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A Description of Some of the Adjustment Problems of Tuberculous Indians to Sanatorium Life

Mary Van Franklin

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Franklin
—
Adjustment Problems of Tuberculous Indians

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A DESCRIPTION OF SOME OF THE ADJUSTMENT
PROBLEMS OF TUBERCULOUS INDIANS TO SANATORIUM LIFE

By

Mary Van Franklin

A Thesis

In partial fulfillment of the
Requirements for the Degree of
Master of Arts in Sociology

The University of New Mexico
1949



A DESCRIPTION OF THE ALBUQUERQUE
PROGRAM OF RESEARCH AND DEVELOPMENT



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In partial fulfillment of the
requirements for the degree of
Master of Arts in Sociology

The University of New Mexico

This thesis, directed and approved by the candidate's committee, has been accepted by the Graduate Committee of the University of New Mexico in partial fulfillment of the requirements for the degree of

MASTER OF ARTS

E. Rastetter

DEAN

Aug. 2, 1949

DATE

A DESCRIPTION OF SOME OF THE ADJUSTMENT
PROBLEMS OF TUBERCULOUS INDIANS TO SANATORIUM LIFE

BY

Mary Van Franklin

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This thesis directed and approved by the candidate's com-
mittee has been accepted by the Graduate Committee of the
University of New Mexico in partial fulfillment of the require-
ments for the degree of

MASTER OF ARTS

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A RESEARCH THESIS SUBMITTED TO THE FACULTY OF THE
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IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

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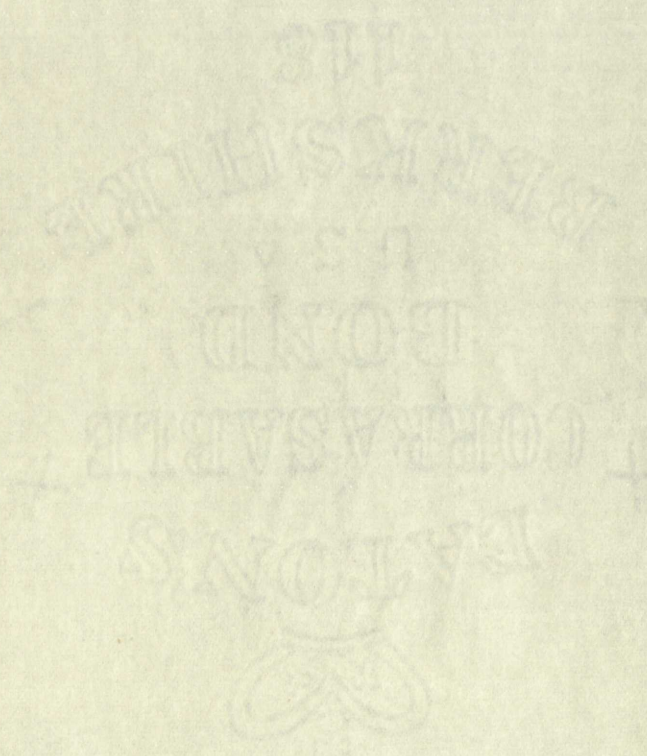
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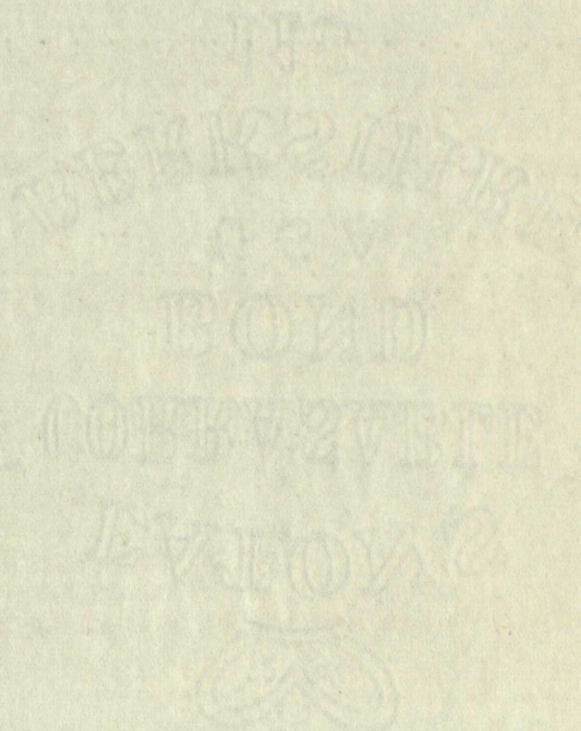
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CHAPTER I

INTRODUCTION

This is a descriptive study of the adjustment problems of tuberculous Indian sanatorium patients to sanatorium life. The problems described are the problems given by the Indian patients themselves in interviews, and problems observed by the medical staff of the sanatorium.

Tuberculosis is an infectious disease caused by the tubercule bacillus which attacks every bodily tissue, although the lungs are most vulnerable. "It appears probable that in civilized countries the bacillus is nearly ubiquitous, and that almost everyone is infected before adulthood, normally so lightly that a resistance is developed."¹ The occurrence of the disease in adolescence depends upon the lowering of normally developed resistance by malnutrition, fatigue, other disease conditions, or upon massive infection. Cure of the disease is at present a prolonged process. Cases can often be arrested or made quiescent by means of bed rest, diet, lung collapse, and other therapeutic treatment. The disease is largely painless, although surgical treatment may introduce

¹Roger Barker, Beatrice A. Wright, and Mollie R. Gonick, Adjustment to Physical Handicap and Illness: A Survey of the Social Psychology of Physique and Disability (New York: Social Science Research Council, Bulletin 55, 1946), p. 118.

strenuous episodes. Treatment is always long, a matter of months or years, the achievement of quiescence being a very gradual process.

Tuberculosis is a disease of young adulthood. The estimated 370 tuberculous Pueblo Indians and the 2,100 tuberculous Navahos² in the state of New Mexico are predominately young adults at the ages when ambition and responsibilities are greatest. If they enter the Albuquerque Indian Sanatorium, the one government Indian Sanatorium in New Mexico,³ they have to renounce all strenuous activity for months or years at a time; and are placed in face to face groups with strangers similarly diseased. The progress of the disease is usually slow and the patients' feeling of well-being is not closely related to the actual seriousness of the disease.

It is the problem of this investigation to describe some of the adjustment difficulties of the tuberculous Indian to sanatorium life; to discover what classifications of patients have the most severe adjustment problems.

The term adjustment is here taken to mean: modifying personal behaviour, as through accommodation into harmonious

²Based on estimates from the Medical Office of the United Pueblo Agencies Consolidated.

³There are 14 Government Indian Sanatoriums in the United States, any of which a tuberculous Indian may enter upon request, provided the sanatorium of his choice has space to accommodate him.

strenuous physical. Treatment is usually long, a matter of
months or years, the achievement of which is a very
gradual process.

Tuberculosis is a disease of young adults. The

estimated 370 tuberculous people living in the U.S. today

show various in the state of New York are approximately
young adults at the age of 20 years and 70 years old. The
greatest. It is the Algonquian Indians of the reservation.

one government Indian community in the United States have to
remove all strenuous activity for many years at a time

and are placed in beds to rest with complete isolation
disease. The progress of the disease is very slow and

patients' feeling of well-being is not usually maintained. The
actual seriousness of the disease.

It is the problem of the modern world in general.

some of the earliest difficulties of the tuberculosis

to sanatorium life. It is a disease with characteristics of patients
have the most severe adjustment problems.

The term adjustment is used to mean the

personal behavior, as shown in the following table.

Passed on to the United States from the National Tuberculosis
United Public Health Association.

There are in government Indian communities in the
United States, and in other parts of the world, many people
upon request, granted the same as the United States has
to accommodate him.

and effective relationship with the institutional environment.⁴

There is a paucity of data in the field of adjustment to sanatorium life as regards the whites, and none was found concerning Indians. Because of the nature of their cultural background it was hypothesized that the Indians would have special problems of adjustment which would be peculiar to them. Despite the fact that numerous able writers have been tuberculous there are no personal documents describing experiences, with the exception of the recent publication of Betty MacDonald's The Plague and I. This is, as far as the author has been able to discover, the only description of sanatorium life as seen from the viewpoint of the patient, and there seem to be no studies reporting the patients' viewpoint. Barker, Wright, and Gonick report that they have been unable to discover any personal documents relating experiences with tuberculosis as they have found with the blind, the deaf, and the crippled.⁵ They also state that the whole problem of adjustment of the sanatorium patient to sanatorium life and the organization of the sanatoria for

⁴Based on the Dictionary of Sociology definition of adjustment.

⁵Barker, Wright and Gonick, op. cit., p. 132.

and effective adjustment with the environment. ¹
There is a tendency to think of adjustment
to sensorium life as a matter of degree, and to view it
as a matter of degree. However, the nature of adjustment
is not a matter of degree, but a matter of kind. It is
a special problem of adjustment which is peculiar to
them. Despite the fact that numerous cases have been
reported there are no personal accounts of adjustment to
perception, with the exception of the recent publication of
Betty MacDonald's *The Human Mind*. In this book the
author has been able to discover, through observation of
adjustment life as seen from the viewpoint of the patient,
and there seem to be no studies regarding the patient's
viewpoint. Barker, Wright, and Gordon report that they
have been unable to discover any personal accounts relating to
perception with tubercular cases. They have found that the
blind, the deaf, and the crippled, they also state that the
whole problem of adjustment of the sensorium patient to
sensorium life and the organization of the mind is to

¹Based on the Dictionary of Psychology, definition of
adjustment.

maximal patient adjustment is one of the most neglected yet the most fruitful fields for social-psychological research,⁶ which is as true concerning the Indian as the white.

Since there has been an attempt to describe the areas of medical and sanatorium procedures in which the hospital is assisting the patient in his attempts to adjust, the findings of this study may point the way to suggestions which will aid the adjustment of the Indian to sanatorium life. The importance of this may be seen in the fact that medical experts appear to be agreed that social-psychological factors are of the utmost importance for "recovery."

⁶Ibid., p. 148.

CHAPTER II

METHODOLOGY

The principal method used in this study to determine adjustment problems, was the interview with patients, results of which were supplemented by interviews with and observations of members of the sanatorium medical staff.

Speech is man's characteristic means of bringing about intimate relationships and fine adjustments with his fellow-man. In the course of his contacts he must obtain information, give information, and influence or be influenced by other persons. He speaks that there may be an interplay of attitudes, motives, ideals, and feelings as well as an exchange of information and ideas. Interviewing serves this variety of purposes and enters into many social situations. It is as old as speech itself and as extensive as our leading professions. The priest, the journalist, the physician, the lawyer, the detective, the salesman, the anthropologist, the employment manager, the psychiatrist, the research worker, and the social worker all regularly use the interview in the daily practice of their work. For this reason no single, formal, or inclusive definition of interviewing is feasible. It has been called "conversation with a purpose,"¹ "purpose-

¹C. Luther Fry, The Technique of Social Investigation (New York: Harper and Brothers, 1934), p. 60.

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RECORD

The principal method used in this study was observation
adjustment problems, was the interview with patients, the
scale of which were supplemented by interviews with some of
servations of members of the community center staff.
Speech is seen as a characteristic means of expressing
lasting relationships and the adjustment of the individual
man. In the course of his contacts he must obtain information,
then, give information, and adjust to the information he
other persons. He seeks to know what he can learn of
attitudes, motives, beliefs, and feelings of others, and
change of information and ideas. Involving a variety of
variety of purposes and acting into many social situations.
It is as old as speech itself and as extensive as our knowledge
has professions. The artist, the journalist, the physician,
the lawyer, the detective, the scientist, the politician,
the employment manager, the investigator, the social worker,
and the social worker all require in their daily practice of their work
to make, or inclusive definition of information in the social
It has been called "conversation" in a general sense.

