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ABSTRACT

International and cross-cultural research concerning populations living in poverty have uncovered similarities in attitudes and behaviors associated with participation in society's institutional systems. One of these similarities is that feelings of alienation are an inevitable "reaction of the poor to their marginal position in a class-stratified, highly individuated, capitalistic society" (Lewis, 1966:21). These feelings, in turn, have led poor people in general to withdraw from participation in community life, including the community's institutions charged with the task of delivering services associated with physical welfare. The central task of this paper is to report findings that suggest that the degree of social stability among a poverty sample is inversely associated with favorable attitudes toward a public clinic's nurse practitioner program charged with the task of treating infants.

CLASS-ALIENATION AND HEALTH SERVICE USE

A number of studies and theoretical papers have noted the relationship between lower class life and/or alienation, and the utilization of health services. For example, Morris, et al. reported that mothers who feel alienated are less likely to have their children vaccinated than mothers who are not alienated. Bullough found that alienation was negatively related to obtaining pre- and post-natal care and well-child care, including immunizations (cf., also, Gray, et al., 1967; Nakagawa, 1971). A basic assumption of studies on alienation and health care behavior reported thus far is that underutilization is one manifestation of the general estrangement of the poor from the mainstream of middle-class society and its

social institutions. Researchers following the "culture of poverty" argument noted that:

> Utilization, then, becomes the direct result of the culture and values of the poor and presumably little or nothing can be done to improve health conditions for the poor without a change in these values. The policy implications of this interpretation of the medical behavior of the poor are clear. Short of full participation and integration into American life, policy guidelines would stress the importance of education in reducing...cultural impenetrability... (Goering and Coe, 1970:310-311).

Other researchers adhering to a "structural", rather than "cultural" approach to poverty, have also noted the poor's alienation from society's health-care delivery systems. Strauss (1969:155) contends that among lower-class persons the "pervasive problematic character of life tends to make unreal the careful and solicitous attitude toward health held out by the health professions, and by and large subscribed to by the higher income groups." Strauss further suggests that the present structure of medical care "is so alien to lower-class individuals that they cannot intelligently or sanely take advantage of its services" (Chalfant, 1974:230). Further, the highly personalized world view of many lower-class persons (Gans, 1962) makes it difficult for them to understand or cope with the bureaucracies involved in the delivery of health care.

> The way the poor think and respond, the way they live and operate, has hardly ever (if ever) been considered in the scheduling, paperwork, organization and mores of clinics, hospitals and doctors' offices (Strauss, 1967:8).

The sense of powerlessness of feeling that one has no effective control over one's destiny engendered by a lower-class existence is verified in medical settings where the lower-class patient is "markedly subordinate" in his relations with health care personnel. Sjoberg, et al. (1965:395-96) have noted that "bureaucratic systems are the key medium through which the middle class maintains its advantaged position vis-a-vis the lower class".

Regardless of cultural and national context, a wealth of research findings and analytical writings point to the suggestion that the lower-class in society differs from the middle class in both

life style and perception of the social environment. Middle-class residents, for example, are more prone than their working class counterparts to perceive themselves as living within a manageable environment. The middle-class child learns he can expect to plot his life's history in terms of a steady progression "upward" from secondary school to college and on to professional or managerial occupations. Middle-class environment is thus predictable in that it provides the resources necessary for the individual to shape his own destiny (Rainwater, et al.), and it can be manipulated to one's advantage for career advancement. The middle-class world is also predictable because it consists of a legitimate set of occupational and residential positions. Middle-class individuals participate in community life because such participation makes sense in a stable life world that implies an identification of oneself in terms of others within the system, and a perception of a stable and on-going set of roles defined as legitimate within the community itself (Farber, 1971). The middle class of the 1970's may be less certain about the state of its society and institutions than it was in the 1950's. However, the idea of the society providing the resources for one's career advancement and placement within the community status system continues to be an entrenched middle-class fact of life.

