestic medicine in the Greater Southwest. It led me to the lay literature of healing, both Mexican and European. This scholarship gave me entrée to the best libraries for medical history in Mexico, Europe, and the United States, and a wonderful sabbatical at the Wellcome Institute for the History of Medicine. It led me back to the ancients, Hippocrates, Galen, Soranus, and Dioscorides; to medieval Arabic and Spanish writers; to the English in the Crusades; and to renaissance western medicine. This has been not only for the fun of it but also to apply to the study of lay care today. Folk medicine, said the historians (Grattan & Singer, 1952), was formerly scientific medicine. Lay care also derives from medicine previously believed to be scientific.
An early course in The Cultures of Japan had led me to translations of writings of Engelbert Kaempfer, a German physician “passing” in the Dutch embassy to the Japanese Emperor’s court at the end of the 17th century. Familiarity with the medical literature of 17th- and 18th-century northwestern New Spain then alerted my interest in the many correspondences in systems of care through time and space. The classical anthropological controversy between independent invention of culture traits or their diffusion was evoked by the conflicting evidence. Diffusion as a determinant for the many similarities was supported by the correspondence of 17th-century missionaries and travelers to John Ray, secretary of the (British) Royal Society, and to Hans Sloane, who also served as secretary after his own research in the Caribbean.

I was beginning to develop a model for lay care. Particularly, I looked at what changes in health were selected for notice and interpreted as illness by lay people, and which aspects of the environment were adjusted in domestic medicine. Now arguments for independent invention, stemming from psychic unity or common physiology, were supported. The Galenic “nonnaturals” of air and water, food and drink, sleep and wakefulness, evacuation and retention, exercise and rest, and the passions of the mind have been rediscovered by nursing theorists, but they appear to have been attended to since ancient times, as shown in the primary sources. The nonnaturals were particularly emphasized in medical teaching in the 17th century (Vivian Nuttall, Wellcome Institute for the History of Medicine, personal communication). Thus, I immersed myself again in 17th-century culture. I read Burton’s Anatomy of Melancholy (1651) and Samuel Pepys’s Diary (Hunt, 1978). I read women’s books of domestic instruction, which included recipes for ointments, syrups, and care of the sick (Markham, 1625), and I visited historic homes and gardens maintained by the British National Trust, for the household manager of these estates was considered responsible for knowing how to treat illness. The Countess of Shrewsbury’s Hardwick Hall, which she built in the 1590s, still has an outstanding herbal garden (Pearson, 1983). The Chelsea Physic Garden, built by the Royal Society of Apothecaries in 1678, was inspired by Dr. Hans Sloane. The magnificent gardens at Kew, outside London, include the herb garden planted by Queen Anne’s house. Here, each plant is labeled with a quotation from one of the herbals written in the 16th and 17th centuries. For primary sources, I read the herbals, too, as well as the guides to domestic medicine, written in Latin until the end of the 16th century, English, Spanish, and German thereafter (Kay, 1987; Kay & Yoder, 1987). Woodall’s The Surgeon’s Mate (Kirkup, 1978), a guide to the ship’s surgeon of long oceanic voyages, had more
information pertaining to lay care. I also found new documents by secular authorities in northwestern New Spain, written in the 18th century. There were also excellent secondary sources on this period that proved useful.

Uniquely helpful were tertiary sources, the works of those whom Aristotle called poets, including writers of fiction. According to Aristotle, it is the poet’s business to tell what type of thing can happen and what is possible, not what has happened. Thus, it follows that poetry is more scientific or true because poetry universalizes whereas history particularizes (Barnet, Berman, & Burto, 1960). Nevertheless, I needed particulars to derive universals in care. I was interested in the health care that women give their families and themselves today. In the past decade, I have looked at health problems that stem from being a woman: menstruation, childbirth, menopause, and most recently, the health of the recently bereaved widow. We, graduate students and I, collected data on grandmothers as health care advisors. Thus, I concentrated on domestic medicine, that is, the care that women gave, which has led to theory of lay care.

In most studies, I have focused on Mexicans or Mexican Americans. This started with my dissertation. I learned about how Mexican American women perceive, interpret, and respond to illness, using the once-trendy ethnoscience methods. Few major theorists in anthropology have continued this methodology; nursing, however, has seized it, modifying the techniques and all but eliminating the elaborate statistical analyses such as multidimensional scaling, which had given it a scientific lustre. Ironically, this methodology has given us more credibility among the nurse scientists who are not anthropologists. In fact, we have adapted ethnoscience, calling it by an old name with narrowed meaning, ethnography. We have found it a key to understanding the world of our clients. It explains why trying to do research with other ethnic groups using only questionnaires translated from one language to another is unsatisfactory as well as invalid. It forces us to listen and, by listening, to learn another’s point of view. The academic exercise of learning the way that my informants categorize aspects of illness, cures, curers, menstruation, childbirth, menopause, and aging made it possible to discover underlying principles, with great relevance to predicting health behavior. But making these discoveries required knowledge both of their history and of the insights that came from people writing from the point of view of the lay givers of care, writers of “poetry.”

My informants also classified responses to illness, causes. These led me into ethnobotany, kicking and screaming, for my father had been a plant scientist and I had thought the whole topic boring. However, the Mexican American women who shared their health care problems with me needed cures and bought them in herb stores or found them in their gardens or
growing in dry riverbeds. They classified plants according to their use: I had to learn to classify them according to morphological criteria and learn each plant’s Latin name. Botanists the world over use the same system of Latin nomenclature. Folk labeling, however, is done by different criteria. Both systems of labeling, however, led me again to universals. We have a data assembly of ethnotherapeutic agents in women’s health care and from it have learned that the same kinds of plants have been used through time and space for the same problems. Which plant cures were independently discovered in remote prehistory and which were diffused is a question that now intrigues me.

There are many specific questions of domestic care, which the humanities can help to answer, answers that may lead to the discovery of underlying principles. Studies of words made by careful linguistic methods can reveal change, especially the changes that come when various cultures come into contact. If there were time this afternoon, I would illustrate with the history of fallen fontanelle, a condition labeled today as dehydration, known back through the ages and in different languages successively as mollera caída, fontanellae collapsus, blattschiessen, Entzündung des Gehirns, Coup de soleil, head-mold shot, to medieval Spanish as apostema calido del cerebro, to medieval Arabs as stibundum, and to the ancient Greeks as siriasis.

Mexican American women’s lay theory is changing rapidly as a result of contact with biomedicine (Kay, 1977, 1979). Throughout history, major conflicts have brought change in lay care of the sick. The Crusades brought the ancient Greek medical knowledge, which had survived in Arabic writings, to Western Europe. The conquest of the New World brought the revived knowledge to the cultures of the Indians. The technology of modern warfare, while widely affecting professional medicine, has also touched lay care, in new ways every day. Thus, I continue to research lay care, using ethnohistorical and language study. However, as pointed out by Sass (1986), such methods of study of lay care build science on the “shifting sands of interpretation,” interpretations we have learned to be bound in time. Ethnohistorical methods inevitably distort cultural reality but, I believe, less so than using contemporary biomedical categories. To attempt to learn the illness idiom of a culture (Good & Good, 1986) is essential to nursing.

NOTES

1. Several classes of students in N771 at the University of Arizona College of Nursing have been assigned to search the Human Relations Area Files for various components of care. This has proven to be a useful pedagogical challenge, not an easy task.
2. I do not separate the concepts of domestic medicine and lay care. Nursing has chosen to attach the word *medicine* exclusively to the activity of physicians; this distinction is not made by lay people and was particularly irrelevant in previous centuries when criteria for this title were so different from today.

3. Note the works of Sister Calista Roy and Dorothea Orem for recognition of the same items. Also, see Hierarchy of Needs.

4. A seminar on Patients at the Wellcome Institute for the History of Medicine, April 6, 1983, by Roy Porter alerted me to Pepys’s Diary and other works.

5. The writers range from the giants of the 17th century such as Shakespeare, to not universally known 20th-century writers such as Augustin Zamora and Francisco Rojas Gonzalez in Mexico, Rodolfo Ayana, La Verne Clark, Ernesto Galarza, Miguel Mendez, Tom Miller, John Nichols, and Carter Wilson to list a few that come to mind. It is limiting in that only one writer, among not only these tertiary sources but also the primary and secondary sources, is a woman.

6. This databank was assembled by M. Kay and M. Yoder and is located at the College of Nursing, University of Arizona.

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Markham, G. (1625). Coventry contentments of the English housewife, containing the inward & outward virtues which ought to be in a compleate woman. London: B. Alsop.

Addendum

My contribution to The Anthropology of Nurse Anthropologists ended with the sentence, “To attempt to learn the illness idiom of a culture is essential to nursing.” How awkward! In the years that followed, I have tried to improve my writing—but not the content. When we submitted the Grandparents’ Papers, as we called them, to the nursing journal that we thought appropriate, they were turned down. The editor said that she was not interested in papers that complained about our “marginal status,” perhaps referring to my article. Apparently, I had not made my point clear. I was celebrating our marginality. It meant that we could look at both nursing and anthropology from an outsider’s point of view. That, to me, was valuable.

I had retired from teaching, finding that I could no longer drive more than short distances because of chronic pain. I consulted several neurologists; psychologists, one a specialist in pain, the other in biofeedback; acupuncturists; and a doctor of osteopathy. One neurologist asked me what I planned to do. I replied, “I have three books to write.” I’ve written two of them.

The first was Healing With Plants in the American and Mexican West. As recounted in Anthropologist of Domestic Care, I was trying to devise a model for lay care. I had worked in many libraries, spending two sabbatical leaves where I enjoyed the vast holdings at the Wellcome Institute for the History of Medicine, helped by Robin Price, deputy librarian of the Americanist collection. I had conducted historical research also at the Huntington Library in Pasadena, California, the National Library of Medicine in Bethesda, Maryland, the Library of Congress, and specialized collections of the University of Arizona. In all these places, I wrote data on 5x8 cards. Now I wanted to use the data to describe which plants were used for medicine and the people who used them. I bought or borrowed ethnographies, texts on phytomedicine, and translations of ancient writers of medicine.
By now I had a computer and a program written by Gary Kabakoff. I collocated plant information, organizing by genus, 100 genera in all, with an average of five medicinal species in each. Following the style followed by the ancient describers of plants, I included many names for each plant, the Latin binomial and the various lay names of the different peoples of the United States and Mexican West. For example, *psyllium*, the name given by English speakers to the plant used as a bulk laxative, was *plantaine* in Renaissance England, *lanten* in Spanish, *yerba del pastor* in Tarahumara, and so on. The seed of this ubiquitous plant has been used since the time of Pliny for bowel complaints. The Paiapai bind two or three of the large leaves for headache. Now what does all this have to do with anthropology and nursing? Potentially a great deal.