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(New York: Harper and Brothers, 1914)

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ful exchange of meanings,"² "a specialized form of conversation,"³ and "a systematic method by which one person enters more or less imaginatively into the inner life of another, who is often a comparative stranger to him."⁴ Webster's Collegiate Dictionary defines it as: a mutual sight or view; a meeting face to face; usually, a formal consultation. However, for the purpose of this study the definition offered by the Dictionary of Sociology is more pertinent. It is: the securing of information through a professional conversation with an individual for a research study or to aid in social diagnosis or treatment.

Although the interview as a method of social research has been subjected to well founded criticism, it cannot be abandoned as a technique in studying human beings and their relationships since much of the necessary data required for such studies can be obtained only by individual questioning. In defense of this method Bogardus states: "Until intimate human attitudes and values are brought to light no social situation is understood. Attitudes and changes in them may

²Walter Van Dyke Bingham and Bruce Victor Moore, How To Interview (New York: Harper and Brothers, 1941), p. 1.

³Pauline V. Young, Interviewing in Social Work (New York: McGraw-Hill Book Company, 1935), p. 1.

⁴Ibid., p. 4.

best be secured by the personal interview."⁵ Beatrice Webb says: "By the method of interview I mean an instrument of research and discovery through the process of skilled interrogation. As advice for investigation it is peculiar to the social scientist. It is his compensation for inability to use the chemist's test tube or the bacteriologist's microscope."⁶

The interview affords the opportunity for observation of the subject at the same time the interviewer is gaining factual verbal material from him. It has an advantage over the questionnaire in that the interviewer is able to alter the wording of his questions until he is sure the subject understands. He is also able to retrace his steps over material on which the subject seems hazy or reluctant to give information. The researcher is interested not only in the objective data secured from the interview, but also in the personality of the informant, his attitudes and prejudices, as revealed by his verbal behavior and the subtle gestures that accompany it, such as facial expression and tone of voice.

⁵Pauline V. Young, Scientific Social Surveys and Research (New York: Prentice-Hall, Inc., 1939), p. 174.

⁶Loc. cit.

The factors affecting the interview are numerous and complex. Perhaps the most troublesome is the tendency for statements of fact to reflect in some measure the emotional reactions of the two persons concerned, their attitudes toward each other, and to be colored by self-interest.

One danger lurks in the interviewer's own predilections and attitudes. He sees and hears the interviewee's responses through a haze of preconceptions and is apt to interpret them in the light of his own attitudes and prejudices. "... data obtained from an interview are as likely to embody the preconceived ideas of the interviewer as the attitudes of the subject interviewed."⁷

The interviewer's failure to make himself understood is often a bar to the successful interview. It is the duty of the interviewer to frame his questions in a manner that can be readily comprehended by the subject. Wording should also be such that it does not lead the subject to a response in keeping with information most to the interest of the interviewer's hypothesis: that is, it should not be a leading question. Care must also be taken not to use words that are either ambiguous or carry connotations which might color the response. Language used must be in keeping with the

⁷S. A. Rice, editor, Methods in Social Science (Chicago: University of Chicago Press, 1931), p. 561.

The factors affecting the interview are numerous and complex. Perhaps the most troublesome is the tendency for statements of fact to reflect in some measure the emotional reactions of the two persons concerned, their attitudes toward each other, and to be colored by self-interest. One danger lurks in the interviewer's own predilections and attitudes. He sees and hears the interviewee's responses through a haze of preconceptions and is apt to interpret them in the light of his own attitudes and prejudices. . . . Data obtained from an interview are as likely to reflect the preconceived ideas of the interviewer as the attitudes of the subject interviewed. The interviewer's failure to make himself understood is often a bar to the successful interview. It is the duty of the interviewer to frame his questions in a manner that can be readily comprehended by the subject. Wording should also be such that it does not lead the subject to a response in keeping with information most to the interest of the interviewer's hypothesis; that is, it should not be a leading question. Care must also be taken not to use words that are either ambiguous or carry connotations which might color the response. Language used must be in keeping with the

intellectual, educational, and social level of the subject.

"A defect of the interview for the purposes of fact-finding in scientific research is that the questioner takes the lead. That is, the subject plays a more or less passive role. Information or points of view of the highest value may not be disclosed because the direction given the interview by the questioner leads away from them."⁸ Thus by the fact that the interviewer must question he falls heir to this accusation. To lessen this evil the interviewer must make more use of subtle suggestion and less use of direct and leading questions to guide the course of the interview. Merton and Kendall offer a correction of this disadvantage by the use of questions of varying degrees of structure: the unstructured question, which is couched in such terms as to invite the subjects to refer to virtually any aspect of the stimulus situation; the semistructured question, wherein there is increased guidance by the interviewer, but the subject still retains considerable freedom of reply; and, the structured question, in which the interviewer assumes almost complete control of the interview.⁹

⁸Loc. cit.

⁹Robert K. Merton and Patricia L. Kendall, "The Focused Interview," American Journal of Sociology, 546, May, 1946.

interview, educational, and social level of the subject.
"A defect of the interview is that the subject is not
finding in scientific research in that the subject is
the lead. That is, the subject plays a role of less or
role. Information on points of view of the subject is
not be disclosed because the subject is not the subject
the questioner leads away from them. That is, the subject
the interviewer must question the subject in a way that
tion. To answer this, the interviewer must have a
of subtle suggestion and lead the subject to the point
tions to guide the course of the interview. The subject
del offer a conversation of this character by the use of
questions of varying degrees of subtlety and suggestion
question, which is covered in each case by a specific
subjects to refer to directly any aspect of the situation
situation; the questioner must be able to lead the subject
crossed guidance by the interviewer, but the subject will
retains considerable freedom of reply, and the questioner
question, in which the subject is asked to answer about certain
control of the interview.

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Another disadvantage of the interview method lies in the subject's responses which contain rationalizations, conscious and unconscious untruths, and haphazard tricks of memory. Men do not like to admit even to themselves that their activities are irrational or illogical and they invent rationalizations for them. They give socially expected and accepted reasons rather than their real reasons for doing a thing. People also have a tendency to idealize their experiences out of all keeping with what really occurred. Lapses of memory may account for unintentionally false answers. Outright untruths are also important for they often times reveal important truths. In interpreting such testimony the researcher often must go beyond official documents available or the prudent statements of officials, and in this lies the danger that the results will reflect personal prejudice rather than objective fact itself.

The fact that the interview does not lend itself readily to easy tabulation calls forth another criticism. Even when a schedule is employed in conducting the interview it is difficult to tabulate the responses. If the responses are used in a statistical form it is necessary to qualify the material.

Some of these disadvantages that beset the interview technique are being corrected by the undertakings of the interviewers in improving its reliability and the validity

Another disadvantage of the interview method lies in the subject's responses which contain distortions, omissions and unconscious wariness, and perhaps a lack of memory. Men do not like to admit even to themselves that their activities are irrational or illogical and that they have rationalizations for them. They give socially expected and accepted reasons rather than their real reasons for doing a thing. People also have a tendency to idealize their own performance and of all things which really occurred. Lapses of memory may account for inaccurately stated answers. Outright mistakes are also important for they often lead to very important findings. In investigating such findings the researcher often must go beyond official documents available or the present statements of officials, and in this case the danger that the results will reflect personal prejudice rather than objective fact is real.

The fact that the interview does not lend itself readily to easy falsification calls for another criticism. Even when a schedule is employed in conducting the interview it is difficult to falsify the responses. If the responses are used in a statistical form it is necessary to qualify the material.

Some of these disadvantages that beset the interview technique are being corrected by the advantages of the interviewers in improving its reliability and the validity

of the data that it yields.

The interview is employed in this study as a means of obtaining subjective information from the patients in the Albuquerque Indian Sanatorium: to discover his attitudes toward, and his prejudices for and against his life in the sanatorium as an indication of adjustment problems; and, to discover previously met adjustment problems of their sanatorium life. The interview was also used to supplement factual data of hospital records on points where information was omitted, was sketchy, or warranted verification.

Interviews were obtained with some members of the medical staff of the sanatorium concerning their opinions of the patients' adjustment problems, as well as to corroborate information given by the patients.

The interview was announced to the patient as an interview with its purpose and authority stated. To aid in establishing cooperation the nature of the study was announced to the patients by the Medical Officer in charge of the sanatorium. As a result of this preparation many of the patients were not only cooperative, but eager to impart the requested information. In a few instances it was difficult to establish the sought-for degree of rapport, and in each of these cases a language difficulty was the obstacle. To overcome this, interpreters were used.

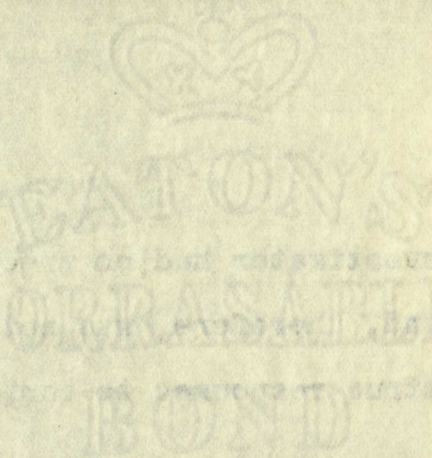
of the data that it is...
The interview is...
obtaining subjective information...
Albuquerque Indian...
served, and his...
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of the patients'...
referred information...
The interview was...
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nounced to the...
the sanatorium...
the patients were...
the requested...
identical to...
each of these...
to overcome this...
Interview was...
Interview was...

The investigator had no preconceived ideas of what she would find, and, therefore, was not tempted to frame questions or construe responses to conform to a predetermined hypothesis.

Since the patients interviewed were all what sociologists term marginal¹⁰ persons upon their entrance to the sanatorium, it was necessary to recognize that adjustment problems of this situation would carry over into the sanatorium environment, and to recognize that those problems would not always be distinguishable from problems produced by sanatorium life.

The cultural inheritance of the interviewer and the interviewees was in this case much different. It was therefore necessary to keep constant vigilance when articulating concepts so that they conveyed the same idea to both the interviewer and the interviewee. This was difficult in those cases where the interviewee's knowledge of the English language was limited. In a few cases information was gained through the use of an interpreter who was aware of the information wanted and had a grasp of the concepts the information connoted. Simple words and colloquial phrases were used when indicated. In some cases it was impossible to

¹⁰Dictionary of Sociology definition of marginal is preferred here: lying on the borderland of any recognized and relatively stable area, either territorial or cultural.



The investigator had to be satisfied that the
would find the evidence in the case of a
tion or constant to the case of a
hypothesis.

Since the evidence in the case of a
is not only in the case of a
hypothesis it was necessary to consider the
problem of this evidence would be the same
evidence in the case of a
would not always be the same in the case of a
by separation of the evidence.

The evidence in the case of a
investigation is in the case of a
in a necessary to the case of a
concepts so that they can be used in the
investigator and the investigator. This is the
cases where the investigator is in the case of a
evidence was limited. In the case of a
through the use of the investigator the evidence
formation was not and the evidence in the
formation was not. This is the case of a
used when indicated. In the case of a

10. The evidence in the case of a
investigation is in the case of a
relatively small amount of evidence.

convey concepts and in those instances only factual information that could be verified was obtained.

It was almost impossible to observe facial expressions since all of the patients were obliged to wear masks which cover all of the face except the eyes and forehead. Hearing the interviewee was difficult under the conditions of mask-wearing, and required much repetition of responses on the part of the interviewee in order that the interviewer could be sure that the patient's response was heard and understood correctly.