Lower-class residents do not have the luxury of such a life view. Their social universe is unpredictable at best. Life is not perceived in career terms. Life is seen as a series of jobs interspersed by periods of unemployment and crises. Even for the wage earner with a steady job, the treat of lay-off hangs over his head as a threat to the economic security of both him and his family. Indeed, the basic life conception surrounding lower-class existence is clearly stated by Rainwater, et al. (1959:44) in their description of the working-class woman's perception of herself in the world:

> A central characteristic of the working-class wife is her underlying conviction that most significant action originates from the world external to herself rather than from within herself. For her, the world is largely unchangeable, a kind of massive, immovable apparatus that is simply there.

And again:

> This feeling of smallness before the world is not restricted to a specific context, but is pervasive in... (the workingman's wife's)...outlook...She tends to see the world

beyond her doorstep as fairly chaotic, and potentially catastrophic (Rainwater, et al., 1959:45).

Research findings from several investigations (some of which are cross-cultural) tend to suggest that, regardless of the culture studied, people located in the lower recesses of society tend to share a number of central characteristics (Gans, 1962; Prince, 1969). Of special interest here are the cross-cultural findings that working- and/or lower-class members tend to: (1) define the entire social world outside peer group and family as "them", with a concomitant distrust of all "them" and "their" institutions; (2) perceive the outer world as chaotic and fear its unpredictable and catastrophic qualities; (3) seldom participate in community life; and (4) surround themselves with a family circle consisting of both immediate and secondary relatives.

It is argued here that lower- and working-class people "seldom participate in community life", and "surround themselves with a family circle consisting of both immediate and secondary relatives" because such behavior patterns make sense given the nature of the environment in which they live. There is little perceived reward for participation in community life among lower- and working-class populations. The catastrophic nature of the world ruled by "them", and the stigma associated with lower-class occupations and areas of residence lead to a shunning of community involvement. In an unstable social structure involving an environment in which modes of identification of individuals with others in the structure do not exist, positions within the structure do not endure, and those positions that do not endure (e.g., "laborer"; "the little people") are not legitimated; community participation becomes at best a painful reminder of one's inferior station. To the extent that activities are perceived to be "community" organized and run, lower- and working-class populations will hold their involvement in these activities to a minimum. Emotional and physical needs will be satisfied where possible on an informal basis through interaction with kin and friends--people with whom the individual has sentimental attachments and has established trust relationships.

POVERTY AND CLASS: THE STABLE VS. UNSTABLE POOR

Although agreeing in general with the "life in poverty" conceptualization summarized above, S. M. Miller (1964) notes that the poor

do not comprise a homogeneous population. Miller makes a distinction between the "stable" and "unstable" poor. Stable poor populations are steadily employed and are characterized by stability in other phases of their daily lives. Unstable poor people are characterized by rapid changes in employment, are more likely to be on welfare, and are less likely than the stable poor to live organized lives in general.

Hypotheses

No attempt is made here to refute the fact that all poor people are structurally alienated from society in general. It is argued, however, that the stable poor are more likely, than are their unstable counterparts, to possess the emotional strength necessary to criticize the activities of a bureaucratic agency involved in distributing services and commodities to the poor. Specifically, it is hypothesized that: Social stability among a poor population is directly related to that population's tendency to criticize an agency's methods of servicing poor populations.

DATA AND MEASURES

Interviews with mothers of infants enrolled in the nurse practitioner program of a Southwestern city's "well-baby clinic" were conducted between June and August, 1977. A major purpose of this survey was to ascertain clients' evaluations of the program's overall effectiveness. Other research goals included surveying the extent to which the clinic provided a vital medical need for its clients, and clients' knowledge concerning the role of nurse practitioners in the practice of contemporary medicine.

The well-baby clinic studied is an agency whose main purpose it to make available medical facilities which promote good health in babies from infancy to age five and to offer these facilities and services to families of low income. A secondary purpose is to immunize children. The clinic also acts as a referral agency. The family nurse practitioner program of the clinic involved the teaching of young mothers of high-risk infants the importance of early detection of illness and especially the importanct of regular physical examinations in addition to the regular immunizations. The nurse practitioner (and an LVN) was also charged with instituting a home visit program in which infants were seen in their homes several times during the first year of life.