People like to take care of themselves. Research with large populations demonstrates that a large percentage of people not only use alternative medicine but don’t tell their health care provider. As people find it more difficult and expensive to use biomedicine and to consult with a doctor or nurse practitioner, they first go to health food stores or *yerberias* for advice and herbal medicine. Then they may consult a physician. And as can happen, the doctor may prescribe a medicine that is potentiated by the herb, works synergistically, or combines dangerously. For example, there are about 20 plants used to control diabetes. Taken in addition to the prescribed hypoglycemic, the person’s blood sugar may fall precipitously. When the nurse records a patient’s health history, he or she needs to ask if any plant medicine is used and to have a source of information about the medicinal properties of that plant.

This book is not written for specialists such as phytochemists or botanists. They may use texts such as the *PDR for Herbal Medicines*. *Healing With Plants in the American and Mexican West* (Kay, 1996) describes different plants and ones used by specific populations in the southwestern United States and northwest Mexico. The *PDR* omits, for example, any species of *Argemone*, *Casimiroa*, *Anemopsis*, *Ambrosia*, *Agave*, *Baccharis*, *Buddlia*, *Bursera*, *Kohleria*, and *Hintonia*, to list but a very few plants commonly used by people here. Many health care providers are aware that *Datura* is poisonous, but they may not know that it is hallucinogenic, can cause blindness because it contains scopolamine and atropine, and is called *toloache* by Spanish speakers and that some apply the leaves, with great care, for pain? Many plants may be used therapeutically by knowledgeable people. Nurses who are anthropologists can advise in a sensitive but also informed way.
And now I remember that the idea for writing my book of medicinal plants came from Pamela Brink. “Why don’t you write a book on those herbs for nurses to use?” she asked. Thank you, Pam.

The second book that I have written derives from my interest in linguistics. Doctors and patients find it difficult to talk about illness because they use different words, even when they speak the same language. It is even harder for them to communicate when the first language of each is different. I specify first language because, even if eventually they share speech, when sick, in pain, or frightened, people are likely to revert to their first language. Nurses know this. And in the southwest, if the first language is Spanish, its form is not likely to be that of the Real Academia Española. Patients commonly do not know the scientific lexicon of biomedicine, whether English or Spanish, but have a lay vocabulary. That is why I, as a nurse-anthropologist, compiled a Spanish/English, English/Spanish Dictionary of the Southwest, improving it with a second, new edition (Kay, 2001).

My sources were native speakers. I listened, taped, and transcribed. I asked questions: How do you use the word X? Can I say X? When is it better to use Y? I have a 6-foot shelf of transcriptions and drawers full of interviews. Only an anthropologist trained in linguistics would collect data in this way. And only a nurse would want to.

The plant book is in its second printing. The dictionary is now available. Although labeled as a second edition, Southwestern Medical Dictionary (Kay, 2001) is quite different from its predecessor. This version has more entries, new subjects that reflect current health problems and treatments: Spanish definitions of English words, information on medicinal plants including an appendix of poisonous and nonpoisonous plants with their English and Spanish common names as well as Latin binomials, and anatomical drawings with bilingual labels, all additions to the previous edition. Nurses teach, and this book should help them.

It has been said that anthropology developed as a discipline in Britain to control the peoples of its empire, and medical anthropology for the same reason. Both of my books come from a disinterested, relativistic point of view. I would argue that this point of view predominates among medical anthropologists, despite the scandal arising over Napoleon Chagnon’s study of the Yanomami people of the Amazon and James Neel’s participation in the research (see Geertz, 2001, pp. 18-22).

Patients and doctors still do not understand either nursing or anthropology, let alone the combination. Here, our marginal status becomes a problem. Scholarly papers may be interesting, but applications of this research are still rarely accepted. I think most of us have taught large classes with
cross-listing in other disciplines; this should help our message to be heard, perhaps by younger professionals. I hope so.

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Current Issues in Using Anthropology in Nursing Education and Services

Madeleine M. Leininger

Today, more nurses are entering the field of transcultural nursing and taking courses in anthropology. They are realizing that anthropology has something important to offer nursing and, especially, to expand their worldview and the differences and similarities among cultures. Although some anthropologists show interest in nursing, they have done less to discover nursing’s contribution to extend their clinical care and health knowledge from a nursing viewpoint. In a figurative sense, the two worlds of nursing and anthropology are orbiting, but there have been fewer “touchdowns” to pause and examine the actual and potential commonalities and differences between the two disciplines. For these reasons and others, it is important to explore some critical interdisciplinary issues and trends to stimulate future research, theory, and practices between nursing and anthropology. The purpose of this paper is to identify a few contemporary issues and trends between nursing and anthropology, and discuss their actual or potential impact to facilitate future developments between the two disciplines.

For the past three decades, nurses studying in the field of transcultural nursing have identified anthropological concepts and research findings that seem pertinent to nursing or that need further study in relation to nursing’s clinical and theoretical interests. On the other hand, very few non-nurse-anthropologists have drawn on nursing’s concepts, theories, and research findings. Some anthropologists are just discovering that nursing is a discipline that is developing its own unique body of knowledge.

A major difference between nursing and anthropology is that nursing is a profession and its members are licensed to serve society, whereas anthropologists do not have this societal mandate. Chrisman and Maretzki (1982), strong supporters of nurse-anthropologists’ contributions, substantiate further these points with their statements that anthropology does not have a “socially sanctioned (and therefore morally experienced), clinical, or
service mandate . . ., (thus) anthropological understandings must be translated by anthropologists so that they are relevant to patient care."

Unfortunately, many anthropologists and other social scientists refer to nursing as “medicine.” Anthropologists need to recognize that nursing is a separate and different discipline from medicine. Anthropologists need to realize that the nursing profession is a professional discipline and, as such, is responsible for developing nursing knowledge and skills to ensure quality nursing care. The foci of the two disciplines differ. Physicians as medical practitioners focus on the diagnosis, treatment, and cure of medically defined diseases. In contrast, nursing focuses on human care and ways to prevent illness and maintain wellness in varying environmental contexts. A lack of awareness by anthropologists of nursing’s conceptual, research, and practice foci often thwarts a meaningful dialogue between nurses and anthropologists. Anthropologists need to study nursing’s theoretical and research interests, such as my early field work on care and health with the Gadsup from 1961 to 1963 and the work of Horn (1977), Aamodt (1978), Leininger (1978), Watson (1979), and others on care, health, and contextual features. These works have been significant in advancing nursing knowledge and in explicating the essential features of nursing. For more than three decades, I have held that care is the central, dominant, and unique focus to know, explain, and describe nursing (Leininger, 1978, 1981, 1984a, 1984b, 1985a, 1986a, 1986b).

I well recall in 1984, and again in 1986, encouraging the Executive Committee of the Society of Medical Anthropology to make health and care programs the future focus of the organization and to title the newly proposed journal, “Health Anthropology.” But, the Committee clung firmly to the medical title and had limited interest in exploring further the conceptual and practical differences between medicine as a medical disease focus and nursing with a care and health emphasis.

A second issue is the lack of interest on the part of anthropologists in pursuing the theoretical and research interests between medical anthropologists and transcultural nurses. More attention to this area would increase the interest of nurses in anthropology. Because transcultural nurses have focused on the theory of comparative cultural care, health, and environmental contexts of individuals, families, and cultural groups, I believe that these dimensions would enrich and expand anthropologists’ medical interests. Microlevel and macrolevel care and health patterns of different cultures, with their distinctive worldview and sociocultural features, are new knowledge areas to most anthropologists. My theory of “Culture Care Diversity and Universality,” used since the 1960s, continues to generate many different perspectives
about human care and its impact on healing and well-being (Leininger, 1985a). Granted, there are some medical anthropologists interested in health and health-related behavior, but few have systematically studied care as a powerful influencer of human behavior, wellness, and illness patterns. Indeed, most medical anthropologists have not focused on health and care phenomena but remain absorbed in folk illnesses and curing processes (Foster, 1974; Navarro, 1976; Young, 1982).

One wonders why medical anthropologists have persistently focused on medical diseases, symptoms, and pathologies. Could it be related to their need to gain acceptance, recognition, and power from the medical profession, especially physicians? Could their interests be largely gender-related, as most Western physicians are males and nurses female? This differential focus between anthropologists and nurses clearly distinguishes the two fields in goals and outcomes. I contend that medical anthropologists need to rethink their goals, especially in light of the current need to give far more research emphases to health care promotion and maintenance. Transcultural nurses are providing active leadership to support these goals using ethnography and other ethnomethod types (largely qualitative research methods) to discover the meaning and expressions of human care and health to different cultures. We are also studying cultural care actions to promote health and well-being.

Third, I believe that nurses and anthropologists could gain much from collaborative research that focuses primarily on holistic health maintenance and diverse prevention strategies within different environmental and cultural contexts. Nursing’s traditional focus on personalized nursing care practices would greatly extend anthropologists’ knowledge about clients’ views from “within the mind” and “outside the mind” as life care referent experiences. Accordingly, nurses would benefit from the anthropologists’ research findings in the analysis of complex social systems and comparative cultural systems from a holistic perspective. I have found that many nurses need much time and guidance to analyze data from social structure, worldview, and language expressions to get an accurate holistic picture of the client’s care and health needs. Anthropologists have more in-depth education and experiences in the analysis of social and cultural systems, which could assist nurses in this area. An accurate and comprehensive sociocultural care perspective is so essential to help anthropologists understand human behavior in diverse sociocultural systems.

Some of the past common traditions and characteristics of nursing and anthropology have been identified in the literature, especially with the writings of Chrisman and Maretzki (1982), Dougherty and Tripp-Reimer (1985),
Leininger (1970, 1978), and Osborne (1972). The complementary nature and benefits of nursing and anthropology need further investigation. Using the commonalities and differences that characterize nursing and anthropology could ultimately strengthen both disciplines and provide a much broader and more in-depth perspective of human caring, health, and the prevention of unfavorable conditions of cultural groups.