It was necessary to use direct questions for the factual data. When eliciting information concerning attitudes unstructured, semistructured, and structured questions were used depending upon the displayed intellectual level and the educational level of the interviewee. For example: in the unstructured type of question something similar to this might be asked: "What things did you notice most, or impressed you most when you came to the sanatorium?" "How did you feel about the sanatorium when you first came here?" is an example of the semistructured type of question asked. The structured type of question asked would restrict the response more than the above types by restricting the stimulus. For instance, "Judging from your experiences here and at the other sanatorium do you think it is better, worse, or about the same here?" In all cases the patient was allowed

convey concepts and in these instances only limited data

material that could be verified was obtained.

It was almost impossible to observe facial expressions

since all of the patients were confined to their beds.

cover all of the face except the eyes and mouth. During

the interview was difficult under the conditions of work-

ing, and required each repetition of responses in the

part of the interview in order that the interviewers could

be sure that the patient's responses were heard and understood

correctly.

It was necessary to ask direct questions for the

actual data. When eliciting responses from the patient

interviewers maintained a neutral, non-judgmental attitude

there were used questions such as "displayed facial

level and the educational level of the interviewers.

examples in the unstructured type of questions were

similar to this: "What did you think of the

most, or impressed you most when you saw the

"How did you feel about the hospital when you first came

here?" is an example of the unstructured type of question

asked. The structured type of question asked was

the response more than the above types of questions.

stimulus. For instance, "Thinking from your experience here

and at the other hospital, do you think it is better, worse,

or about the same here?" is an example of the structured

the opportunity for free expression of thought, and in some cases was guided by suggestion until he had control of the interview situation to the extent that any information volunteered, relevant or not, was given full attention by the interviewer, as will be seen when the interview data is presented.

Information given to the interviewer was in some instances checked for suspected inaccuracies, both with the records and with sanatorium officials. In only one instance was the interviewee's statement contradicted by this checking, and in that instance it was discovered that the interviewer had misunderstood the patient's remark. Through this experience and the testimony of the sanatorium officials, as well as others who have done extensive work in the field with the Indian, the author is confident that information given in the interview was true with the exception of error due to memory lapse. The patients tended not to give information rather than tell anything about which he did not know. He tended to decline information rather than give misinformation. He also claimed in some instances not to comprehend when he did not wish to answer a question or to commit himself.

Tabulation of the interviews was conducted on the factual data by simple counts which were converted into

the opportunity for two expressions of opinion. In cases was guided by suggestion until we had reached the interview situation to the extent that any interview volunteered, relevant or not, was given full attention. The interview, as will be seen, was the interview itself presented.

Information given to the interviewers was in the form of answers checked for suspected inaccuracies, both with the records and with interviewing officials. It only remained for the interviewers' statement, confirmed by the records, and in that instance it was discovered that the interviewers had misinterpreted the police's report. This experience and the testimony of the interviewers as well as others who have done extensive work in the field with the Indian, the author is confident that the interviewers are more with the interviewers than with the interviewers due to memory loss. The interviewers' report was to the effect that the interviewers had said something about which the interviewers know. He tended to decline interviewers' questions and to give information. He also stated that some interviewers had been present when he did not want to answer a question or to answer it himself.

Tabulation of the interviewers was completed on the factual data by almost equal with the interviewers.

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percentages. The subjective material of the interviews was arranged so that the uniformities in large numbers began to stand out and group themselves into general patterns for greater ease of interpretation.

The consensus of opinions of writers who make a statement concerning conditions of the interview seems to be in favor of privacy, quietness, and use of formal office environment.¹¹ The social researcher, however, on the quest of some kinds of information has found it necessary to seek out his subject and carry on the interview under more informal conditions. The interviews conducted for this study were done in private, except when the services of an interpreter were needed or in the case of bed patients who were in wards. The bulk of the interviews were conducted on a large sunporch on the first floor.

No time limit was set on the interviews by the interviewer but circumstances of the sanatorium routine imposed limitations in that the patients could be contacted only between 3:30 and 4:30 in the afternoon. If it was the opinion of the interviewer that not enough time was available to get all of the desired information in one interview a second interview was conducted, but this was done in only three

¹¹Ruth Shonle Cavan, "Interviewing for Life History Material," American Journal of Sociology, 35:113.

percentages. The subjective material of the interview was arranged so that the interviewee in large measure was to stand out and show themselves from personal experience for greater ease of interpretation.

The consensus of opinion of visitors and some of the most concerning conditions of the interview seems to be in favor of privacy, privacy, and use of formal office environment. The social researcher, however, on the ground of some kinds of information has been in accordance to avoid out his subject and carry on the interview with more formal conditions. The interviewers conducted for this study were done in private, except when the services of an interview were needed or in the case of bad patients who were in wards. The bulk of the interviews were conducted in a large room on the first floor.

No time limit was set on the interview by the interviewers. The circumstances of the interview were not limited in that the patients could be contacted only between 9:30 and 1:30 in the afternoon. It was the opinion of the interviewers that was enough time was available to get all of the desired information in one interview. A second interview was conducted, but this was done in only three

1. First Interview: Interviewing for the History
2. Second Interview: Interviewing for the History

STATION
CORRASABLE

cases.

The interviews were formal in that the patient was aware he was being interviewed, for what purpose, and that his responses were recorded as given.

On the matter of recording the interview there is no uniformity of practice. Some interviewers advocate that the questions and answers be recorded verbatim by a stenographer. At the other extreme are those who believe that there should be no note-taking during the interview. The middle ground is held by those who jot down a few notes during the course of the interview and fully record them later.¹² The interviews in this study were recorded during the course of the interview for two reasons. Though it has often been argued that the recording of responses in the presence of the subject tends to stilt and inhibit their answers it was the opinion of the sanatorium staff that the Indian subject would feel that his answers were important if they were written down in his presence. Once he was assured that his name would not appear in the study, the answers were given freely. Also the pressure of time did not allow the investigator to write up each interview immediately following it, since several interviews were conducted each day during the time allowed, and the interviewer did not wish to rely upon her

¹²Ibid., p. 106.

cases.

The interviews were formal in the sense that the patient was aware he was being interviewed, for both himself and the doctor. His responses were recorded as given.

On the matter of recording the interview there is no uniformity of practice. Some interviewers advise that all questions and answers be recorded verbatim by a stenographer. At the other extreme are those who believe that notes should be no more than a brief summary of the interview. The latter is held by those who feel that a few notes during the course of the interview and fully typed notes later. The latter view in this study was favored during the course of the interview for two reasons. Although it has often been argued that the recording of responses in the presence of the subject tends to stifle and falsify their answers it was the opinion of the investigator that the patient's self would feel that his answers were important if they were written down in his presence. Once he was assured that his answers would not appear in the study, the answers were given freely.

Also the pressure of time did not allow the investigator to write up each interview immediately following the interview. oral interviews were conducted during the day and the interviews were not typed until the following day.

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memory for accurate reporting of the interviews.

The same lack of uniformity is evident in the use of a schedule. In some cases the schedules are filled out in the presence of the interviewee, in others the questions are kept in the mind of the interviewer, and in still others there is no set order of approach. In this study the questions were kept in the mind of the interviewer and the order of approach was not set, although some questions asked by the interviewer were the same in all cases, that is, those questions concerning factual data. The patients who showed a willingness and ability to answer questions concerning more conceptual material were asked questions covering the same field of inquiry, but the questions were not identical in all cases. In some cases it was not advisable to ask questions that were asked other patients. For instance, those who were known to be orphans were not questioned on their family organization type. However, most questions asked were asked of all interviewees, the above mentioned being the few exceptions.

In a research study the researcher selects for consideration only certain phenomena from the innumerable characteristics and relationships that are actually present. Out of the observations so selected he makes whatever generalizations the data justify. The data on which he bases most generalizations are only a part, a sample, of all the

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memory for such a long period of time. The subject of this study is a study of a schedule. In addition to the schedule, the presence of the interviewee, the questions kept in the mind of the interviewee, and in this study there is no set order of approach. In this study the questions were kept in the mind of the interviewee and the order of approach was not set, although the questions asked by the interviewee were the same in all cases. That is, the questions concerning factual data, the interviewee was asked a willingness and ability to answer questions concerning conceptual material were asked questions concerning the field of inquiry, but the questions were not repeated in all cases. In some cases it was not difficult to see questions that were asked other questions. For instance, those who were known to be organized were not mentioned in their family organization type. However, these questions were asked of all interviewees, and those mentioned being the few exceptions.

In a research study the researcher selects the subjects for study only certain characteristics from the interviewee's characteristics and relationships that are socially relevant. Out of the observed and selected subjects, the researcher examines the data further. The data on which he bases most generalizations are only a small portion of all the

relevant data. These generalizations rest upon the assumption that what has been found characteristic of the sample data actually observed will also be characteristic of the whole body of data which he cannot observe. To the extent that this assumption is valid, a generalization based on a sample will be as valid as a generalization based on all the data. To the extent that the assumption is false, the generalization will be invalid.¹³ To study all of the data would be impossible and prohibitive, but through the sampling method the researcher is able to make highly accurate generalizations about the whole from the part.

Selection of the sample may be random, under which conditions each item in the universe is assured an equal chance of being selected. A standardized or proportional sample may be used, under which conditions the proportions of the significant elements in the universe have the same proportional representation or distribution in the sample. The selected sample may also be used. The selected type of sample is determined by the type of problem and is used under conditions in which the researcher deliberately selects cases which meet certain qualifications.

¹³George A. Lundberg, Social Research (New York: Longmans, Green and Company, 1948), p.134.

relevant data. These generalizations rest upon the assumption that what has been found characteristic of the sample data actually observed will also be characteristic of the whole body of data which we cannot observe. To the extent that this assumption is valid, a generalization based on a sample will be as valid as a generalization based on all the data. To the extent that the assumption is false, the generalization will be invalid. It is to be noted that the sampling would be impossible and worthless; but through the sampling method the researcher is able to make highly accurate generalizations about the whole from the part.

Selection of the sample may be random, which means that conditions each item in the universe is assumed an equal chance of being selected. A stratified or proportional sample may be used, under which conditions the proportions of the significant elements in the universe have been represented in the sample or distribution in the sample. The selected sample may also be used. The selected type of sample is determined by the type of problem and is used under conditions in which the researcher deliberately selects cases which meet certain qualifications.

George A. Lundberg, Social Research, New York
Longmans, Green and Company, 1938, p. 134.

The sample used in this study is a peculiar combination of the proportional and selected types of samples. The interviewer did not select the sample; it was selected by the circumstance of permitting only those who were physically able to stand the strain of talking to be interviewed. It was selected in that approximately ten possible subjects were ruled out because of either their youth or a lack of ability to speak English. In the latter case the reason for not using an interpreter was that an able interpreter was not available at times when it was possible to see the other patient, or when an interpreter could be used the patient was not physically able to cope with the interview situation. The sample was proportional in that the significant subgroups or elements of the universe (total sanatorium population at the time of the interviewing) had as proportional a representation in the sample as was possible considering the number of those too ill to be interviewed. Sixty-one patients were interviewed, thirty-eight females and twenty-three males, out of a total census of ninety-six patients who were in the sanatorium at the time of the interviewing.

Secondary sources of data in this study were the medical records of the sanatorium. Factual data such as religion, marital status, tribe, degree of Indian blood, age, sex, were obtained from the registration records and were tabulated and then converted into percentages. The years selected for the

tabulations were the fiscal years 1939 to 1949. The sanatorium fiscal year is from July 1 to June 30. The year 1939 was selected because trial runs done on previous years indicated that the economic conditions in the United States, which was at that time in a depression era, would tend to distort the patient load percentages. The years following 1939 presented the intrusion of the war period which also was considered to have a distorting effect. The selection of the year 1939 was also made because of a lack of complete records for another year which might have been selected. The year 1949 was selected because of the ten year interval; because it presented a post war picture, and because it contained the records of patients now in the sanatorium, many of whom were interviewed. The form of the records was changed in 1943 and in 1945 and some information gathered from the 1939 record was omitted from the 1949 records; therefore this material was discarded.