Because of financial limitations, a nonrandom sample of sixty-one of the 150 mothers enrolled in the nurse practitioner program were interviewed in a private room at the clinic. These mothers ranged in age from 14 to 40 (med. = 23.5), possessed an approximate median income of $500. per month and a median 9.5 years of schooling. Fifty-nine percent of the sample were Mexican-American, 26 percent were Black and 15 percent Anglo.

Measures

Questions on the interview schedule were designed to measure respondents' attitudes toward the clinic (the study's dependent variables) and respondents' social stability. Attitudes toward the clinic were measured by questions concerning (1) the clinic in general; (2) the clinic's home visit program; (3) time spen in the clinic's waiting room before the doctor could be seen; (4) how comfortable respondents felt in dealing with the clinic's personnel; and (5) whether or not respondent felt the clinic was effective in dealing with the child's medical problems.

Social stability was measured by asking respondents (1) whether or not they had a regular source of medical care (whether public or private); (2) whether or not they had a family doctor, (3) whether or not they had any alternative source for their child's medical care other than than provided by the clinic, and finally, (4) years of formal education was used as an indicator of respondents' integration into the larger society. Actual wording of interview measures can be found in Figure 1.

Findings

Table 1a-1d shows the relationship between respondents' feelings about the clinic in general and the four measures of social stability. It can be seen that three of the subtables in Table 1a-1d possess scores running in the hypothesized direction. It should be noted that only two of the gamma values show any meaningful degree of association. When education is used as a social stability measure, results are obtained which are contradictory to those predicted. "Unstable-poor" respondents were more likely, than were their "stable" counterparts, to note needed improvements in the clinic's operation.

Stronger results were obtained in Table 2a-2d. The first two subtables show moderately strong degrees of association (G's = -.57 and -.47, respectively) between respondents' social stability and his tendendency to criticize the length of time spend in the clinic's waiting room. Strangely, social stability measured in terms of

whether or not respondents possess an alternative medical source to that provided by the clinic demonstrates results opposite to those found in the first two subtables. It should also be noted that education (subtable 2d) again led to results contradictory to those predicted.

When satisfaction with the clinic is measured by respondents' feelings about personnel (Table 3a-3d), all four social stability measures provide gamma values running in the predicted direction. Education, however, again provides no important degree of association when linked to respondents' satisfaction with clinic's personnel.

Table 4a-4d shows the relationship between respondents' perception of the clinic's ability to deal with infants' medical problems by social stability. Gamma values in three of the four subtables tend to support the study's hypothesis. In these three subtables (4a, 4b, and 4d), social stability is inversely associated with satisfaction.

Finally, the four subtables of Table 5a-5d tend to support our hypotheses, although only subtables 5b and 5c have gamma values of moderate strength. In summary, results in the five tables tend to support the study's major hypothesis that social stability among a poor population is directly related to that populations' tendency to criticize an agency's methods of serving the indigent. It should also be noted, however, that many of the gamma values are relatively weak, and that five of the 20 gamma scores actually ran in the opposite direction from that which was predicted.

CONCLUSIONS

The nonrandomness of our sample and its meager sample size renders, at best, a pilot study. Nevertheless, data presented in the study's five tables tend to support our original hypothesis. In each case where indigent respondents are categorized by whether or not they possess a regular source of medical attention (whether public or private), satisfaction with the clinic, its operations, or its personnel is negatively related to social stability. However, when social stability is measured by respondents' degree of education, or by whether or not respondent possesses an alternative source of health care to that provided by the clinic, mixed results are obtained. Clearly, more data is needed before anything definitive can be said about the relationship between stability and the tendency to criticize a health care delivery agency. The overall findings, however, do support the study's hypothesis. It would perhaps be beneficial to

expand the study to include respondents who are members of the clinic, but who are not part of the clinic's nurse practitioner program. We would predict that results would be stronger in such a group.