More nurses recognize the need for preparation in transcultural nursing, as they are being confronted by clients who expect nurses to know and respect their cultural values and beliefs. Moreover, the nurses’ competence is threatened when clients of strange cultures do not respond well to them, and it slows down their work. Anthropology faculty can expect more nursing students in their courses because of this societal trend. Nursing students are eager to learn, and they will challenge anthropologists if they do not understand nursing or fail to appreciate their professional work world with clients from multiple cultures. How to understand and deal specifically with nursing problems that are culturally based is the task of the transcultural nursing faculty. Transcultural nursing faculty have helped to facilitate nursing students to take anthropology courses over the past three decades and to work on collaborative relationships with anthropologists.

Having developed five transcultural nursing programs and taught hundreds of students since the 1960s, I can attest to the fact that most nursing students become genuinely interested in anthropology if their instructors can relate the concepts and research to nursing and human behavior. I have found that, if the disciplines support each other and value their differences and commonalities, undergraduate and graduate students benefit greatly from this interdisciplinary respect and working relationship. I do believe, however, that nurses and anthropologists must take time to learn about the norms and values of each discipline.

In general, I have found that faculty in departments of anthropology are most cooperative and can be facilitative as nurses participate in anthropological courses and research projects. To date, some anthropologists have been outstanding as they serve on the nursing students’ master’s theses and doctoral dissertation committees. In recent years, transcultural nurses are beginning to serve on similar graduate student and curricular committees in anthropology. Progress is being made with some excellent outcomes, but both disciplines must continue to work together in a supportive way and to address issues that limit collegial relationships and knowledge use.

A fourth issue between nursing and anthropology is the difficulty in getting desired anthropology courses for nursing students. Transcultural nurse faculty have been strong advocates for anthropology courses to serve as
liberal arts course requirements for nursing curricula. Over the years, I have recommended that all nursing curricula should have at least one or two courses in cultural, physical, or social anthropology. These essential foundation courses are needed to understand human beings in health and illness. Recent university budget cuts have left many anthropology departments without faculty to offer courses. As a consequence, many nursing schools have not been able to schedule these foundation anthropology courses. Consequently, students have had to take other courses. This development is ironic in that students and faculty need cultural and physical knowledge to deal with many multicultural problems and conflicts in our society and worldwide. Anthropology faculty need to work closely with administration and nursing to express, more convincingly and assertively, the critical need for anthropology courses.

A fifth issue between the two disciplines appears to be a shift away from anthropology’s traditional qualitative to quantitative research methods. It appears that anthropologists are shifting their interests to accommodate federal agencies to get research funds. In the process, they may be forsaking their uniqueness at a time when qualitative methods are coming of age among nonanthropologists. This trend is problematic for nursing because nurses are now becoming more interested in ethnomethods. Since the early 1960s, several nurse-anthropologists have been active leaders in demonstrating the use of qualitative methods as a rich source of empirical knowledge and for generating nursing theories. Therefore, it is disappointing that many anthropologists have shifted more to quantitative research at a time when they could reaffirm the importance and values of ethnography to nursing colleagues and other disciplines.

It has only been in recent years that qualitative research methods are slowly beginning to be valued in schools of nursing. Spradley’s (1979, 1980) research publications had an important impact on nursing research, along with my early writings (1970s) and those of Ragucci (1972) and Byerly (1969). Mine (Leininger, 1985b) was the first comprehensive book in nursing on qualitative methods. This publication marked the turning point, and more nurses discovered alternative methods and the importance of qualitative research methodologies. In general, ethnomethods have been extremely important in explicating largely unknown and complex nursing phenomena such as care and health from nursing and cultural contexts. They have been valuable in deriving the epistemological base from nursing theories and building nursing knowledge. Anthropologists would be of great help to nursing if they would demonstrate their support for qualitative methods in their writing, teaching, and research. There are some glimmers of
hope as graduate students are requesting courses on qualitative methods, and more books and articles are being published on qualitative research.

A sixth issue that makes communication and research rather difficult between nursing and anthropology is the limited use and construction of explicit theories in anthropology. During the past two decades, several nursing theorists have emerged, and graduate students and faculty have become active in theory development and testing. In anthropology, there tends to be less emphasis on theory construction and explicit uses of theories in the field.1 This difference in emphases and uses often poses problems in communication and research collaboration. In earlier days of anthropology, there were several outstanding British social and American cultural anthropologist theorists such as Nadel, Evans-Pritchard, Radcliffe-Brown, Spiro, Kroeber, and others who emphasized social and cultural theories (Evans-Pritchard, 1962; Garbarino, 1977).

Some collaborative discussion on theory development would be worthwhile to explore between the two fields. It would be interesting to have transcultural nurses and anthropologists develop some common theories and theoretical areas of interest related to care, health, social structure, cultural values, and environment, and to involve students in the discussions. This could lead to synthesized theories or an expansion of knowledge and research between nursing and anthropology.

A seventh issue is the lack of recognition by non–nurse-anthropologists of the pioneering work by nurse-anthropologists. For several decades, a cadre of nurse-anthropologists has truly opened the doors to many nurses and other health personnel about anthropology. They have been active in making anthropology meaningful to colleagues in these health fields in teaching, research, and clinical work. Their pioneering efforts, although noteworthy, have received limited recognition from anthropologists. Anthropologists seem quick to acknowledge work by physicians, but there is a glaring absence of recognition for the innovative strategies in teaching and other areas by nurse-anthropologists and in nursing publications. It is also interesting that few anthropologists use nurse-anthropologists’ work. For example, I have known several anthropologists who have written and published many articles on health care, but they seldom cite research done by nurse-anthropologists. Nurse-anthropologists, however, are usually attentive to acknowledge the work of their colleagues in anthropology in public addresses and research. What might account for such persistent omission of anthropologists acknowledging nurses’ written and public works as well as leadership to make anthropology useful to health personnel? Is it a gender problem, a lack of knowledge about transcultural nurses and their contri-
butions to both nursing and anthropology? A focus on this topic might bring different knowledge and practices to anthropologists.

The eighth issue is more of a trend in that there is future potential of the alignment of anthropologists with transcultural nurses and other nurse practitioners. This alignment would facilitate health anthropological practices in health care institutions, clinics, and community settings. Nurses are the largest group of health care providers and the key facilitators and advocates to help clients receive quality of care. With the current trend of more medical anthropologists wanting to function in health institutions, some anthropologists are having difficulties entering these institutions or remaining in these settings. From my years of experience and in a number of health settings, anthropologists are still clinical strangers, and there is a general distrust of their motives and work. However, transcultural nurses can be enormously helpful in facilitating anthropologists’ entry into the health field and in clarifying their interests and potential contributions. To facilitate their work, medical anthropologists would be wise to align themselves with transcultural nurses.

Finally, there is the issue that some anthropological research has had little applicability in explaining and advancing nursing and medical practices. This issue is questionable, but more public and professional efforts and different strategies are needed to help health personnel understand and apply anthropological findings. Transcultural nurses can again be helpful in linking anthropological research findings into meaningful uses in health care practices with the strong development of transcultural nurses who are committed to advancing nursing knowledge and to improving health care in different settings. Both anthropologists and these nurses need to share their research and work with each other at national meetings, and to develop future research strategies together for health care. With transcultural nurses prepared to advance nursing knowledge related to human care, health, and environmental context, an alignment with anthropologists could well yield new directions and approaches to basic health and human care science.

It is also important to note that we are moving from the past trend of the 1960s and 1970s when some nurse-anthropologists functioned as anthropologists to advance anthropology but failed to value and help develop nursing knowledge and practices. This latter movement has led to more substantive contributions to nursing science. It is also providing true interdisciplinary exchanges and understandings of each discipline’s goals, interests, and contributions to society. And, it is also helping anthropologists to understand nursing as a scientific and humanistic discipline, and not as only an applied field.
In general, this is an exciting and promising era in nursing and anthropology. Transcultural nursing is now an essential, legitimate, and growing field of interest and practice to many nurses. Considerable progress has been made in the field of transcultural nursing, but many issues also need to be addressed (Leininger, 1981). Transcultural nurses and anthropologists have some vitally important and unique knowledge and ways to help people in this multicultural world. But much more study, understanding, and collaboration seem in order if we are to spearhead together a more substantive base of knowledge to make comparative cultural phenomena meaningful to other health colleagues and to others we service. Through creative collaborative efforts, and attention to some of the issues identified in this paper, nursing and anthropology can be a powerful and effective societal force through their mutual endeavors.

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**Addendum:**

**Retrospect and Current Views on CONAA**

As the initiator, founder, and first president of the Committee on Nursing and Anthropology (CONAA) that began in 1968, I am pleased to share a few past and current views of the organization over the past four decades. Having completed my Ph.D. in anthropology in the mid-1960s and having previously discovered that culture and other dimensions of anthropology were patently missing in nursing education, research, and practice, I realized the need for a close interface between nursing and anthropology (Leininger, 1970). I encouraged a number of nurses to become grounded in anthropology to change, expand, and develop a new discipline I identified as transcultural nursing. With the establishment of the Nurse Scientist (NS) doctoral programs in the United States, some nurses began to enter the field of anthropology. In some NS programs, there were no seminars where nurses could discuss and identify the linkage between nursing and anthropology. Hence,
CONAA was viewed as imperative. Some nurses who did not have the opportunity for such critical discussions became wedded to anthropology rather than advancing the discipline of nursing. Some of these nurses sought employment in schools of nursing and taught anthropology without conceptualizing and developing synthesized research and theory-based nursing perspectives.

I envisioned CONAA as a great opportunity for active and vigorous dialogue with anthropologists and other social scientists who were fascinated why nurses were pursuing anthropology and wondered what they would do with the knowledge. Some saw only a one-way benefit of nurses gaining from anthropology; however, I could see that nursing had much to contribute to anthropology. Such discoveries had to be made and established through dialogue and research. Moreover, most anthropologists were hooked on medical diseases and other medical interests but knew very little about human caring, health, and related nursing knowledge. Nurses needed to study and systematically learn care as the essence of nursing and health as presented in the first definitive book on the subject (Leininger, 1984).

Early CONAA meetings were exciting and well-attended with active participation from anthropologists, nonanthropologists, and nurses. The commonalities and differences began to emerge between and among disciplines. However, nurses committed to the medical model and symptom-disease focus and with limited theoretical nursing science knowledge reinforced the medical anthropology perspective. By the late 1970s and into the 1990s, membership began to decrease and signs of frustration and questions about where CONAA was going were expressed (Glittenberg, 1994).