Another complicating factor was the practice of the Sanatorium Administration of treating each individual as a new case whether he was or not. If a patient left the sanatorium and returned three months later he was assigned a new registration number. Therefore, if a patient was in and out of the sanatorium three times in one fiscal year he would have a new record for each time entered. Since this is a stable factor for all years there was no need to make adjust-

ments in the data; but this factor makes the average daily patient load a more significant indicator of the number of patients per fiscal year than does the total number of registration records. For instance, in the fiscal year 1939 there was a total of 187 registration records and the average daily patient load was 88.8.

Other secondary sources were the records of the Chief Medical Officer of the United Pueblo Agencies Consolidated, and the United States Commissioner of Indian Affairs Statistical Supplement Reports.

Use was made of the informer technique as a source of information in this study in those cases where the patient was well known to another or other patients; as in the case where more than one patient came from the same town, village, or pueblo. In this way the interviewer was able to check information given by the patients and also to gain information that was not imparted by the patient himself. Informers were in all cases patients who were better educated than the average patient, and had a better understanding of the conceptual information sought for by the interviewer. The medical staff of the sanatorium was also used as an informing source.

The least used technique of research in this study was direct observation as concerns seeing the patient outside

ments in the data, but this was not the average daily
patient load a more detailed analysis of the records of
patients per clinic was made from the 1940-1941
registration records. In the fiscal year 1941
there was a total of 1,121 patients treated and the
average daily patient load was 3.1.
Other noteworthy findings from the records of the United
Medical Officer of the United States Army, Camp 100, Japan
and the United States Department of Health and Human Services
Statistical Supplement, 1941.
Use was made of the following information as a source of
information in this study: (1) Information from the patient
was well known to the medical officer in the camp
where more than one patient came from the same area, usually
or people. In this way the information was able to check
information given by the patients and also to find out
information that was not furnished by the patient himself. Informants
were in all cases patients who were better educated than the
average patient, and had a better understanding of the camp
and the information given by the informant. The
local staff of the camp was also interviewed as a source
of information.
The first use of the information was to find out
was direct observation of the camp and the information

of the interview situation. Little opportunity was proffered for observing the patient in his room or in his ward. Observation was possible only on those occasions when the interviewer visited the wards for interviews with bed patients. The patients were always seen at a time when they had finished their afternoon rest hour and thus were refreshed and alert; although in some cases the process of the interview was observed to have a fatiguing effect. Observations of the medical staff were utilized whenever the investigator needed information dependent on their observations.

of the interview. Although the patient was not
for observing the patient in his room or in the ward. The
nervousness was possibly due to the fact that the
interviewer visited the patient for the first time.
The patient was always calm and quiet when alone.
He had been in the hospital for some time and was
labeled as a "chronic case" and was referred to
as such. Although in some cases the patient is
was observed to have a "chronic case" of the
the medical staff and the patient's condition
needed further study and observation.

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CHAPTER III

DESCRIPTION OF THE SANATORIUM

The Albuquerque Indian Sanatorium is located in Albuquerque northeast of the University of New Mexico, at 801 North Vassar Avenue. It is situated on a six-acre campus which is well landscaped. The unit consists of the hospital building, two cottages for resident physicians, a nurses' quarter, and one building containing a workshop and garages with employees' quarters above.

The hospital is a three-story fireproof brick building of stucco finish with terra cotta trim. The cottages and other buildings are of southwest type architecture with stucco finish.

The sanitorium was completed in 1934, the first patient having been admitted March 29, 1934. It has a capacity of 100 beds. The second floor which houses the female patients is made up of four eight-bed wards, seven four-bed wards, two three-bed wards, and two private rooms. The third floor male wards are: six four-bed wards, which now contain five patients each, two-two bed wards, which now house three patients each; and, four private rooms. The average daily patient load for the last five years has been approximately seventy-five, and for the fiscal year 1949 was 96.7. For

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ALBUQUERQUE, NEW MEXICO

DESCRIPTION OF THE CAMP

The Albuquerque Indian Reservation is located in the
northwest corner of the Territory of New Mexico, at the
North Vassar Avenue. It is situated on a high mesa which
is well landscaped. The site consists of the main
building, two cottages for transient patients, a mess
hall, and one building containing a kitchen and laundry
with employees' quarters above.

The hospital is a three-story structure with a
main of stone finish with terra cotta trim. The
and other buildings are of adobe type. The buildings are
stone finish.

The institution was completed in 1911. It has been
having been admitted about 25,000. It has a capacity of
100 beds. The second floor which houses the female patients
is made up of four single-bed wards, seven four-bed wards, two
three-bed wards, and two private rooms. The third floor
has wards are: six four-bed wards, which now contain the
patients each, two two-bed wards, which now house three pa-
tients each; and four private rooms. The average daily pa-
tient load for the last five years has been approximately
seventy-five, and for the fiscal year 1919 was 67.

several months during 1949 the sanatorium was accommodating 106 patients.

The sanatorium is equipped to carry out all of the modern types of treatment for pulmonary tuberculosis. It contains a modern surgery in which surgical thoracic treatment is done. Those patients requiring orthopedic surgery for tuberculosis of the bone are transferred to other government sanatoria or to government general hospitals. Facilities for dental examination, treatment, and extraction are provided. It has a well-equipped X-ray laboratory which not only does necessary X-ray work for the sanatorium but also services patients who have been discharged and return for periodic checks, as well as rendering service to Field Service personnel. The general and serology laboratory is somewhat limited in its facilities in that it does not serve all the needs of the sanatorium. It does all serology work except Wasserman and Kahn tests. It does urinalysis, sedimentations, sputum counts and cultures, but more extensive laboratory work is sent out to the New Mexico Public Health Laboratory at the University of New Mexico.

The occupational therapy department is limited as to the scope of its service by a lack of material and equipment. It does offer the patient some variety of activity in bed or bedside work with materials for: both water colors and oil painting, woodcarving, sewing, knitting, crocheting, embroidery,

leatherwork, and beadwork.

The library is small and contains outdated, worn, and poorly selected books. It supplies the patients with approximately fifteen periodicals, some of which four copies are received, and others of which only two are received. There have been no additions to the library since 1947 when the sanatorium was the recipient of some surplus Army Overseas Books.

The gift shop is maintained to display and sell the work of the patients, particularly in the occupational therapy program. The articles are priced on a basis of the quality of the work, the amount of time taken by the patient to complete it, and the government cost of the material. When an article is sold the government is reimbursed the cost of the material and the remainder is given to the patient. For many patients this is their sole source of income. Contrary to popular belief these patients are not given a government subsistence allowance, nor are their families.

A shopping service is maintained by the sanatorium. A member of the staff takes the patient's order for such things as toiletries, stationery, and soap, and these orders are filled by the staff member from downtown stores. This service is rendered every two weeks.

The sanatorium is administered by the United Pueblo

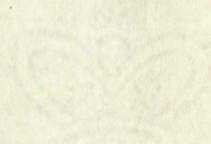
Leatherwork, and hardware.

The library is small and contains limited, worn, and poorly selected books. It supplies no papers and is approximately fifteen years old. Many of the books are received, and others of which only the receipt is there have been no addition to the library since 1957 when the sanatorium was the recipient of some nursing home books.

The gift shop is maintained to display and sell the work of the patients, particularly in the occupational therapy program. The articles are priced on a basis of the quality of the work, the amount of time taken by the patient to complete it, and the government cost of the material. When an article is sold the government is reimbursed the cost of the material and the remainder is given to the patient. For many patients this is their sole source of income. Contrary to popular belief these patients are not given a government subsistence allowance, nor are their families.

A shopping service is maintained by the sanatorium. A member of the staff takes the patients to the store, things as toiletries, stationery, and food, and these are filled by the staff member. For home use, services is rendered every two weeks.

The sanatorium is administered by the United States



Agencies Consolidated which has its central office in Albuquerque. The Medical Officer in charge of the sanatorium is immediately responsible to the Chief Medical Officer of the Agency who in turn is responsible to the Director of the United Pueblo Agencies Consolidated. The Medical Officer in charge of the sanatorium submits a budget estimate for the entire fiscal year to this agency. The operating expense of the sanatorium including the salaries and utilities are allocated to the sanatorium in accordance with Congressional appropriations for the entire United Pueblo Agencies and as closely as possible to the demands of the budget. All monetary transactions necessary to the operation of the sanatorium are carried on through the Purchasing Clerk of the United Pueblo Agencies Consolidated and its Disbursing Officer. Necessary supplies are requested, with the approval of the Chief Medical Officer, from the Purchasing Office where the requisitions are finally approved.

The medical staff consists of one full time Medical Officer in charge; (There is a provision made for a full time assistant medical officer and although the patient load is now very high this position remains unfilled, and has been vacant since 1938); one physician who is employed on a part-time basis as a tuberculosis consultant. A thoracic surgeon or any other specialist is called when needed on a fee for service basis. On the nursing staff are one director of

nurses, one assistant director of nurses, thirteen staff nurses, two nurses' aides, and eight ward attendants. These ward attendants have had some medical training for their jobs, so may be considered a part of the nursing staff, although some of their duties border on those of the house-keeping department.

There is one X-ray technician who also does the laboratory work; one occupational therapist who doubles as librarian; and one medical records secretary.

In the dietetic department there are: one dietitian, one chief cook, two assistant cooks, and seven kitchen helpers.

The engineering department has one engineer, one operating engineer, and three firemen.

The housekeeping department has one housekeeper, one laundress, and four janitors. The grounds are maintained by one laborer.

All of these members of the staff from Medical Officer in Charge to janitor hold their positions through Civil Service appointments.

The following patients' routine is arranged for maximum efficiency in effecting "the cure." (This is a term used by the patients to describe all sanatorium treatment and routine.)

7 AM	Rising Bell
7:30	Breakfast
8	Temperatures
10	Nourishment
10-11	Rest Hour
11-11:30	Visiting Hour (Outside visitors)
11:30	Dinner
1-3 PM	Rest Hours
3	Temperatures and Nourishments
3:30-4:30	Tuesdays Social Hour Downstairs
3:30-4:30	Wednesday and Saturday Visiting Hour (patients visit other patients on their floor)
4:30	Supper
6	Nourishment
6:30-8	Visiting Hours (Outside visitors)
8	Lights out

CHAPTER IV

PRESENTATION OF THE DATA

The sanatorium records for 1939 and 1949 were processed for: sex, age, tribe, degree of Indian blood, marital status, religious preference, length of stay, and types of discharges. These tabulations are presented by percentages and number of days. All fractions over $1/2$ were considered to be the next highest whole number when figuring the percentages.

In Table III the classification "Pagan" is used because that was the classification found on the records. Sanatorium officials reported that it was used to denote those who adhered to an Indian religion and had no other religious affiliation.

In Table IV those Indians belonging to tribes administered by the United Pueblo Agencies Consolidated were listed as Pueblo, and those administered by the Window Rock Navaho Agency were tabulated as Navaho. The Indians classified as "others" were Indians who were administered by other Agencies or who were from other tribes, such as Ute, Cherokee, or Haida (Alaskan), though these examples by no means exhaust the different tribes represented. No breakdown as to representation of these tribes is given except in this category since in 1949 their number is not significant

TABLE I

RELIGIOUS AFFILIATION

The religious membership in 1950 and 1955 was as follows: ceased for sex, age, tribe, degree of education, marital status, religious preference, length of stay, in terms of discharged. These individuals were represented by percentages and number of days. All individuals over 18 were registered to be the next highest whole number when taken in the percentages.