Figure 1. Survey Questions Used to Measure Variables Summarized in Tables 1a-1d through 5a-5d

Dependent variables

1. Satisfaction with clinic
   "...what are some of the things you think could be better in the clinic?"

2. Satisfaction with time spent in waiting room
   "...thought you would have a long time to wait in the waiting room?"

3. Feelings about clinic's personnel
   "Sometimes doctors and nurses, without meaning to, talk down and treat patients like children. Have you ever noticed this happening with the staff at the Well Baby Clinic?"

4. Satisfaction with clinic's ability to ameliorate infant's problem
   "...thought clinic people wouldn't do anything for the condition?"

5. Satisfaction with clinic's nurse practitioner home visit program
   "Home visits have recently been added to the Well Baby Clinic. Some clients like this practice of having Dora (the LVN) visit in private homes; others do not. How do you feel about these home visits?"

Independent variables

1. Regular source of care
   "Is there a physician that you and your family see more often than others? Where do you see this doctor?"

2. Family doctor
   "Do you now have a "family" doctor?"

Figure 1, continued.

3. Alternative Source
"...how would you have handled your baby's problem if you had not been able to come to the clinic?"

4. Education
"0-9 years vs. 10+ years."

Table 1a, 1b, 1c, 1d. Respondents' staisfactions with clinic by the four social stability measures.[a]

1a. Satisfaction with Clinic by Social Stability: Regular vs. No Regular Source of Medical Care

	Satisfaction	
Class	Low	High
USP[b]	15 (54)	21 (64)
SP	13 (46)	12 (36)
Total	28 (100)	33 (100)

Gamma = -.20

1b. Satisfaction with Clinic by Social Stability: Family Doctor vs. No Family Doctor

	Satisfaction	
Class	Low	High
USP	17 (61)	21 (64)
SP	11 (39)	12 (36)
Total	28 (100)	33 (100)

Gamma = -.06

1c. Satisfaction with Clinic by Social Stability: Other Source vs. No Other Source of Treatment of Child

	Satisfaction	
Class	Low	High
USP	10 (36)	18 (58)
SP	18 (64)	13 (42)
Total	28 (100)	31 (100)

Gamma = -.43

1d. Satisfaction with Clinic by Social Stability: 10+ Years of Education vs. 0-9 Years of Education

	Satisfaction	
Class	Low	High
USP	15 (54)	12 (36)
SP	13 (46)	21 (64)
Total	28 (100)	33 (100)

Gamma = .34

Table 1a, 1b, 1c, 1d, continued.

[a]See Figure 1 for exact wording of questions

[b]USP (unstable poor) SP (stable poor)

Table 2a, 2b, 2c, 2d. Respondents' Satisfaction with Length of Time Spent in Clinic Waiting Room by the Four Social Stability Measures

2a. Satisfaction with Time Spent by Social Stability: Regular vs. No Regular Source of Medical Care

	Satisfaction	
Class	Low	High
USP	4 (33)	31 (65)
SP	8 (67)	17 (35)
Total	12 (100)	48 (100)

Gamma = -.57

2b. Satisfaction with Time Spent by Social Stability: Family Doctor vs. No Family Doctor

	Satisfaction	
Class	Low	High
USP	5 (42)	32 (67)
SP	7 (58)	16 (33)
Total	12 (100)	48 (100)

Gamma = -.47

2c. Satisfaction with Time Spent by Social Stability: Other Source vs. No Other Source for Treatment of Child

	Satisfaction	
Class	Low	High
USP	8 (67)	20 (43)
SP	4 (33)	27 (57)
Total	12 (100)	47 (100)

Gamma = .46

2d. Satisfaction with Time Spent by Social Stability: 10+ Years of Education vs. 0-9 Years of Education

	Satisfaction	
Class	Low	High
USP	15 (54)	12 (36)
SP	13 (46)	21 (64)
Total	28 (100)	33 (100)