In the meantime, the field of transcultural nursing had become a recognized academic and clinical area of study and practice. Graduate and undergraduate courses and programs were offered within the United States and a few places overseas. As the leader and founder of transcultural nursing, I encouraged and stimulated nurses to conceptualize traditional nursing into the new discipline holding that all nursing needed to become transculturally based now and, by the 21st century, to provide culturally congruent care to diverse cultures. Many past immigrants, refugees, and other cultural strangers needed to be understood in order to provide meaningful and appropriate nursing care. The first care conference was held in 1973 in Hawaii; then, the Transcultural Nursing Society (TCN) was established in 1974. Gradually, nursing students became eager to learn from faculty prepared in transcultural nursing and to participate in national conferences. During the past four decades, approximately 450 nurses have become members of the TCN
Society and 100 nurses have been certified and recertified to practice transcultural nursing. Both qualitative and quantitative scientific paradigmatic research studies of more than 100 Western and non-Western cultures have been completed, with many reported in publications such as the *Journal of Transcultural Nursing* and other outlets. These trends and others have greatly impacted the development of transcultural nursing in education, research, and practice worldwide.

In May 2001, the Worldwide Transcultural Nursing Society Office was dedicated to move forward communication, research, and educational conferences in the discipline. It has been a dream come true for me, and for all the members, to meet the global imperative to provide meaningful culturally based care in the United States and worldwide. My theory of Culture Care Diversity and Universality remains a major theory to provide research-based knowledge with the goal of culturally congruent care (Leininger, 1991). The Sunrise Enabler, with four other Enablers as part of the ethnonursing method, has provided researchers with unique ways to tap largely illusive and covert care and health in different cultures. The benefits of persistent theoretical and research benefits have been evident in the past four decades (Leininger, 1991, 1997). Shifting nursing into transcultural nursing as a major area of study and practice has required much time, patience, knowledge, and creative strategies. The goal is still in progress.

In light of the original purposes of CONAA and with the above developments and projected ongoing goals in transcultural nursing, it is my belief and position that CONAA has fulfilled its initial purpose. The 21st century is the era of transculturalism, multidisciplinary endeavors, holism, and shared dialogue in academic and people-centered human services. Nurses must be well prepared in transcultural nursing to work effectively in transdisciplinary endeavors with their unique culture care perspectives. This reality has yet to be fully realized and made publicly visible worldwide. Nurses, however, are making great strides toward increasing the depth and breadth of knowledge about human cultures with their caring and healing needs in a growing and intense multicultural world.

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Betwixt and Between, the title of Liz Byerly’s paper, is a good, succinct way to characterize the position of nurse-anthropologists. Based on this catch phrase, I will comment on the papers we have heard and try to put those ideas into a context that makes nurse-anthropologist sense to me. I will mention a series of issues drawn from my participant observation with nurse-anthropologists for 13 years (now 28 years).

One theme that emerges here is that anthropology is useful for nursing. Many nurse-anthropologists echo Rita’s comment that anthropology helped them make sense of their clinical practice experiences. This may have happened when they were in school already, or had heard the odd anthropologist talk, or they might have read Leininger’s Nursing and Anthropology book (Leininger, 1970). Practicing nurses tend to get turned on when they hear that someone has examined, thought about, and most important, named the behaviors that they run into every day. This common experience seems to have recruited those who later turned out to be nurse-anthropologists into anthropology. It did not, however, recruit them out of nursing. So, we end up with this hybrid, the nurse-anthropologist. They keep their caps and pins and their tape recorders and notebooks in both worlds. The existence of nurse-anthropologists is, however, primarily in one world. Most, if not all, nurse-anthropologists exist in their professional lives in a school of nursing and not an anthropology department. Yes, I realize that many of us have appointments in anthropology, but our offices and most of our classes are in schools of nursing. And, as one of my colleagues said, where you are paid makes a real difference. What this means to me is that their primary obligation is to nursing. So, the role of anthropology for the nurse-anthropologist can remain what it was at the recruitment point (i.e., the enhancement of nursing with anthropology).

This is a valuable task. And it fits into nursing very well. For example, I have always been fascinated by the fact that nurses who are lawyers,
philosophers, educators, ethicists, administrators, and yes, even anthropologists are all hyphenated. It seems as if one’s presence in nursing requires that the nursing identity remains even when another identity is possible. I have not seen that this happens in other disciplines. In addition, those nurses who are also anthropologists but who are not in schools of nursing do not identify themselves that way. In fact, they are essentially lost to nursing. So, one of my conclusions is that the phenomenon of nurse-anthropologist is a nursing phenomenon and not an anthropological one. It certainly is a compliment to anthropology—that the discipline can make such a contribution to another discipline—but it does not seem to be anthropology’s “fault.”

This position of being in two places at once, but mostly in one, is common in schools of nursing. As nursing professionalizes and moves more strongly into academic settings (a process that has been going on for decades, but strongly only in the last three), many faculty in nursing schools have Ph.D. degrees in other fields. Byerly laments the likely passing of this phenomenon with the advent of Ph.D.s in nursing science, saying that nursing needs the diversity. Thus, nurse-anthropologists are not odd in nursing schools because they have outside degrees. They are odd because of what they say. The nurse-physiologists and nurse-psychologists pretty much are able to toe the party line. They do not make waves by talking about cultural differences, empowering patients, or doing ethnographic—not quantitative—research. The nurse-anthropologists do. Part of the feeling in a nursing school of being betwixt and between is the nurse-anthropologists’ own fault; if they had not taken their anthropological perspective so seriously, they would not have gotten into trouble. By the way, it is my experience that anthropological and qualitative perspectives are becoming much more respectable both at the national level at the National Institute of Nursing Research and at the local level, at least at the University of Washington School of Nursing.

A question that needs to be asked at this point is, What do, or can, nurse-anthropologists give back to anthropology? As I look at the interests of the nurse-anthropologists I know, I can see that nurses do give something back, such as Liz’s work on the new age people or Rita’s work on Mexican health beliefs. However, to an anthropologist, this reads like what anthropologists do already. You are not giving something back that anthropology does not already have. What you have to give back that anthropology does not already have are some central nursing concepts as they have been worked out by nurse-anthropologists. I am thinking of the concepts of health and care, for example. Neither of these is particularly well represented in the anthropological literature; the latter does not seem to be there at all. Both of these concepts are receiving development in nursing that would not be
nearly as important without the special contribution of anthropology, so why not make them anthropological as well?

Madeleine raises this issue in her paper. She seems to say that the anthropologists need to somehow take more account of nursing, recognizing that it is not part of medicine. Any anthropologist associated with nursing knows this. The trouble is that, to my knowledge, there are very few non-nurse- anthropologists associated with schools of nursing. Mostly, this is the result of the practice of nursing schools hiring only nurses. Thus, this is not something that anthropologists have much control over.

One of the strongest elements in Madeleine’s paper is the lack of help anthropology provides to nursing: Only a few anthropologists have pursued the study of nursing; non-nurses do not go to CONAA meetings. Anthropologists see medicine and nursing as the same. Anthropologists are not interested in health and care. Anthropologists do not recognize the difference between transcultural nursing and medical anthropology (many nurses don’t either). Anthropologists are not helping nursing with qualitative methods.

If nursing is interested in a stronger collaboration, in increasing the number of anthropologists who are interested in these issues, complaining or hoping will not help. Publish! Make it interesting to the anthropologists. The point here for the anthropology of nurse- anthropologists is that nursing is seen in its idealized state and anthropology is expected to follow. By idealized, I mean the following: The vast majority of nursing research is not on health and care; the vast majority of nurses do not recognize the difference between nursing as a profession and as a discipline; the vast majority of nurse-researchers are not going to listen to non-nurses harangue them on qualitative methods, but they will listen to insiders who do convincing work.

Nursing ideas need to enter anthropology through the literature. This is the most potent way for this to occur. Medical Anthropological Quarterly (yes, I too would have preferred Health Anthropology, but it did not fly) is the best forum for beginning this dialogue. This means that papers of interest to anthropologists should be published there with anthropological discussions of central nursing concepts such as health and care. Anthropology can certainly benefit from interchanges with nursing, but the diffusion of ideas must occur in a fashion consonant with anthropological culture. This is not different from the requirement that anthropology for nurses be phrased in a culturally consonant way for them.

Another interesting betwixt and between issue is the relationship of scholarship and practice. I think that anthropology contributes a lot to nursing research and scholarship. Liz says that she is most happy when she’s doing or communicating research; Rita spends hours in dusty libraries...
around the globe doing the very unnursing thing of reading old outdated articles in foreign languages. New ideas can go both directions—from nursing to anthropology and back. This type of anthropological scholarship is an important contribution of anthropology to nursing.

In contrast, there is a practice dimension to this same endeavor, and of course it is related to the scholarly work. I see the practice dimension as cross-cultural nursing or transcultural nursing—it depends on which school you are in at the moment. This aspect of nursing and anthropology is no less important and no less either nursing or anthropology, but it is different. It is also necessary that nurse-anthropologists know the practice dimension if they plan to do research on it or teach about practice.

Obviously, I think that anthropologists can do this task—it is what I have done for the last 28 years. Perhaps nurses can do it better; after all, they are able to (or are forced to) be in the clinical area with students. With students is where the best reinforcement of anthropological knowledge with patient care can occur. What I think is critical here, though, is that a transcultural system of thought needs to be introduced as a system. Here is where Madeleine’s transcultural care diversity and universality (Leininger, 1995) or my culture-sensitive care and the sociocultural assessment (e.g., Chrisman & Zimmer, 2000) are important. They are not simply providing a cookbook of ethnic health-care behaviors to be assimilated into the basically biomedical thinking of nursing practitioners; they are new ways of thinking, requiring different theoretical perspectives and different behavioral patterns of the nurses.

Transcultural nursing, though, is a nursing phenomenon, not an anthropological one. It is nursing modified and enriched with cultural and humanistic ideas from anthropology. I think that all nurse-anthropologists do this in their teaching, but I am not sure that it is well-known systematically. I suspect that if we all got together and exchanged ideas, we would all be enriched. Perhaps something like my Clinically Applied Anthropology (Chrisman & Maretzki, 1982) is needed in transcultural nursing now. Systematizing the clinical practice ideas of the nurse-anthropologists might also help to solidify the identity issue—it might lessen the betwixt and between.