In Table III the classification is as follows: cases that was the classification based on the category Sanatorium officials reported that it was used in 1950 those who adhered to it in 1955 and the other religious affiliation.

In Table IV these religious categories are listed as: administered by the United States, religious affiliation was listed as Pueblo, and those administered by the Indian Health Service Agency were reported as Navaho. The individuals listed as "other" were individuals who were administered by other agencies or who were from other tribes, such as Ute, Cherokee, or Mohave (Alachua). Those who were reported as "other" means exhaust the different and are represented. No breakdown as to representation of individuals is given except in this category since in 1955 total number is not significant.

enough to warrant this as is shown in the Table IV.

The category "Non-Indian" refers to those whites such as nurses on the medical staff who were hospitalized for various reasons, the white wife of an Indian, a white child who was adopted by an Indian tribe, and others.

In Table VI "discharged with medical advice" refers to those patients who were discharge as Improved or Arrested. Those listed as "discharged against medical advice" refers to those who voluntarily left the sanatorium without the sanction of sanatorium officials.¹

Although no attempt has been made to interpret this data, since it is presented for the reader's consideration and for him to draw whatever conclusions he thinks the data warrant, the investigator would like to point out the following interesting divergences over the ten year period.

1. The median age of the males is 5.5 years higher in 1949 and the median age of the females is 6 years higher for the year 1949.
2. The total percentage of those married is 32% higher in 1949, and the total percentage of those classified single is 37% lower in 1949.
3. The total percentage Catholic is 11% lower for 1949 and the percentage Pagan is 6% higher in 1949.
4. The total percentage of Navahos is 21% higher in 1949, while the total percentage "Others" is 13% lower in 1949.
5. The total percentage of full blooded Indians is 14% higher in 1949 and the percentage of mixed blooded Indians is 13% lower in 1949.
6. The total percentage of those discharged with medical advice is 25% lower in 1949; the total percentage of those discharged against medical advice is 34% higher in 1949; and, the total percentage discharged by death is 9% lower in 1949.

¹See Appendix for tables.

enough to warrant this as a basis for the study.

The other group, "Non-Indians," refers to a group of people as nurses on the medical staff, who were employed by the various agencies, the state, and the federal government, who was adopted by an Indian family as a nurse.

In Table VI "Discharged with Medical Advice" refers to those patients who were discharged as improved or cured. Those listed as "Discharged with Medical Advice" and "Discharged with Medical Advice" refer to those who were discharged as improved or cured.

Although we have not been able to determine the date, since it is impossible for the medical records and for him to give any other information on which we can write, the information is not complete.

Following is a list of the patients who were discharged as improved or cured.

1. The patient was discharged as improved or cured in 1911.
2. The patient was discharged as improved or cured in 1912.
3. The patient was discharged as improved or cured in 1913.
4. The patient was discharged as improved or cured in 1914.
5. The patient was discharged as improved or cured in 1915.
6. The patient was discharged as improved or cured in 1916.

Discharged with Medical Advice

7. The average length in stay for males discharged with medical advice was reduced 434 days in 1949, and reduced 582 days for females discharged with medical advice in 1949; males discharged against medical advice reduced their length of stay in 1949 77 days, while the females discharged against medical advice reduced their stay 234 days in 1949; males discharged by death in 1949 increased their daily stay 34 days, and the females discharged by death in 1949 decreased their daily stay 813 days.

Comparative tables in the Appendix indicate the tabulations of information gained about and from the sanatorium patients in interviews in relation to the tabulations of information concerning the entire census of the sanatorium at the time the interviews were being conducted using the factors of: age, sex, marital status, religious preference, and tribal affiliation.

The instances in which there is much divergence from the sanatorium population percentages in the sample it is to be noted that in each case this can be explained by the illness of the patients. For example, the incidence of married women in the sample is fifteen per cent lower than the incidence found in the hospital population at the time of the interviewing. This is due to the fact that the married women generally wait until the disease is farther advanced before coming to the sanatorium than do single women with fewer home responsibilities. They therefore make up a greater percentage of those seriously ill than do the single women. It is also generally speaking true that the Navaho

Indian is more loath to enter the sanatorium and is usually a more advanced case than is the Pueblo, thus accounting for the fact that the incidence of Navahos in the sample is eleven per cent lower for the males and thirteen per cent lower for the females than that per cent of Navahos in the total sanatorium population. Those patients professing adherence to an Indian religion and classified as Pagan for this study are generally more advanced cases than those who are either Protestant or Catholic. They employ the services of the Medicine Man until they are convinced that they are receiving no aid, or some member of the family (usually the younger ones who have had some education) insists on their going to a white doctor. Consequently they are very often in the far advanced stages of the disease by the time they reach the sanatorium. It must also be considered that perhaps the Indians interviewed would decline to admit adherence to their religion in the interview situation. There is too the possibility that in cases where the patient did not give his religious affiliation in his initial history he was recorded "Pagan."

For the reasons stated above, these classifications were numbered heavily in those too seriously ill to be interviewed, and therefore they have a lower representation in the sample.

Upon entrance to the Albuquerque Indian Sanatorium the

Indian is more likely to accept the...
a more advanced state than the...
the fact that the...
per cent lower for the...
the female than that...
for the population...
an Indian religion...
are...
Protestant or...
Medicine Man...
no side, or some...
who have had...
white doctor...
advanced stages of...
assisting...
Indians interviewed...
religion in the...
ability that in...
religious affiliation...
"Pagan"...
for the...
were numbered...
servants, and...
the...
Upon...
the...

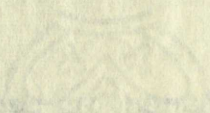


tuberculous Indian is immediately placed on bed rest for the first twenty-four hours. A personal, family, and present and past illness history is taken from the patient. He is given a physical examination including chest X-ray, sputum test, urinalysis, and complete blood count. He is informed as to the diagnosis and is given instructions concerning his way of life in the sanatorium, with main emphasis upon the importance and value of rest to his prognosis. Throughout his stay at the sanatorium he is given physical examinations every three months, and the Medical Officer in Charge gives him a progress report on his condition. When surgery is indicated by the patient's condition his permission is secured to perform the necessary surgery. It is not uncommon for the patient to refuse to submit to surgery even when he has been able to observe the improvement in fellow patients who have had surgical treatment. Streptomycin is used as indicated, but in most cases the treatment consists of rest and a general high protein diet.

There is an attempt to select foods that the Indian patient particularly likes. All of the patients drink some milk each day. The favorite menu of the patients consists of:

²Sanatorium records indicate that the average monthly milk cost is \$1,200.

EVLOV2



tuberculosis infection is immediately apparent in the
first twenty-four hours. A general, low-grade fever
past illness history is taken from the patient. In
a physical examination of the chest, heart, lungs, and
urinalysis, and complete blood count. He is instructed as to
the diagnosis and is given the usual management of the
of life in the hospital. With this knowledge and the
pertinent and vital of what to expect. The first
day of the operation he is given special instructions
every three months, and the hospital is kept in close
him a progress report on his condition. He is advised to
indicated by the patient's condition the operation is
caused to perform the necessary surgery. It is not unusual
for the patient to refuse to return to the hospital even when
has been able to observe the improvement in his
who have had surgical treatment. After surgery is over the
indicated, but in most cases the patient's condition is
and a general high protein diet.

There is an attempt to select foods that the patient
patients particularly liked. It is suggested that some
milk each day. The average man or woman requires
off

Sanatorium records indicate that the average cost
milk cost is \$1.50.

Pinto Beans
Fried Potatoes
Fried Bread (Indian Bread)
Sliced Onions
Lettuce
Fruit

The obvious preference for this diet is that it most nearly duplicates the pre-sanatorium diet to which the Indian had become accustomed. It is recognized that dietary habits are among the most persistent of cultural traits, which fact tends to explain the patients' repeated request for this type of menu. They receive this menu on an average of once a week, and it is seldom served oftener because of its heaviness for bed patients.³

Since satisfaction with the diet is considered to be a factor in adjustment to the sanatorium it is necessary to note the patients' reaction to the menus. In no instance did a patient indicate in an interview that he was dissatisfied with the food, but there was a general expression of the wish that fried bread and pinto beans be served oftener. The patients were aware, however, of the reason that this menu did not occur as often as they would like. One female patient who has been in the Albuquerque Sanatorium for three years stated:

³Note menus presented in the Appendix.

11/11/1911
11/11/1911
11/11/1911
11/11/1911
11/11/1911
11/11/1911

The obvious preference for the left side of the body
explains the preference for the left side of the body
secondly, the preference for the left side of the body
among the most prominent of the left side of the body
tends to explain the preference for the left side of the body
type of work. The preference for the left side of the body
a week, and this is the reason for the preference for the left side of the body
since the preference for the left side of the body is the reason for the preference for the left side of the body
a factor is assigned to the left side of the body is the reason for the preference for the left side of the body
note the preference for the left side of the body is the reason for the preference for the left side of the body
a patient that is the reason for the preference for the left side of the body
with the right, but the reason for the preference for the left side of the body
which that first side and then back to the right side
The patient with the right side of the body is the reason for the preference for the left side of the body
man did not order a right side of the body is the reason for the preference for the left side of the body
patient who has been in the left side of the body is the reason for the preference for the left side of the body
years started

These are the reasons for the preference for the left side of the body

CASE 1

"I like it here--it is easier and the food is better." When asked what she meant by better she said: "I was transferred here from *****where I was for 11 months. The food here is better cooked, and there is more of it, more fruits and vegetables." She was then asked if the food in the sanatorium was much different than that which she had at home. "Yes, here we have more meat and fruit. I will miss that when I go home."

Another female patient said: "Here I eat more meat and fresh fruit, and I drink much milk which I didn't have at home."

None of the men questioned about the food criticized or praised it, with the few exceptions of those who expressed a desire for beans and bread oftener. From this information one can conclude that there is general satisfaction on the part of the patients as concerns their diet which also satisfies the demands of treatment.

Thirty-seven of the thirty-eight females interviewed, and nineteen of the twenty-three males interviewed had made a break from their home and family before their entrance to the sanatorium. Twenty-eight of the females and fifteen of the males made this break by attending the boarding schools maintained for the Indians by the United States Government through its Indian Service. Nine females and four males made the break from home by having been in this or another sanatorium at some time, or had worked away from home. The remaining one female and four males came to the sanatorium directly from the home situation. The female was attending

a day school (Government Indian School) in her home village, and the males in each case were the ones who had not attended any school and had been employed herding their own or their families' sheep or caring for the family land.