Gamma = .33

Table 3a, 3b, 3c, 3d. Respondents' Feelings about Clinic Personnel by the Four Social Stability Measures

3a. Feelings about Personnel by Social Stability: Regular vs. No Regular Source of Medical Care

	Comfortableness	
Class	Low	High
USP	11 (50)	24 (63)
SP	11 (50)	14 (37)
Total	22 (100)	38 (100)

Gamma = -.26

3b. Feelings about Personnel by Social Stability: Family Doctor vs. No Family Doctor

	Comfortableness	
Class	Low	High
USP	12 (54)	25 (66)
SP	10 (46)	13 (34)
Total	22 (100)	38 (100)

Gamma = -.23

3c. Feelings about Personnel by Social Stability: Other Source vs. No Other Source for Treatment of Child

	Comfortableness	
Class	Low	High
USP	15 (68)	13 (35)
SP	7 (32)	24 (65)
Total	22 (100)	37 (100)

Gamma = .60

3d. Feelings about Personnel by Social Stability: 10+ Years of Education vs. 0-9 Years of Education

	Comfortableness	
Class	Low	High
USP	9 (41)	17 (45)
SP	13 (59)	21 (55)
Total	22 (100)	38 (100)

Gamma = -.08

Table 4a, 4b, 4c, 4d. Respondents' Perception about Clinic's Ability to Ameliorate Problem by the Four Social Stability Measures

4a. Satisfaction with Clinic's Ameliorative Ability by Social Stability: Regular vs. No Regular Source of Medical Care

	Satisfaction	
Class	Low	High
USP	13 (50)	22 (65)
SP	13 (50)	12 (35)
Total	26 (100)	34 (100)

Gamma = -.29

4b. Satisfaction with Clinic's Ameliorative Ability by Social Stability: Family Doctor vs. No Family Doctor

	Satisfaction	
Class	Low	High
USP	14 (54)	23 (68)
SP	12 (46)	11 (32)
Total	26 (100)	34 (100)

Gamma = -.28

4c. Satisfaction with Clinic's Ameliorative Ability by Social Stability: Other Source vs. No Other Source for Treatment of Child

	Satisfaction	
Class	Low	High
USP	13 (52)	15 (44)
SP	12 (48)	19 (56)
Total	25 (100)	34 (100)

Gamma = .16

4d. Satisfaction with Clinic's Ameliorative Ability by Social Stability: 10+ Years of Education vs. 0-9 Years of Education

	Satisfaction	
Class	Low	High
USP	8 (31)	18 (53)
SP	18 (69)	16 (47)
Total	26 (100)	34 (100)

Gamma = -.43

Table 5a, 5b, 5c, 5d. Respondents' Satisfaction with Nurse Practitioner's Home Visit Program by the Four Social Stability Measures

5a. Satisfaction with Home Visit Program by Social Stability: Regular vs. No Regular Source of Medical Care

	Satisfaction	
Class	Low	High
USP	11 (50)	22 (61)
SP	11 (50)	14 (39)
Total	22 (100)	36 (100)

Gamma = -.22

5b. Satisfaction with Home Visit Program by Social Stability: Family Doctor vs. No Family Doctor

	Satisfaction	
Class	Low	High
USP	10 (46)	25 (69)
SP	12 (54)	11 (31)
Total	22 (100)	36 (100)

Gamma = -.46

5c. Satisfaction with Home Visit Program by Social Stability: Other Source vs. No Other Source of Treatment of Child

	Satisfaction	
Class	Low	High
USP	9 (41)	18 (51)
SP	13 (59)	17 (49)
Total	22 (100)	35 (100)

Gamma = -.21

5d. Satisfaction with Home Visit Program by Social Stability: 10+ Years of Education vs. 0-9 Years of Education

	Satisfaction	
Class	Low	High
USP	8 (36)	18 (50)
SP	14 (64)	18 (50)
Total	22 (100)	36 (100)

Gamma = -.27

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