Earlier, I mentioned the importance of scholarly anthropological work on the nursing concepts of health and care. I think that research, conceptualizing, and publishing on these ideas in anthropology is important. By subjecting the work to the disciplinary standards of anthropology, we could all benefit. Anthropology would be expanded. More important, the nurse-anthropologist identity would be strengthened because this is a nursing contribution to anthropology. This too might lessen the betwixt and between.
I am arguing that the uncomfortable betwixt and between position is valuable for both groups. Being defensive about nursing is endemic in nursing schools. Reduce the defensiveness and simply introduce nursing concepts to anthropology as valid anthropology. That will benefit anthropology. Being offensive about medicine is also endemic. Reduce that, too. Continue the practice of bringing anthropology (including medical anthropology) to nursing. Whether you bring the research and scholarship standards of anthropology to nursing science or the concepts of anthropology to nursing practice, both can benefit nursing. Gardner and Whyte (1945) said long ago that being the “man in the middle” is hard, but remember, being pivotal is being powerful.

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Addendum

I continue to believe strongly in the argument I made in the original paper. The points are all still valid. Perhaps a few more nurse-anthropologists contribute to anthropology than before (Lauren Clark comes to mind), but it is still very rare. I continue to think that nurse-anthropologists have a lot to offer anthropology. Discussions about cross-cultural practice are extremely relevant to applied anthropology. I hope that the nurse-anthropologists will begin to make a splash in their adjunct discipline.
Care and Culture: An Introspective Commentary

Agnes M. Aamodt

The way I take care of my mother is to wake her up in the morning and then let her sleep 10 minutes longer.

—Girl, 4 years, 8 months

My friend and I mind-read each other and know we will meet in the bathroom when we’re supposed to be in the classroom, that is.

—Girl, 9 years

In hazy, amorphous statements such as these is emerging a sense of care and human response from the thought world of children. For the past 20 years or so, questions have been percolating in the words, phrases, movements, and events of my recorded and nonrecorded field data—Tohono O’odham children, children with cancer, Norwegian women, and elderly women in a nurse-client encounter. For example, there are the “I’m still me,” the “total withdrawers,” the “super copers,” and the “no one knows” when children with hair loss from cancer therapy categorize themselves. Children in the clinic say, “We wait and wait for docs, needles, not feeling good and things like that,” “Treat me normal; treat me special,” “Be good, don’t mess ‘em up,” “It’s the dying I don’t like,” and “I just want to leave the clinic and go home.” How children define their reality brings a different dimension to the practicing nurse and to the development of conceptualizations for nursing theories. The question that now makes sense to me is, “What characteristics of care promote human responses for quality human experience?”

This paper will briefly trace the development of this work through the vicissitudes of long-term fieldwork, the buzzing and booming of ambiguous conversations and behavior, the tentativeness of primitive hypotheses, and the explanations and justifications of them to the many nursing com-
Structuring for the Impossible

How children learn about health and healing was an early interest. The first scraps and patches of this information were collected during my doctoral field experience among the Tohono O’odham American Indians in southern Arizona. In this setting, school-age children became my teachers when conversations between mothers and preschoolers became an impossible field data setting. E. Winans (personal communication, 1966) introduced me to the idea of the “culture of childhood” as an unknown frontier. In large part it still is. Conchita, the mother in the family I lived with, showed me, in many ways, the objects and events clients select from a multihealth system and decide to use, such as both the antibiotic of the Melikan Mankai and the ritual of the medicine lady for a child with diarrhea and fallen fontanel. Jenny showed me the perspective of American Indians for Whites like me when, at 2 years of age, she led me in a chase to get to my room, lost her breath for a full 40 seconds, and achieved a dark, dark cyanotic face I shall never forget. She was scared—of me. Subsequently, I spent a year with Norwegian American women who plied me with two desserts per meal, caffeinated coffee, and meat and potatoes and taught me that tea was for sick people and a person is not really educated when they can’t speak Norsk. The connections between the Tohono O’odham and the Norwegian Americans are yet unlinked and represent another frontier for the impossible. The idea of “presence” in that fieldwork as culturally relevant continues to be a concept recognized by lay and nursing communities but ignored in the ideology of the economically minded medical community.

Finally is the impossibility of getting it, getting it to fit and yet reducing it without it dissolving into nothing. The “it” of course is the sense of the whole related to other wholes as found in ethnographic data. When I try to convey the sense of the cultural theme, “The pits of dependency is not being able to scratch yourself when you itch,” in a two-word phrase, I still and yet come up with nothing. However, somehow, somewhere, there must be a way. Can it really be impossible?
Moments of Insight

Sometimes something just makes sense to me or I put two or three things together in a different way than I had thought of before. This happens to me more frequently after the fact than during. However, when I told Conchita that I didn’t like an outdoor toilet any more than she did, to me that was insightful. I had been given advice in bits and pieces on how to talk with American Indians. The toilet thing just came out and it was right. On the other hand, there was a time I needed the help of an informal consultant to lead me to an understanding of what behavior meant “acceptance.” Three months after beginning fieldwork in the village, I stopped one morning on my way back from town to ask about an accident alongside the road. Later, the village chairman looked me up to find out about it. This was acceptance, I was told by my consultant. The subtleties of many such kinds of social behavior continue to escape me—my moments of insight are often dependent on what is outside of me.

In class at the University of Washington, Madeleine asked me to give an example of one of her care concepts that I saw as culturally relevant to the Tohono O’odham. In a 3-second period, my mind flashed with a picture of a young boy on the grass and a second boy bending over to survey heart rate and breathing. The concept was surveillance, of course, and indeed, as I test out the idea, I find that the Tohono O’odham watch out for each other a lot. The cultural patterning of this kind of care behavior is not well understood.

The focus on neighboring among Norwegian Americans came about 2 months after I had been building a jigsaw puzzle with my Aunt Inga. As we chatted, she said, “... but I miss my neighbors so.” She lived in a rural community where neighbors sometime back had been available for a good talk or a cup of coffee. At the time we held our conversation, the area was known as the bedroom for the cities and the neighbors were commuters and no longer had the same interests and needs as she did. Neighboring became the focus for my analysis of care taking in that community.

In a class with doctoral students, one day I fell heir to a situation well-known to teachers of students who prod and push for greater insight. The stimuli focused on how to categorize the work I was doing—then more primitive even than now. I thought for a bit and wrote on the board for the first time the question that continues to ground the research I do, that is, providing a link between care, human response, and quality human experience. I knew immediately that it fit. “What characteristics of care promote quality human experience?” The “human response” phrase was added after the ANA policy statement came out.
Finally is my view of care as a limited good. For most people, this may seem a simplistic idea; however, I don’t hear too many people talk about it. I happened to be sitting next to a scholarly chemistry professor, the president of our university, and was trying to show him something of the economics of nursing with the right tinge of analytical skill. Suddenly, I heard myself say, “The problem is, care is not a limited good—if it were pearls, emeralds, or oil, we would know a lot about it.” And, of course, everyone can do it, and it—meaning care—is available in all cultures and is expressed in various ways.

Complexities and Constraints

The system that my ideas, my writing, and my fieldwork have been screened through can be characterized as not only nursing and anthropology but, in a sense, the biography of situations (Schutz, 1962). My situations, for example, include the following: a Norwegian American background that insisted that either the only good people or, worse yet, the only people were Norwegian Lutherans; numerous days and nights of monitoring sickness behavior of child patients; talking with students, teachers, and family members about the myriad details of daily living when well and sick; and reading not really enough humanities literature but biographies and anything else about people (a favorite was Kristin Lavårandatter by Sigrid Undset, 1946). My own cognitive maps are not yet well-understood by me, but I uncover and decode new segments with each category I claim, each theme that is appealing and with the many rearrangements of “final outcomes” I happen upon as my mind travels through my data.

For the past 20 years or so, we, in this rebellious field of nursing and anthropology, have been dancing around the logical positivists among our colleagues touching and absorbing from the ideas in the air that maybe, somehow, seem to fit with what feels right to us. We have worked at understanding enough about cultural diversity, variations of ethnography, and the never-never-land of care taking, care receiving, and care eliciting among the culture carriers that we know and the universal behaviors that may possibly exist. In many ways, our system is such that causal explanations work in the marketplace, whereas I cling to the social context of an idea without so much interest in the neat prescriptions leading to a final answer. Often, we are seduced by our system into working toward a merging, negotiating a rapprochement, to become as one with the causal people. If our system absolves a commitment to diversity, we will have, of course, lost the opportunity to
follow the principle of evolutionary potential, that is, only with diversity is there opportunity for growth and development.

Conceptualizing for nursing, thanks to all of us in the world of ethnography, grounded theory and all forms of phenomenology, has now become a part of our system. We are now able to invent something out of nothing for clinical research and, furthermore, to raise it to a higher level of abstraction. In our work, we are contributing, of course, to the constraints of our system, for we are creating labels that may give direction to nursing practice and direction for the ideas to be researched for the next century. For example, the process of “working on acceptance,” emerging from the statements of an elderly client on her view of all her illnesses/sicknesses/diseases, is for me a step forward from the ideas supporting study of acceptance and nonacceptance. How will process statements look 100 years from now? What kinds of constraints will they place on the system? The ideas of Heidegger and Kierkegaard are less than a century old and are just beginning to exert control over what shall be valued in nursing.

Where to Go From Here?

The near future for me holds questions like, What kind of methodology can be developed to provide for optimum utilization of data ensconced in a social cultural context? Nursing is an applied science. Where we can go is probably largely dependent on how we can translate our knowledge into practice. When I attempt to explain the use of ethnographic data, for example a taxonomy portraying all of the inconsistencies in the world of the members of a cultural system, I must resort to the clinical judgment of practicing nurses who use the information. A second question is, “What are the details in care and human response? The range of attributes, of ways to do, of kinds of, of stages in? What are the universals and what are the cultural specifics?” Looking for diversity can only help us look interesting to ourselves and to others. Sameness can be deadening. Diversity is one of my reasons for being.

And finally, What are the unanswerable questions for nursing? What are the human experiences for which we hope there are no answers? For we know that if we touch them, like a bird they will take flight. I like to think about the importance of intimacy in nursing as distinct from social or psychological distance, of nidology (the study of nesting), and the idea of “being” in the larger sense of Heidegger’s Dasein (1958). We are on the way in our discoveries.
NOTE


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Addendum

The past 15 years have generated within me more questions than ever before. Continually, I ask, “What can add to conceptualizations of care useful in promoting human responses for quality human experience?”—a question that, to me, grounded nursing yesterday, does today, and has potential for tomorrow.

Three questions central to what the University of Arizona College of Nursing has studied and researched over the past 45 years (Aamodt et al., 1997) are, What is the potential of the nursing process in health and healing? What is the potential of human beings for health and healing? What is the potential for human adaptation?