Of those who had already had the experience of being away from their families five females and two males said that they had no trouble adjusting to sanatorium life; and, two of the males who had never been away from their family stated that they experienced no difficulty adjusting to sanatorium life. One of the females said:

CASE 2

"I graduated from high school at the Albuquerque Indian school and went to work in Flagstaff. I did housework there for two years when I got sick and I went to the sanatorium. Before I went to school I lived with my mother, five sisters, and one brother in Flagstaff. We never lived on the reservation, and I guess we were never as close to each other or the other Indians like those that live on the reservation. I'm glad we lived in town. When I got sick I knew I had to go to the sanatorium to get well. I was in the hospital at Phoenix for three years before I was discharged. I never had any trouble getting used to it there, I guess because I knew that going to the hospital and taking the cure was the only way I would get well. I was home for three months when I got sick again, and then I came to this sanatorium. I guess the only trouble I had here was getting used to the disappointment that I had to come back. It wasn't the hospital, just me. Even that wasn't hard after the first couple of weeks. I read a lot and do some sewing. I've been here four years now and I'm used to it. I don't know what I'll do when I get out, probably rest at home for a while and then try to get a job that won't be too hard on me."

a day school (seventy-two hours a week) in the morning
and the girls in the afternoon. The girls who had not
attended any school and who had no previous training
or their families' desire of having them educated.
Of those who had already had the experience of being
away from their families, the girls and the boys told us
they had no trouble adjusting to the situation. They
of the girls who had not had a chance to be educated
that they experienced no difficulty adjusting to the
life. One of the teachers said:

"I graduated from high school and the University of
school and went to work. I was a teacher. I had
there for two years when I got married. I had
assistant, before I went to school. I had a
mother, five sisters, and one brother. I was
never liked on the reservation. I found it very
as either of each other or the other. I was
that live on the reservation. I had a chance
when I got sick I knew I had to go to the
to get well. I was a teacher. I had a chance
years before I was ill. I had a chance
getting used to it. I had a chance. I had
going to the hospital. I had a chance. I had
way I was a teacher. I had a chance. I had
I got sick again, and knew I had to go to the
guess the only trouble I had was my feeling as
disappointed that I had to work. I had a chance
hospital. I had a chance. I had a chance. I had
couple of weeks. I had a chance. I had a chance.
been here four years. I had a chance. I had a chance.
what I had a chance. I had a chance. I had a chance.
while and then try to get a job. I had a chance.

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One of the males who had been away from his family to go to boarding school said:

CASE 3

"I've been here two years now. I was a jewelry maker for a trading post, and I went to get my test for the army. They told me I had tuberculosis and that I should come here and talk to the doctor. He said I would have to come to the sanatorium, so I went home and told my folks I would be with _____, my brother who had already been here before I came. I missed my work a little bit, and going and coming when I wanted to, but it didn't last long. I never did mind it here, I guess having my brother helped. Also I go home once every year to the ceremonial--I have a big part in the ceremonial. So I get to see my sister, my father, and my other two brothers. They come to see us when they can, and they write to us so it isn't so bad."

One of the males who had never been away from his home situation says:⁴

CASE 4

"I didn't go to school--my family was a great disappointment to me. I wanted very much to go to school, but I was the oldest son and had to help care of the stock. Yes, I was a sheepherder. When I came here two years ago it was not hard for me, my wife was already here and it was good to be with her, even though I had to leave my two children. My mother takes care of the oldest and my sister-in-law has the youngest. It was very hard for me when my wife died, but I knew that I had to stay to get well, and my mother and sister take better care of my children than me, and I didn't want them to get sick too, so I will stay 'til I get well."

⁴An interpreter was used with this patient because he spoke very little English.

One of the males who had been away from his family to go to

boarding school said:

CASE 3

"I've been here two years now. I was a traveling man for a trading post, and I went to get my feet in the army. They told me I had responsibilities and that I should come here and talk to the doctor. He said I would have to come to the reservation, so I went home and told my folks I would be with them. My brother was dead, and I had been here before I came. I missed my work a little bit, and going and coming when I wanted to, but it didn't last long. I never felt like I was here, I guess having my brother helped. Also I go home once every year to the ceremonial--I have a big part in the ceremonial. I get to see my sister, my father, and my other two brothers. They come to see me when they can, and they write to us so it isn't so bad."

One of the males who had never been away from his home said:

Native says:

CASE 4

"I didn't go to school--my family was a great big appointment to me. I wanted very much to go to school, but I was the oldest son and had to help care of the stock. Yes, I was a shepherd. When I came here two years ago it was not hard for me, my wife was already here and it was good to be with her, even though I had to leave my two children. My mother took care of the oldest and my sister-in-law had the youngest. It was very hard for me when my wife died, but I knew that I had to stay to get well, and my father and sister took better care of my children than me, and I didn't want them to get sick too, so I will stay till I get well."

An interpreter was used with this patient because he spoke very little English.

Being here never did bother me. I am learning a little English and will learn more when they start the school. I will go home when I am well, but I don't know if I can keep my land and stock, the work is hard. If I know some English it will be better for me to get a job."⁵

The interpreter told the interviewer that the above patient is called the "rest-taker" by the other patients in his ward. He doesn't enter into any of the various activities of the occupational therapy program. "He really takes the cure, all he does is rest."

Of the thirty-eight females interviewed twenty-two stated that their major problem in adjusting was leaving their families and homes.

CASE 5

"This is my third time in the sanatorium. The first time I was in I didn't have any children, and I didn't mind it. The thing I missed most was my children, but not so much this time. The second time was the hardest because I had to leave my children with someone, my sister, and I didn't like to leave them with her. When I came back the second time I used to cry every night because I missed them and was worried about them. This time my children are in the _____ mission, and I know they will get taken care of and also learn the Bible and to read it. I am Episcopalian and my children are at the Episcopalian mission. This time I do not worry about them, just miss them. They have come to see me three times but I tell them not to send them because it costs so much for them to come. All I want to do is get back to my children, but I won't leave until the doctor says I can."

⁵At the time of this interview the starting of an educational program was nothing more than rumor to the patients. It is at the present time in operation.

Another says:

CASE 6

"I cried and cried when I first came, I missed my children so much, and I was worried about my oldest girl. I have six children, my oldest girl is fifteen and she had to quit school to take care of them so I could come to the sanatorium. This is a very great sacrifice for her to have to make, and too much responsibility for her, but I couldn't do anything else. My husband works all day and can't be home to take care of them. I know how hard it is for my daughter to do this because I had to quit school in the last half of my senior year to take care of my mother who got sick. My daughter is only in the tenth grade and she is young, she can go back to school, and she is very ambitious, so I think she will go back when I am discharged. I want to get well and go home so she can go back to school. I did not have any other trouble getting used to the sanatorium, except I missed my husband, but I have home for a day eight times since I've been here, so I don't mind that so much."

CASE 7

"It was very hard to come back to the sanatorium this time, my youngest child was only three years old, and I missed him very much. I cried and cried, but my husband told me this is foolish, that I must not worry, and get well. My husband is on the tribal council and he is very wise. He believes in education for our people. Even though I have an uncle who is a medicine man I came to the sanatorium to stay because my husband and I believed it was the only way to get well. I was well when I left the first time, and was home eleven years before I had to come back. I have faith that I will get well again, so it is not so hard to stay as before. I know my baby is well and my husband takes care of all the children, but I still miss them very much."

CASE 8

"When I came I missed my little sister and my two little brothers, I took care of them most of the time be-

fore I came here. My grandmother takes care of them now. My father died with tuberculosis, and my mother got married again, and then my mother died with tuberculosis. I see my step father every day because he works here at the sanatorium, but my brothers and sister and grandmother only come every other week to see me. I don't miss them so much now. When I go home I want to go back to school, my brothers and sister go to school and I think I should have more, I only went the seventh grade. No, I didn't miss my school friends because I had already quit school before I came here."

CASE 9

"I had been living with my daughter and helping to take care of her children. It was very hard for me to leave them. I missed my daughter too, but mostly my grandchildren. My own children are all grown up and away, or dead. My husband is dead too. Two sons and my husband died with tuberculosis. All in our family were very highly educated, all of my children graduated from high school, and one son was going to school in Las Cruces. He got sick while he was there and had to come to the sanatorium, he died here. Before I came to the sanatorium I was very worried about my other son. He was taken to the Army, and there was where he learned to drink. He was a good boy and always did what I told him, but when he came home from the Army he was always drunk and into trouble. He did not look after my land or the stock, and he wasted away good money. Now almost all of my stock is gone, I still have some money. He was a great worry. When I came here he told me he would stop drinking. I have heard from my daughter and the people in my village that he is being a good boy so I don't worry about him any longer. It was just the Army that did this to him, he was a good boy before. My daughter comes to see me two or three times a month, and sometimes she brings the children, so I do get to see them sometimes, and I don't mind it here now."

Five of the females stated that leaving school and missing their school friends was their only adjustment problem:

CASE 10

"This is the second time I have been in the sanatorium. I was going to school and they gave us our physical exams, and told me I would have to come to the sanatorium because I had tuberculosis. I was in here for five months and they told me I could go home. My mother took care of me for one year and then I started back to school, but got sick again and had to come back here. It was very hard for me the first time to give up my schooling and leave my friends. The second time it was not so bad, but I was disappointed to have to leave school again. No, I didn't miss my family, mostly my school. My mother and father are wanting me to stay here until I am cured, and I will but I would like to go back to school. My mother and father and one of my brothers come to see me four times a year."

"I was in the senior year of my school when I got sick and had to go to Phoenix to the sanatorium. I left for one week to go home and then I got transferred here. It was very hard for me to stop my schooling then. I missed my family some, but was disappointed not to be able to graduate from school. My family comes to see me every four months, and they all write to me every week. I would like to go back to school when I get out and am well, but I'll probably be too old."

Three of the females interviewed specified confinement to the sanatorium and to bed was their most difficult adjustment:

CASE 11

"I graduated from the Albuquerque Indian School and then went to Phoenix to work in a war plant there for one year. I got sick while I was there. I came home to tell my mother and father that I would have to go to the sanatorium. It was hard for me to get used to having to stay in bed, and to rest. It was hard for me to not go out. When I was in Phoenix I used to go out almost every night. I was used to doing whatever I wanted to so the sanatorium rules were hard to get used to. No, I

didn't miss my family, I have been away from them for a long time. They came to see me once while I have been here. I have two cousins who work in Albuquerque and they come two or three times a year. Now I am used to resting I don't mind it."

"After I graduated from the Albuquerque Indian School I had several jobs. My last job was as an informant for the Window Rock Agency. I liked my job but my mother is very old and needed someone to care for her so I left my job. I took sick soon after that and came to the sanatorium. I have always done what I wanted and so coming to the sanatorium was hard for me. Staying in bed so much and not being able to do things was hard to get used to, but now that I have been here for a while it doesn't bother me so much. My daughter was here in the sanatorium for a while with me, but she died. My son-in-law comes to see me about once a month. I don't miss anyone or anything so much, it was just that I hated to stay in bed and now that isn't bothering me any more."

Three of the female patients interviewed reported that they had the most difficult adjustment to make in the giving up of their work:

CASE 12

"My brothers and sisters and I never went to school. I was working in Aztec as a dishwasher in a cafe. I got sick and a doctor there told me I would have to come here to get well. I missed my work. No, my family doesn't come to see me, once in 1947 my sister came but that is all. I didn't miss my family, just my work. I will go back to work when I get well."

An interpreter was used for the above interview.

Twelve of the males interviewed indicated that the major problem of adjustment for them was leaving their family:

FACTORS

didn't know of any other...
long time...
here. I have...
come two or three times...
I don't mind it.

"After I returned from the...
I had...
the...
very old and...
job. I had...
before. I have...
to the...
which had...
need...
doesn't...
handwriting...
in...
anyone...
stay in bed...

These of the...
they had the most...
up of their work.

My brother and...
I was working...
sick and...
have to...
come to see...
all. I didn't...
back to work...

An...
Twelve of the...
major problem of...
lastly.

CASE 13

"My wife and children need me to take care of them, and when I had to come to the sanatorium it worried me very much how they would be without me. Also I missed them a lot. I got used to not being with them, but I still worry about them. I guess I didn't miss them so bad because my brother is here. We go home every year, we got a big part in the ceremonial. I liked my job, but I don't know if I can do it when I get out, I did jewelry inlay work. Now my father takes care of my wife and children. All of the children go to school, and my wife sees that they have their physicals so they don't get sick like me and my brother. My father and my aunt come to see me and my brother, but my wife doesn't come, it costs too much. I tell her to stay home, but she writes to me every week. I don't worry so much now because I know my father takes care of the family but I want to get out as soon as I can because he is old. It will be hard to know what to do when I get out."