We, as nurses and anthropologists, shall always be asking for all the patients in the world, “What can add to the problem-solving activity of the practicing nurse from developments in the personal, academic, and practice world of the nurse scientist?” (Aamodt, 1992).

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When Evelyn Barbee told me that she was putting together a special session of the “old guard” of nurse-anthropologists to talk about their anthropology, I was delighted and pleased to be asked. I can’t think of anything anyone likes to do better than talk about themselves. And so, I have taken her at her word and am talking about myself.

From the moment that I took my first anthropology course from Gustav Carlson at the University of Cincinnati, I was completely convinced of the importance of anthropology to nursing. This course, as Carlson taught it, covered a full year and touched on all four fields of anthropology. Before I had finished my first semester, I had applied to Boston University to study anthropology for my Ph.D. under the nurse-scientist grant program. To my immense surprise and intense pleasure, I was accepted! The next 5 1/2 years were the best educational years of my life. I was challenged to think in a different way, was positively reinforced for asking questions, and was allowed the freedom to explore new methods of research and writing. I did two pieces of fieldwork while I was at Boston: a summer field study of a southeastern Kentucky community and fieldwork among the Pyramid Lake Paiute of Nevada for the dissertation (Brink, 1971a, 1971b). My dissertation was to have been on the socialization of Northern Paiute children but ended up being a quasi-acculturation study, as I was unable to get the sample needed. I learned to use the HRAF files at Harvard University and did Gutman Scaling of cultural materials under Ira Buchler. Unfortunately, this work on a cross-cultural study of adoption (which turned out to be highly significant) was lost during moves around the country.

Since my doctorate (1969), my research has broadened from anthropological ethnography to more descriptive work. In the early 70s, I was a nursing consultant (wonderful title, no pay) to an inpatient acute care psychiatric ward of the UCLA Neuropsychiatric Hospital when they admitted their first heroin addict for detoxification. The subsequent uproar that this admission caused among staff led me to design a series of studies on that unit that dealt
with a description of the withdrawal program (Brink, 1972a), the staff nurses’ attitudes toward the addicts as “legitimate” patients (Brink, 1973), and finally an attempt at getting at just what was the matter with these patients that the staff resented them so much (Brink, 1974). This attempt ended in a behavioral description (Brink, 1972b) of the addict but did not answer the question.

In 1972, I became the assistant dean for student affairs at the UCLA School of Nursing and began a series of studies on the student populations. The first was an experimental program to admit nurses with bachelor’s degrees in other fields to the master’s program in nursing (a very risky project, as this was against the accreditation rules of the National League for Nursing) with some required course work. The experiment lasted for 3 years and was terminated until the data were analyzed. Unfortunately, there were so many errors in the data that the findings could not be relied on to be valid, so I never published the study. The second study (1978a) was a descriptive analysis of the undergraduate students from admission application through to state board results. Both of these studies taught me a great deal about the rigors of doing research on available data.

I was granted a sabbatical leave from UCLA for the academic year 1974-1975, which I had planned to spend in southeastern Nigeria among the Annang. But, as is so common in anthropological fieldwork, the visa did not come through as planned. I was delayed getting to the field until late October, and due to a very serious bout of hepatitis (after several malarial attacks and a severe ear infection), I had to leave the field a month earlier than planned. So, my first African field experience was severely attenuated and took me almost a year to recover from. Nevertheless, I was able to return in 1980 to reinforce the fact that my notes were valid, despite the problems in data collection. Not enough papers have come out of that fieldwork (Brink, 1977, 1982b, 1982c), but the data continue to be analyzed and plans continue to be made (and postponed) for return visits.

At the University of Iowa, I worked in the area of obesity, specifically the area of successful dieters—people who lose weight and are able to maintain that weight loss for years. So far, I am one of the unfunded, but I keep trying and the research goes on without funds, as usual. It just takes much longer and is spread out over many years. What are my themes? I think my research is descriptive, in the sense that I am fascinated by the world as lived by other people and want to capture that world on paper without explanation, without my interpretation. At best, I am fascinated with process, particularly the decision-making process, and I continue to work in that area. I have wanted to have the time to develop the Patientology idea, looking at the patient role
as distinct from the sick role, and feel it is a core concept from which I am always working. Although I have presented a number of papers on the Annang (“Mbobo,” “The Fattening Room,” “Psychosis in the Bush,” “Annang Value Orientations,” “Birth in the Bush,” etc.), I have not taken the time to formalize them into publishable articles. There is work that still needs to be done from the Paiute fieldwork, particularly the completion of a photographic essay on how to make cradleboards. It has been more than 10 years since I have had any kind of a leave since my sabbatical, and I find that I work best with an undisturbed period of time within which to develop a project. Summers are so often split up with meetings, writing grants, and planning for Fall that planned work never gets finished.

What can I say about what I have learned from my fieldwork? Well, when you don’t plan to collect data systematically, you end up with a great deal of unrelated material that has a lot of gaps and holes. I was totally unprepared for not being able to do the study I set out to do with the Northern Paiute. I had planned to do a childhood socialization study, a la the Whiting, Child, Lambert, and Whiting (1963) *Six Cultures* series, including their data collection, and did indeed find 25 families with children under the age of 10. But what I was unprepared for was the political life on an Indian reservation; when you befriend one family, you alienate all their enemies. And so, out of 25 families, only 7 agreed to be interviewed. So that ended that study. At that time, Boston University did not have an Americanist on the faculty, so that the field supervision was by an Africanist and a sociologist, neither of whom knew my field situation very well. In the Nigerian situation, I was totally unprepared to have my interpreter/primary informant have a psychotic break in the middle of my stay and was never sure until 1980 what was valid data and what was not.

This has been my research, and as I look over my vitae, I am amazed at how few actual research publications I have to show for the work I have done. And so, I looked over my vitae again to see what was there. What I found, to my amazement, was a great deal of effort expended on trying to convince other people of the wonders of anthropology, to convince other nurses that they should look at culture as a critical variable in the care of patients (Brink, 1972d, 1976), an attempt to apply theories (Brink, 1972c, 1972e, 1980b, 1985; Brink & Saunders, 1976) and methods (Brink 1980a, 1984a; Tripp-Reimer & Brink, 1985; Tripp-Reimer, Brink, & Saunders, 1984) learned through my studies to nursing problems, and to share with other anthropologists what content nurses need to know to nurse more effectively (Brink, 1984b; Byerly & Brink, 1979). And then there were the “asides.” The papers that we work so hard on just because someone flatters...
us by asking us to do it (Brink, 1979, 1984b; Byerly & Brink, 1979). It is amazing to me how one walks through one’s life by reviewing the list of publications. The periods of thought are so well defined, the movements from one set of self-imposed goals to another. They are so clearly demarcated for me in my life but must seem confusing to anyone else looking over my vitae and wondering where they came from. The pieces on Patientology (Brink, 1978b, 1984c, 1985) were actually conceived and drafted in 1974 while I was waiting for my Nigerian visa to arrive. I had to do something while I was waiting! As I was reworking the heroin addict materials, trying to get another publication out of that work, I was personally confronted by the victimization of the patient at the hands of the health care delivery system. Over time, the material has been reworked, but the ideas remain as they were back then. Nothing much has changed.

When I returned to UCLA from my sabbatical in 1975, I found myself in the awkward position of having to return to the professorial role after being an administrator, finding that others had been assigned to teach my courses while I was on sabbatical, and not having a niche of my own. Fortunately for me, I had a marvelous dean (Rheba de Tornyay) who believed in self-actualization for her faculty and allowed me my head to do as I pleased and develop myself. At the same time, the anthropology department invited me to apply for a joint appointment, which I did; when that came through, I began my career as a medical anthropologist, teaching an undergraduate course and a graduate seminar every year in medical anthropology that were jointly sponsored courses, and finally having doctoral students in anthropology, many of whom were nurses. For the first time, I attended both nursing and anthropology department meetings and discovered the essential dichotomy between the two in relation to curricula, flexibility of requirements, teaching of research and theory, and practical experience in the two fields. I found I loved both disciplines in entirely different ways and taught differently in the two settings. I had developed a course on Nursing in Other Cultures for the School of Nursing in 1970 and taught this course yearly with the two anthropology courses, finding a difference in the students and in my own methods of teaching (Brink, 1972d).

Quite by chance, the associate dean for academic affairs (Betty Dambacher) asked me to teach the undergraduate research course to the nursing senior students, as she had no one to teach the course that year (1975) and would I try my hand at it. Assigning me to teach research and allowing me to develop the two courses in medical anthropology essentially moved me out of the psychiatric/community mental health nursing section to which I had belonged from the time I arrived at UCLA and placed me in the section...
called “Allied Sciences,” the grab bag of faculty who did not fit into a clinical section. This section included the faculty who taught the nursing administration, nursing education, research, and basic sciences. One year later, I developed and taught a graduate seminar on qualitative research methods in addition to the other four courses. By this time, I was teaching six courses a year, with the course on introductory research methods taught twice a year. The move quite effectively took me away from psychiatric nursing, my nursing specialty, into methods and medical anthropology exclusively.

I became fascinated with research methods and spent an enormous amount of time trying to teach methods in a way that was simple and understandable to the novice. I kept trying to figure out the process. Although I had research courses in every graduate program, I learned it as a series of disconnected steps that had little relationship to one another, and I saw it as a deadly dull activity. My anthropology program offered no methods courses on how to do fieldwork or how to analyze data. That was something one sort of muddled through experientially and hoped it all worked out. I figured there had to be a better way. And then Spradley and McCurdy (1972) came out with their book titled *The Cultural Experience*, and I was delighted. So I too began to try to piece together “How to Do Nursing Research” at a very basic level and, with Marilynn Wood, came up with our text *Basic Steps in Planning Nursing Research* (Brink & Wood, 1978, 1983), which is now being developed into its third edition.

This experience led me to begin emphasizing research methods as the way for nurses to document their work, to prove that they had something to offer in the world of health care delivery. From 1978, I have been almost exclusively involved in methods as a teacher of methods, as a writer about methods (Brink, 1980b, 1982d; Brink & Wood, 1983), and in 1979, as the founder and editor of the *Western Journal of Nursing Research* (currently beginning its 9th volume), where I am able to influence nursing by publishing qualitative research papers and transcultural nursing research. And now, because of this background, I have recently been appointed as associate editor to Robert Ness (among several others) in his journal, *Medical Anthropology*.