CASE 14

"The thing that was hardest for me when I came here was to leave my family. I left school in the third grade to help my father with the sheep, and I never was away from home. It was hard to leave my mother, she worries about me. I didn't miss my sister so much because she had been away working in Albuquerque. She comes to see me every week and so do my mother and father. Now I am used to it here and I don't miss my family so bad, and it isn't so bad when they see me. I missed working with my father, and wonder how he gets along without me to help him, it is hard for him to do it alone. I will go back and help him when I am well."

CASE 15

"I was working in California and my wife got sick and had to go to the sanatorium. I had already lost one son with tuberculosis. When my wife went to the sanatorium she took my other son with her. She was in a county sanatorium there and they had a ward for the children to stay. She was in there for about five months when I

got sick and hemorrhaged at work and they told me I would have to go to be with my wife. It was hard to have to give up my job, but I was happy to be with my wife and son. My wife died there and I decided to come back here and have my mother take care of my son. No, he didn't have tuberculosis. This was a big responsibility for my mother because she is old, but I didn't want to leave my son with anyone else. I stayed out for about three months and then came here. I missed my son very much because he is all I have left since my wife and other son died. I didn't miss my mother because I had been away from her for a long time when I was going to school and working. I will have to learn a new trade when I get out so I can support my son. I want him to go to college, I was always disappointed that I couldn't go, I didn't have the money. I would like to be a bookkeeper or something like that, I could not go back to my old trade, or to my job as a shipping clerk. I was a combination welder during the war and made lots of money, but it is almost gone. My mother brought my son to see me once, but it is far for them to come and costs too much, so I tell them to stay home unless I get worse they don't need to come. My brother works here and he comes to see me every Sunday. Now my only worry is what I will do when I get out, and learning a new trade to support my son. I wish that we could learn more here. I read a lot, and I would like to take a correspondence course, but I guess that would be too hard. Sometimes I try to teach the other boys to speak English because I don't know what they can do when they get out of here and have to go to work if they can't speak English. I guess all they can do is herd sheep or work for the railroad, but that is too hard work for them. Maybe if they start the school here some of them will go, and learn to read and write. This is a big problem of my people, that they are not educated. I am glad I have a good education so I can get work that won't be too hard on me. No, it isn't hard for me here now. Just at first it was and I guess that wasn't as hard for me because I had already been in the hospital."

Four of the males missed school more than anything else and their hardest adjustment was interrupting their school work and leaving school friends?

CASE 16

"I was in my first year of high school when I had to quit to come to the sanatorium. This was very hard for me because I wanted to graduate from high school. My family thinks education is very important for our people, and they were sorry I had to quit. I don't miss them much, they have come to see me five or six times, and they write to me. While I am here I read, do a little painting, yes, with water colors, and mostly I practice my penmanship. See, I am a pretty good writer. I write letters for some of the boys who can't write. When I get out of the sanatorium I will go back to school, my family wants me to stay until the doctors say I can go and I guess that is the best thing. I was up on exercise when I hemorrhaged and had to go back to bed, but maybe it won't be so long now."

CASE 17

"I was here for seven years the first time. I got sick when I was in school and had to quit when I was in my first year of high school. When I was discharged the first time I went back to my home for a little while and then came here to go to the Indian school. I finished all but about one month of my tenth grade when I got sick again and had to come back. This was a great disappointment to me, because before when I was here I looked forward to getting well so I could go back to school. No, I didn't miss my friends at school just my school work. I want to get a good education, I don't know how long I will be here this time, but I will probably be too old to go back to finish my high school. Mostly I read, and read, but sometimes I try to teach some of the boys English and to read. Some of them don't care whether they learn, but the young ones would like to learn. I would like to go if they put in some school here. I didn't miss my family much the first time, I guess, because I had been away to school. I didn't miss them at all this time. My brother has been to see me but it is a long way for them to come, and I don't expect them to, but they would come if I get real sick."

The one male who stated confinement as a major problem

"I was in my first year of high school when I was
put to come to the sanatorium. I was very young
because I wanted to get away from home. My
family thinks education is very important for me
and they were sorry I had to leave. I don't miss them
much, they have come to see me live in a little
write to me. While I am here I read a little
yes, with water colors, and usually I am
ship. Yes, I am a pretty good sailor.
for some of the boys who can't swim. I am a
the sanatorium I will go back to school. My family
me to stay until the doctor says I can go and I know
is the best thing. I was up in a room when I
phased and had to go back to bed. I am
so long now."

"I was here for seven years the first time. I was
sick when I was in school and had to go to the
my first year of high school. When I was in the
first time I went back to my home for a little
then came here to go to the first school. I
all but about one month of my first year when I
again and had to come back. This was a very
ment to me because before when I was here I
ward to getting well so I could go back to school.
I didn't miss my friends at school but my school work
I want to get a good education. I don't know how
I will be here this time. But I will probably be
to go back to finish my high school. I don't
read, but sometimes I try to teach some of the
fish and to read. Some of the boys like to
learn, but the young ones would like to learn. I
like to go to the hospital but I don't like to
miss my family much the first time. I miss them
I had been away to school. I don't miss them
this time. My brother has been to see me
long way for them to come, and I don't
but they would come if I get very sick."

The one who stated that the patient was a member of the



of adjustment says:

CASE 18

"I am the only one left in my family, they all died with tuberculosis. I've worked lots of places, because I like to see the country. Mostly I've worked here in the southwest and in California. When I graduated from the Indian school here I had a trade as a silversmith. I went to Kansas City and worked there for a while, and then in Phoenix, and then went to California where I stayed with my cousin. I got tired of that and came back to Albuquerque to work, and got sick while I was here so they sent me to the sanatorium. It was very hard for me to get used to staying in bed and in one place for so long. I like to see other towns and people, and here I could only go from one ward to another. Now that I am used to it it's not so bad but when I get well I'll go back to California I guess. I liked it there most. I don't know what I'll do, but I guess my old trade won't be too hard for me to work at."

Two of the males found giving up their work as their most important adjustment problem. Concerning this one of them says:

CASE 19

"I quit school in my tenth grade to go home when my mother got sick so I had to take care of the cattle and sheep. My brother was too young. I did the farming and watched the sheep and cattle for my mother until I got sick and had to come here, so now my brother takes care of the stock, but I will do it when I get well. My brother is young and doesn't understand the farm as well as I do. I worry all of the time about what will happen to the sheep, I didn't miss my family so much. My father is dead and my mother and sister and brother come to see me every two weeks. I don't think it will be too hard for me to farm when I get well, and I understand about it and that is all I want to do. It was hard when I came here because I was worried about my brother being able to do

of adjustment says:

CASE 18

"I am the only one left in my family, they all died with tuberculosis. I've worked lots of places, because I like to see the country. Mostly I've worked here in the southwest and in California. When I graduated from the Indian school here I had a trade as a silversmith. I went to Kansas City and worked there for a while, and then to Phoenix, and then to California where I stayed with my cousin. I got tired of that and came back to Albuquerque to work, and got sick while I was here so they sent me to the sanatorium. It was very hard for me to get used to staying in bed and in one place for so long. I like to see other towns and people, and have could only go from one ward to another. Now that I am used to it it's not so bad but when I get well I'll go back to California I guess. I liked it there most. I don't know what I'll do, but I guess my old trade won't be too hard for me to work at."

Two of the wives found giving up their work as their most important adjustment problem. Concerning this one of them says:

CASE 19

"I quit school in my tenth grade so as home when my mother got sick so I had to take care of the cattle and sheep. My brother was too young. I did the farming and watched the sheep and cattle for my mother until I got sick and had to come home, so now my brother takes care of the stock, but I will be there when I get well. My brother is young and doesn't understand the farm as well as I do. I worry all of the time about what will happen to the sheep. I didn't miss my family so much. My father is dead and my mother and sister and brother come to see me every two weeks. I don't think it will be too hard for me to farm when I get well, and I understand about it and that is all I want to do. It was hard when I was young because I was worried about my brother being sick so I

the work and I hated to leave the stock."

On the basis of incidence the main categories of the Indians expressing adjustment problems are:

1. Mothers with small children, and males with families and males with other financial responsibilities.
2. The Indians who reached the high school level of education and those whose education had been interrupted.
3. Those whose activity and independence before entering the sanatorium made confinement of the sanatorium situation a major problem.
4. The non-English speaking Indians who were less acculturated than the English speaking Indians.

It is impossible to make hard and fast categories of the patients' adjustment problems, because these problems overlap, but the classifications used were made on the basis of the expression of the patients themselves. There is overlapping between those whose main concern was giving up their means of livelihood and those whose major problem was restriction and confinement; between those who are troubled as to how to earn a living when they get out of the sanatorium, because their schooling was interrupted, and those who express concern over family conditions at home, and others.

There is an old tradition that individuals with pulmonary tuberculosis are characteristically hopeful, cheerful, and optimistic to a degree entirely unwarranted by the seriousness of their physical condition. As can be seen from

the word and I have not used it in this sense.
On the basis of the above, I have concluded that the
Indian expression is not a true cognate.

1. The word "cognate" is used in two senses: (a) words which have a common origin, and (b) words which have a similar meaning. In this paper, I am using it in the first sense.
2. The word "cognate" is also used in a third sense: (c) words which have a similar form. This is the sense in which I am using it in this paper.
3. The word "cognate" is also used in a fourth sense: (d) words which have a similar sound. This is the sense in which I am using it in this paper.
4. The word "cognate" is also used in a fifth sense: (e) words which have a similar meaning. This is the sense in which I am using it in this paper.

It is impossible to find a word in any language which is a true cognate of a word in another language. The best that can be done is to find words which are cognate in one or more of the senses mentioned above. In this paper, I have found that the Indian expression is not a true cognate of the English expression in any of the senses mentioned above. It is, however, a cognate in the sense of having a similar meaning. This is the only sense in which it is a cognate. The fact that it is a cognate in this sense does not mean that it is a true cognate. It only means that it has a similar meaning to the English expression. The fact that it is a cognate in this sense does not mean that it is a true cognate. It only means that it has a similar meaning to the English expression. The fact that it is a cognate in this sense does not mean that it is a true cognate. It only means that it has a similar meaning to the English expression.

the above interviews that particular behavior characteristic of the tuberculous is unfounded as concerns tuberculous Indians in the sanatorium situation. The author does not mean to imply here the exclusion of that euphoria which is characteristic of some patients.

Almost equally venerable in tuberculosis folklore are the beliefs that the tuberculous show an increase in sexual urge and an increase in intellectual acuity. Any comment of the author about the latter claim would be mere opinion or speculation since it would be necessary to administer a battery of tests of mental ability to make any statement concerning the validity and reliability of that belief in regard to Indian patients. The evidence of data of past studies of white tuberculous subjects as concerns intelligence gives no indication that tuberculosis has a regressive effect; the bulk of the data supports the tentative hypothesis that tuberculosis may be associated with a slightly increased level of intellectual functioning.⁶

In regards to the belief of increased sexual urge of tuberculous patients the author accepts the opinion of medical experts in the field of tuberculosis, and the opinion of the Medical Director of the Albuquerque Indian Sanatorium,

⁶Barker, Wright, and Gonick, op. cit., p. 130.

the above interview, these patients are characterized
of the tuberculosis is characterized by a
Indians in the same manner as the white
mean to imply here and elsewhere in the paper is
characteristic of some patients.
Almost equally venereal in the tuberculosis patients are
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of the Medical Director of the Albuquerque Indian Hospital.