So what have I learned from this perusal of my vitae? I find I am very much a “hyphenated nurse,” a person who wears two hats, who is a generalist, who is interested in an incredibly rich and varied world, who is easily bored with only one job or one focus and therefore can never settle down to one single specialty area, who is so completely convinced that anthropology is the “true word” that I will proselytize to the entire world (“have mouth, will travel!”) given the slightest chance, and who is completely convinced
that nursing will never amount to much if we don’t do research on our practice and on our patients. And I want to be there to watch the whole process grow and to help it along as best I can. What do I want to be known for? For my epitaph, I guess I would like to be known for being a conduit, for helping other people achieve their potential because I offered them something they needed to grow and teach and help others. My research is descriptive—I provide data for others to use to develop theory. My writings are introductory—I provide (I hope) an idea that will make someone else’s ideas germinate and develop. I am told that my writings are simplistic and that’s OK. I do want people to understand me. I am not very important in the scheme of things, but I do want to contribute to the growth of the field and to others’ growth. That’s all. I guess first and foremost I am a teacher—in my work and in my writings. I hope to be known through the work of my students. For me, that is the most important praise of all.

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Addendum:
Nurse-Anthropologists in the New Millennium

Nancy Anderson has asked for an update to the personal paper I gave at the CONAA Grandparents’ Project. My personal philosophy is the same, my two-pronged career path of nursing and anthropology remains the same, and I am still the editor of the *Western Journal of Nursing Research*. One thing has changed. When I wrote the first paper, I had not been funded for the Successful Dieters project. The project was funded in 1988, and I have had several publications from that. I never did find out just what makes a successful dieter. I have more ideas or hunches about what makes a successful dieter now than I did when I began. As is usual with qualitative work, the findings raised more questions than were answered.

I returned to Nigeria for the last time in 1989 with a graduate student. This time, I focused on the “Fattening Room,” specifically. My personal struggle with the data and publication of findings lay in the secret nature of this custom (Brink, 1993). The Fattening Room is a part of the initiation into a secret society. I was privileged to have those secrets shared with me. Would I be untrue to that trust by telling what I knew? Others have gone in and photographed the female circumcision that occurs, apparently with no qualm at all about ethical issues. Others have written up all they know for publication. I believe that will be the last I will write about my Annang experience.

In 1999, the Canadian International Development Agency funded a project I headed to provide graduate nursing education at the University of Ghana. In many ways, I saw this project as my way of giving back to Africa what I had gained through my experiences in Nigeria. I believe that having a graduate program in nursing in Ghana will be of invaluable benefit to all of West Africa, as it is the first to be offered. Our plan was to offer a graduate nursing curriculum in Ghana, created by the Ghanaian faculty, in partnership with the Ghanaian faculty. The project took 7 years to mature but is now under way with its first graduating class. We anticipate that by the end of the 5th year of the project, the curriculum will be taught completely by Ghanaian nursing faculty with master’s degrees in nursing. I feel very, very good about this.

I have been privileged to have joint appointments in schools of nursing and departments of anthropology where I have taught courses and supervised graduate student research projects. Having master’s and doctoral students in both fields has reinforced for me my conviction that these two
disciplines inform each other in unique ways. When nursing students read anthropology, they became overwhelmed at the richness of the research and its applicability for nursing. When anthropologists read nursing, they discover that nursing has something to offer them.

As I look into the future, I see a great need for anthropology in nursing curricula. Practice environments are more and more culturally diverse, not just in patient populations but in professional populations as well. To provide safe and respectful care, health professionals need to understand the differences between cultures and how culture affects attitudes and beliefs about illness and disease. To gain that understanding, our research needs to inform us what these differences are or what to look for in our work environments.

The National Institutes of Health are now requiring population representation in sample selection. If an ethnic group is represented in the population but is not present in the sample, the researcher must present an explanation as to why the group is omitted. To include these ethnic groups, the literature review must support the lack of data on this population or describe the existing literature on this group.

This requirement is good news for nurse-anthropologists. Literature reviews based only on nursing sources are not adequate to describe the existing knowledge base. Because most nurses have had no anthropology in their educational background, they have no idea how to search the literature in anthropology. Nurses read nursing sources and may have had a course or two in sociology. This does not provide them with adequate tools to work with or study culturally diverse populations. It’s a start, but it is not sufficient for a detailed research proposal. When a nurse only cites nursing literature and ignores the vast body of literature on the topic written by other disciplines, that proposal is sure to fail.

A nurse-anthropologist on a research grant can help researchers find relevant literature, especially if that nurse-anthropologist has also done research on that particular population. The nurse-anthropologist, knowledgeable about the four fields of anthropology, can direct the researcher to focus on specific phenomena to answer the question. Having no nurse-anthropologist as a consultant on a grant, when looking at values and beliefs about health and illness, is to ignore an invaluable resource.

The time has come when schools of nursing need to consider anthropology as a core course in curriculum planning; whether a school is accredited or not on the basis of its ability to teach students about cultural diversity in health care; when researchers think about cultural diversity in their work and realize that there is no longer only one possible grounded theory on a topic but several, depending on cultural background.
Those of us in the Grandparents’ Project should be proud of what we have begun.

REFERENCE

In a real sense, I should not have had a career as a nurse or as an anthropologist. Along the way, I was forced to surmount such barriers as a nursing service administrator who attempted to debar me from taking the competitive New York State Regents Scholarship Examinations for graduate studies. Of the hundreds who took that test, I came out among the top 10. Then, there was the highly regarded nursing professor who advised me that I was not qualified to pursue a doctorate degree. Her counsel was reminiscent of high school advisors who counseled me against seeking admission to college. There was also my first anthropology professor who wondered at my presence in his class and idiosyncratically refused to give me a grade.

I did not start out to become a nurse or an anthropologist. Indeed, I entered both arenas by mistake. They were happy mistakes...but they were mistakes. I entered nursing a decade before the civil rights struggles of the 60s. Opportunities for young African Americans were extremely limited. I had just finished high school and saw before me a lifetime working as a hospital clerk in a Brooklyn ghetto. Perhaps a year passed before I met my first male nurse. Within months, I entered a nursing school—not because I wanted to be a nurse. I just wanted some kind of career. Equally important, the school was in the country, and I believed that 3 years of rustic life would be most beneficial to my view of the world, myself, and my real life’s work. My brother drove me to the hospital on a sunny day in September. As we drove through the grounds, I remarked on the beauty of the place and how pleasant my 3-year sojourn there would be. Only a few moments later, I realized that I had condemned myself to 3 years in a nursing school that was part of a state mental hospital. I nearly faltered, but I had quit my job and night college and promised my brother that he could have my half of our jointly owned car. I continued on my way and, to this day, remain a psychiatric and mental health nurse.

Some 10 years later, I began my second bumbling at career hunting. After completing my master’s degree in psychiatric and mental health nursing, I
accepted an assistant professorship at Michigan State University, where I worked at integrating behavioral concepts into the nursing curriculum. At that time, I confronted two problems. First, I recognized that a university faculty career required a doctorate; second, I craved greater intellectual discipline. Within a year after arriving at Michigan State University, I entered the Department of Sociology and Anthropology.

I studied social psychology for a year, presuming great correspondences between it and my earlier studies in psychiatry and mental health. I found it stultifying. A year in sociology proved more intellectually rewarding, yet still too conservative. It focused on a few established questions and seemed distant from such dynamic issues as civil rights and the developing third world. I decided to try anthropology, which, until that point, seemed an ancillary component of the department. Shortly thereafter, the joint department split and the new anthropology department quickly proved markedly mature and strong.

In anthropology, I found a discipline that captured my imagination. It is an extraordinarily broad field of study and I found its methodologies, particularly its commitment to field studies, peculiarly compatible.

In moments of reflection about my career in anthropology and nursing, I tend not to distinguish between nursing and my anthropological work. Rather, I make distinctions between my work overseas and my work at home. My dissertation studies led me to Africa, where I spent some time studying the life ways of a Yoruba kingdom, as well as such problems of medical anthropology as alternative health care systems and their relationship to official medical systems (Osborne, 1968, 1969a, 1972, 1980; Osborne, Balintulo, Barbee, Brown, Fako, & Mbere, 1977). These interests took me back to Africa on several occasions as researcher and consultant. It was on one of these visits that the Yoruba people I had studied made me Chief Adila of Ibara. I cherish that title. It was vested in me because the people believed that I had been instrumental in keeping peace among them during the internecine strife that spread through Nigeria before the Biafran war.

In fact, too many of my visits to Africa resulted in my being caught up in some coup or other form of political strife. This, and the reduction of monies for African studies, limited my work in Africa. Although unfinished, the overseas anthropological work that I accomplished has contributed immeasurably to my understanding of myself and my knowledge of culture, social systems, politics, and economics. It has also given me a broader vision of the world and the generic human condition than I would have received in nursing or my other studies.
In 1969, after completing my dissertation and nearly 2 years as faculty in the School of Nursing, Wayne State University, I went to the University of Washington to chair the small psychiatric and mental health nursing program. The challenge to build the program into a department, create a doctorally prepared research faculty, compete for and manage National Institute of Mental Health (NIMH) training and research grants, participate in numerous undergraduate and graduate curriculum projects, contribute to building the school’s doctoral program, return to academic administration during a university financial emergency, provide workshops, teach, present papers at professional meetings, publish on issues of psychosocial nursing (Nakagawa, Osborne, & Hartman, 1974; Osborne, 1984; Osborne & Larson, 1974), and rear five children and help them through college detracted from my anthropological teaching and overseas research.

Nevertheless, I believe my peculiarly anthropological contributions to nursing have not been wanting. I consider myself among the first who articulated the holistic view of nursing as well as the importance of anthropological studies for nurses (Osborne, 1969b, 1974). My efforts related to the issues of nursing and oppression have been enlightened and invigorated by my anthropological background (Osborne, 1976a, 1979; Osborne, Nakagawa, & Hartman, 1976a, 1976b; Osborne, Carter, Pinkleton, & Richards, 1983). I have long advocated qualitative methods in nursing and am gratified that this approach to study is now being appreciated by nurse researchers (Bush, Ullom, & Osborne, 1975; Osborne, 1976b; Osborne et al., 1977). Of my many and varied academic and administrative labors, I am most proud of my anthropologically oriented community mental health courses and research.

During the halcyon years of NIMH funding, my mental health courses provided student internships in the offices of the state mental health authorities of Oregon, Idaho, Alaska, and Washington. Now that those years are over, there remains a core course in the master’s curriculum entitled “Social-Ecological Approaches to Community Mental Health.” Intellectual orientations developed in this course contributed to the doctoral program core course “Environments: Supporting and Non-Supporting.”

It is the nurse-anthropologist in me who has allowed me to pursue 7 years of collaboration with the Washington State Department of Mental Health and its two state hospitals in a program designed to improve the nursing care of the hospitals. This is an extremely difficult collaboration characterized by budget crises, factional disputes, radical changes in organizational structure, and sudden firings of administrators. Over time, I have been a director of a research project in one of these hospitals that looked at the fascinating
relationship between changing social images and changing symptom complaints (Osborne & Nakagawa, 1973; Osborne, Nakagawa, & Hartman, 1976a, 1976b) and in a research project related to the problems of the increasing population of downtown homeless (Whitley, Osborne, Godfrey, & Johnston, 1985).

How does all this sum? Ultimately, I have found close correspondences between psychosocial nursing and anthropology. I spoke of these in an article written some time ago. In psychosocial nursing, we teach that nurses must know themselves. As an anthropologist, I believe that the first and continuing methodology is the ethnography of self.

I have several selves. Among my selves are a nurse, an anthropologist, and a nurse-anthropologist. I am also an African American in a predominantly Caucasian society, a male in a female profession, a prevention- and community-oriented nurse in a cure- and hospital-oriented medical system, a psychosocial nurse in a mechanistic and materialistic health care industry, and a student of macro-social-cultural phenomena, whereas much of nursing and anthropology seems mired in the quirks and quiddities of medical interpersonal action and micro-events. How is it that more nursing and anthropological attention is not devoted to the study of a country whose political, economic, health, and other institutions are being returned to the early 1900s? For medical anthropologists, how is it that we neglect the study of the many fascinating issues related to the 350,000 to 3 million homeless, or the fact that the so-called “safety net” is full of large holes? Did I blunder into two professions dominated by conservatives?

These major contradictions in myself and my circumstances have caused me much pause and reflection. My continuing challenge has been to find the sense in it all. I see this in my studies of downtown street people. There, I ask questions about the relationship between disenfranchisement and health care. I see this in my studies of changes in symptom patterning as reflections of changing societal images. There, I seek the potential for the forecasting of future institutional populations and patient behavior. I see this in my hospital change projects. There, I wonder at the relation of the political economy to the plight of nursing staff, who are stalled in their professional development by the machinations of paraprofessional labor unions, the strivings of other professionals, and the requirements of state bureaucracies and politicians. And I see this in my alternative health care research. There, I pose the question of how alternative healers might participate in official health care systems.

Parenthetically, I have concluded that this last question is wrong. Given the imperialistic requisites of official systems, the uncritical participation of
alternative healers in such systems must lead to their being, ultimately, politically and economically coopted. The new question is, How do alternative healers use official systems to enrich their own contributions to the health care of people?

I sometimes wonder if all of my involvements have been distractions from my real work—that is, if they are my real work, or if they are somehow preparing me to do my real work. I now recognize that the many contradictions of my life have resulted in my being quizzical and dissatisfied about much of medical anthropology and nursing anthropology. They both seem so staid and preserving of the status quo. My awareness of alternative possibilities in both areas was validated by my reading Dell Hymes’s *Reinventing Anthropology* (1971). Since then, I have been committed to ideas and activities that were earlier called radical anthropology. This area has recently been rediscovered and named critical anthropology. My continuing readings in the area of political economy have sharpened my thinking about the study of institutions and macro-systems and, importantly, provide me with an intellectual and action context for my future anthropological and nursing studies.

In reflecting on this statement, I am at first impressed with a sort of thrashing-about quality to the manner in which I have pursued my way. But, isn’t that the way most of us live our lives? Upon close examination, I do see some continuing themes. These are my interests in systems of care, the political and economic aspects of health care delivery, the contributions of alternative health care systems, the needs of the oppressed, and an enormous amount of activity directed toward achieving system change. It is my expectation that my future work will continue in these directions and become increasingly focused. It is my hope that I will soon recognize a cadre of like-minded nurse anthropologists with whom I might collaborate in the critical study of macro health systems issues.

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**Addendum**

Sixteen years have passed since this paper was presented. I closed the paper stating my expectation that my future work would focus on systems of care, alternative health care systems, political and economic aspects of health care delivery, the needs of the oppressed, and institutional and health systems change. In writing this addendum, I find myself surprised at how, in a variety of ways, I attended to all of these ambitions. In collaboration with university
and clinical colleagues and a wide variety of community collaborators, I created the Public Sector Nursing project. The principal program within this general project was the development of the professional capabilities of state hospital psychiatric nurses through university graduate degree programs, research, political support, individual counseling, and regional and national conferences (Osborne, 1987, 1990, 1991, 1992; Osborne, Murphy, Leichman, Griffin, Hagerott, & Thomas, 1990; Osborne, Hagerott, Hilliard, & Thomas, 1992, 1993; Thomas, Beaven, et al., 1999; Thomas, Eklund, Griffin, Hagerott, Leichman, Osborne, & Reno, 1990; Thomas, Hagerott, Hilliard, Kelly, Leichman, Osborne, & Thurston, 1999). The public sector project also resulted in research and consultation programs within prisons (Osborne, 1995a, 1995b; Osborne, Duryea, Herman, Kersten, & Zunkel, 1995; Osborne & Thomas, 1991) and the community (Osborne, 1996).

In collaboration with Professor David Allen, I developed and, for a number of years before my retirement in 2001, taught the graduate multidisciplinary course “People of Color, Psychosocial Nursing, and the Culture of Oppression.” In my final professional years, I returned to teaching Africa courses in the Department of Anthropology and completed an article on African health care systems for Microsoft’s Encarta encyclopedia (Osborne, 2000). Now I act as a news analyst for Radio Alfaz del Pi in Spain, where I regularly spend a portion of the year in my home in Altea.

My career in nursing and anthropology was long and, in most ways, satisfying. My greatest regret is that I could not entice more nurses into careers that emphasize social rather than individual change, and prevention as contrasted with treatment. I retired from the field with the sense that I did my best.

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Several of our panel members have spoken or written about the commonalities between nursing and anthropology. Brink’s, Osborne’s, and Aamodt’s comments about their careers as nurse-anthropologists are symbolic of the dialectical tensions operative in both disciplines. Today, this dialectic seems particularly intense in our common subfield, medical anthropology. On one hand, there is one tradition, as represented by proponents of the explanatory model (including some nurse-anthropologists) who essentially view the task of medical anthropology as one that contributes to the efficacy of clinical medicine. On the other hand, there is another group, as represented by the members of an invited session titled “The Medicalization of Medical Anthropology.” Their concern is that medical anthropology, as a subdiscipline, is becoming more clinical than cultural in its research concerns and practice.

Although there may be many commonalities between nursing and anthropology, our major commonality is our pursuit of, and struggle to develop, theories based on our close work with human beings in their natural and human developed settings. A major problem that seems to have beset our first three presenters is the dialectical tension created by getting a doctorate in anthropology and remaining a nurse. A basic theme that runs through their papers is what anthropology has to contribute to nursing and what nursing has to contribute to anthropology.

It seems to me that the tasks, challenges, and conflicts facing both of these disciplines are mirrored in their remarks. They all spoke of the evolution of and changes in their work, the importance of teaching others about anthropology, and how they articulated and demonstrated their fusion of anthropology with nursing. Too often, when nurses engage in discourse about these issues, there is a tendency to become too concrete. Thus, we are left with something called the “cultural component” of health care rather
than sociocultural processes and the relationships among these processes and health care.

This remains our dialectic because what few people realize is that there is both a discipline of nursing and a profession of nursing. Yet, at the same time, for nurse-anthropologists, it is difficult at times and impossible at others to remain true to the mission of one discipline or the other. An overriding theme in all of their work is how their values, their assumptions about health care (an entity that we see as distinctly different from medical care), and their approach to knowledge has been influenced by anthropology. Their work is best described as explicating rather than explanatory because of their refusal to explain away the irreducible complexity and ambiguity of social life and the influence of social life (Hagey, 1986) and social structure on health care. It is precisely because of their interest in the foibles of human and system responses to health, illness, and sickness that their work is explicating.

As mavericks and seminal thinkers, their worldview has been formed and influenced through the study of anthropology. Thus, their work demonstrates a valuing of diversity, the importance of context, and a questioning about the basic assumptions about people under the conditions of health, illness, and sickness. They have used the inductive approach and the theories of anthropology to examine underserved populations, poorly understood populations, and the medical care system in general. Their contributions to anthropology lie in their emphases on the importance of context and wholism. They are antireductionistic in their explication because of their emphases on context and wholism. They explain their findings rather than making them disappear with a neat explanation.

A major challenge that remains is how we can continue to fuse or integrate the discipline of anthropology with the professional practice of nursing. Aamodt spoke of the crucial test of her work as being how it is used by practitioners. Although I agree with Aamodt, at the same time, I think we must heed Geertz’s caveat about the dangers of oversimplification. As Geertz (1973, 1983) notes, because knowledge is built on sands of interpretation, knowledge about human life necessarily lacks a solid foundation. Reams of factual data may not supply any relevant insight in a particular case. This is particularly true of how our work is used in clinical nursing practice. For as Rebecca Hagey (1986) asked recently, Do you sometimes get the feeling, as I do, that the level at which intercultural practice has been taken up in nursing is, “What to do if E.T. comes to your ward” or “How to accurately assess E.T. in five minutes”?
Brink spoke of our need to do research on our practice and our patients. But there may be a greater need for us to do research on our practice settings. The relationship between nursing labor unions and patient care, constraints of the practice settings on the professional practice of nursing, and the influence of ideology and reproduction of the social order in the provision of health and medical care are just a few of the areas that need our particular expertise. However, using our expertise in these endeavors also raises other questions.

Do we take an approach to knowledge that is the tradition of the discipline of anthropology for the development of the discipline of nursing? Or do we derive theory from one field and apply it to another? We need to pursue both the knowledge of nursing and the knowledge of anthropology in a manner that retains the intellectual vigor of one (anthropology) and yet allows us to recognize the needs of the other (nursing). Our challenge is to use the tradition of anthropological rigor and scholarship to develop culturally relevant knowledge for nursing and to use the basic premises from anthropology to challenge the narrow views of culture in nursing and the narrow views of nursing in anthropology. This approach requires that we examine the process of health care in its broadest sense. As Osborne suggests, our interests should be in process, the relationship among phenomena, explicatory rather than explanatory. As nurse-anthropologists, we are ensnared in a dialectic and as a result, our transformation and the transformation of the session participants is both instructive and exciting.

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