Parker, Wright, and Gentry, 1934, p. 155.

as well as findings of the data on the subject as regards white patients. This question was not included among those asked in the interview. According to Barker, Wright, and Gonick the data on sex drive in the tuberculous is inadequate, but what there are do not support the theory of increased sex drive. They report the opinions of forty-four medical experts who were asked to express opinions on various behavior characteristics of the tuberculous patients. Eight of these experts expressed a belief that there was an increase in the sex drive while three stated that there was no increase.⁷ It must be considered that not all of the forty-four experts expressed themselves on this subject. It is the opinion of the Medical Officer in Charge of the Albuquerque Sanatorium that the sex drive of the patients in that institution is neither increased or decreased and remains about normal.

There are no known cases of homosexuality in the patients at the Indian Sanatorium, nor any known cases of sexual intercourse between patients while in the sanatorium. Masturbation is occasionally suspected but is not known with certainty. In the two cases in which both husband and wife are in the sanatorium they see each other no oftener than do any of the other male and female patients and under the

⁷Ibid., p. 129.

as well as findings of the study on the use of the
white patients. These questions are not intended to be
asked in the interview. According to the study, the
Gordon the data on sex drive in the investigation is not
but what there was not enough time to do a full
sex drive. They report the patient's sexual
exposures who were asked to respond to a series of
behavior characteristics of the investigation. The
of these exposures expressed a belief that there was no
increase in the sex drive while the study was in progress
no increase. It was also suggested that all of the
forty-four subjects who were in the study
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during the investigation that the sex drive was not
investigation is neither increased or decreased and was
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There are no known cases of homosexuality in the
patients at the Naval Hospital. The highest number of
sexual intercourse was reported by the study group.
Masturbation is occasionally practiced by the study group
certainly. In the two cases of the study group and the
are in the investigation very few cases of the study group
do any of the other side and female patients reported the

same conditions. In order to release tension, sublimate drives, and make for a more normal situation the patients are allowed to visit with members of the opposite sex one afternoon each week (note schedule). This "courting hour," as it is referred to by the sanatorium officials, is only for those patients who are able to go to the first floor where they visit in the hall and on the sunporch. All of the patients asked were in favor of this visiting hour privilege and those of them who can take advantage of it eagerly look forward to it each week. Most of the married patients have an insight into the reasons, from the standpoint of the cure, why doctors advise against sexual relations. It is, of course, impossible for the doctors to do more than advise when the patient leaves to go home on furlough.

There was enough dissatisfaction among the patients of the Albuquerque Indian Sanatorium during the fiscal year 1949 to cause forty-five per cent of them to leave without the consent of the physicians. This is obviously an unfortunate situation for the individual patient and for his family and community since such individuals are sources of infection, and they are seldom able to provide suitable care for themselves.

As would be expected from the problems of adjustment admitted by patients interviewed and by secondary data, the most probable reasons for patients to leave without consent

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same conditions, and when the patient is
admitted to the hospital, the patient
are allowed to visit with their families
afternoon each week (one hour). The visiting hours
as it is referred to by the attending physician is only
for those patients who are able to go to the hospital
where they visit in the hall and on the grounds. All the
the patients asked were in favor of this visiting hour
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family and community since such individuals are sources of
infection, and they are seldom able to provide adequate care
for themselves.

As would be expected from the problem of a patient
admitted by patients' initiative and by voluntary care, the
most probable reason for patients to leave without consent

are:

1. concern over affairs at home and homesickness.
2. financial worries and difficulties
3. dissatisfaction with hospital life and wanderlust
4. religious convictions and superstitions
5. dissatisfaction with progress of their case, misinterpretation of improvement, and the desire to die at home

These last two reasons were not mentioned in the data presented from the interviews and are based upon opinions of the sanatorium staff. No significance is meant to be attached to the position of any of these reasons in the listing; they are not weighted as to incidence of occurrence or as to importance of one over another.

A number of medical authorities have expressed opinions as to what should be done to create desirable sanatorium situations from the viewpoint of the patients' greater ease of adjustment. These opinions center around two aspects. The first consists of general statements such as: "It must be emphasized that rest means not only physical, but also mental rest." "Cheerful and mentally stable patients show better progress." Secondly, these medical men are often concerned with the physical aspects of factors in the patients' situation, such as food and housing. This latter aspect we have dealt with, showing how the Albuquerque Indian Sanatorium has attempted to meet this phase of the problem.

A different viewpoint is taken by Sir Pendrill Varrier-Jones, founder and medical director of the Papworth Village

1. conduct of the investigation
2. financial statement and other data
3. distribution of assets
4. religious organizations and activities
5. physical condition and health
6. investigation of the past and the future
7. other matters

These last two matters were not mentioned in the original report.

From the interviews and the data upon which the report was based

the following facts were ascertained: In 1934, the subject was

possessed of any of these assets in the United States and was

weighted as to inclusion in the list of persons who are

one over another.

A number of additional facts were ascertained:

as to what amount of the subject's assets were

situated in the United States and the following facts were

of adjustment. These facts were ascertained from the

first contacts of the subject with the United States and

emphasized that the subject was not a native-born citizen

and that the subject was not a native-born citizen

progress. The subject was not a native-born citizen

with the subject's assets in the United States and

nation, such as the subject's assets in the United States

dealt with, showing the subject's assets in the United States

attempted to meet the needs of the subject.

A different viewpoint is taken in the report of the

Jones, founder and leader of the Peoples Temple.

Settlement in England. He suggests that a good environment includes not merely good material conditions and physical exercise, but a mental state. He says:

Much more than material conditions are responsible both for well-being, and for their success or failure in keeping the disease in check. . . . Enforced leisure may spell disaster . . . which could be easily avoided if the psychology of the patient were taken into account. . . . It is still believed by some that work simply as a therapeutic measure . . . is beneficial. This is not so . . . Hope and work produce vitality. Neither of these alone will produce the desired results. Our new conception of the environment must provide a set of circumstances calculated to provide what we all recognize under the term 'well-being' . . . Work is essential, but work of the right kind. It is fatal to well-being to be transferred to a different social group. No one can keep his well-being if degraded to an inferior occupation. Also it is disastrous to thrust responsibility on one not used to it. . . . Man does not become a philanthropist just because he gets tuberculosis. Many schemes provide that a man should give his labor to the cause . . . (It is) far better to organize the work so that the patient can earn decent wages and pay for his own way. . . . The man who has contracted tuberculosis has done nothing wrong. On the contrary, he is frequently the victim of our present civilization. It is not for us to despise him, but it is rather our duty to compensate him for the wrong society has done to him. This we can best do, not by restoring his working capacity, but especially by contriving the kind of environment which has been postulated so that the sense of well-being may be recovered.⁸

It was on this premise that the Papworth Village Settlement was developed. The institution provides medical treatment and opportunities for patients to contribute to their own economic and social well-being in a permanent colony. H. Banister presents a like picture when he says:

⁸Ibid., p. 138.

It is the organization of the individual's sentiments that is of prime importance. A man with his principal sentiments organized around some ideal which is not egocentric is able to bear the disorganization caused by the disease, to re-organize his life as may be necessary; the other, whose chief sentiment is ambition, or other self-centered sentiment, loses morale at once. . . . Toxemia by lowering vitality makes the personal problems loom larger, and this gives rise to worry, poor sleep, etc. Since rest is the main way of treating tuberculosis, it becomes essential to avoid these worries. Bromides are not a solution. Neither is work, unless it is directed at a solution of the worries; not because it gives the patient something to think about.⁹

This recognition of the fact that being occupied per se is not of therapeutic value may explain the tendency noted by Beulah Burhoe¹⁰ for sanatoria to replace occupational therapy with educational programs.

The Albuquerque Indian Sanatorium has made an attempt to approach the theory of these suggestions by allowing the patients to sell the items that they make in connection with the occupational therapy program and by maintaining a shop to display and sell these items. The shortcomings here are those of the occupational therapy program. That is, there is not enough variety of activity, nor enough activity of the nature that will be of value to the patient in earning a livelihood when he is discharged from the sanatorium. Education, vocational training, and part time work are possible for many

⁹Ibid., p. 139.

¹⁰Ibid., p. 146.

patients. It used to be thought that so-called diversional activities such as occupational therapy and recreation¹¹ were valuable because they kept the patient's mind off his troubles. There is increasing recognition of the fact, however, that the value of any sanatorium activity derives almost exclusively from its contribution to the solution of the patient's personal problems. Education, vocational training and work, by allowing the patient to progress toward definite goals, are effective in aiding in his medical cure because they change his situation from one of conflict and frustration to a situation which provides some satisfaction. It is thought that work which does not provide present financial returns or contribute to future vocational placement is almost useless since economic security is a central problem with most tuberculous Indians, as it is in the lives of all mankind.

The problem of education is just beginning to be met by the sanatorium by the very recent instituting of a cooperative education between the sanatorium and the Albuquerque Indian School. As the program is still in the embryonic stage of operation it is impossible to state results of the program. But certainly it would not be premature to state that if it provides service only for those patients who are unable to

¹¹There is no organized recreational program at the Albuquerque Indian Sanatorium.

speaking, reading, and writing English it will have made a great contribution to the well-being of the patient. As the program is now planned it will service only those patients above-mentioned but may later be expanded to include those whose education was interrupted at a higher educational level.

A part time work and a vocational training program could be implemented to serve the needs of the patients if the present facilities of the occupational therapy department were expanded to include, for instance, a small shop. wood-working tools, and small bedside looms. Important here is also the fact that these patients are eligible upon discharge with medical advice for training under the Federal-State Vocational Rehabilitation Program. In the fiscal year 1949 one patient took advantage of this opportunity, and this patient is the first patient to do so since 1946. It is obvious that the patients should be given more information about this service of the Government. This patient is being trained to be a seamstress, a vocation which will not be too taxing physically, and one at which she can support herself and her children.

In the case of the tuberculous Indian who is a sanatorium patient there exists the double problem of marginality. If the Indian is on the borderland of his own and the white man's culture, he is, upon his entrance to the sanatorium, also on the border of the sanatorium "culture" and his past

"culture" of a situation of apparent health. When he comes to the sanatorium there is an overlapping of his behavior which was determined by the factors that operated before he became ill, and his sanatorium behavior. By virtue of becoming tuberculous and entering the sanatorium the individual does not wholly drop the motivations, or escape the factors that guided his behavior as a healthy person. As can be seen by the interview data presented, in the beginning of his sanatorium experience the potency of the behavior in a situation of health is relatively great for the tuberculous Indian; but, with the enforced isolation and the necessary preoccupation with imposed medical regimens, the potency of the sanatorium behavior increases. While this adjustment is taking place there is no doubt that the overlapping situation gives rise to a great amount of interfering and antagonistic behavior. Upon how the patient solves this conflict partially rests the matter of whether or not the patient stays to complete the cure or whether he fails to resolve the conflict and leaves the sanatorium against medical advice. In some patients this conflict and antagonism is greater or lesser than in others, which would tend to explain why some patients have no major difficulty in adjusting to the sanatorium situation. Important in bridging the gap between these behavior patterns is an adequate and functioning educational, vocational, and work program. How a particular patient will

"culture" of a situation of significant change. This transition
to the association with an environment of the behavior
which was determined by the factors that operated before he
became ill, and his association with the environment of the
coming tuberculosis and during the association in the
does not wholly drop the maladjustment, or rather the
that guided his behavior as a healthy person. As can be
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his association with the environment of the behavior in a
situation of health, the maladjustment of the behavior was
indicated by the behavior data, and the necessary
precondition for the behavior in the environment of the
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agonistic behavior. When the patient returns to the
that partially meets the matter of whether or not the patient
stays to complete the cure or whether he returns to the
conflict and leaves the maladjustment system and the
In some patients this conflict and maladjustment is greater or
less than in others, which may be due to various reasons.
patients have no major difficulty in adjusting to the environment
for the situation. In the majority of the patients the
behavior patterns in the environment and the maladjustment
vocational, and work habits. In a patient's behavior with

react and organize himself to meet this conflict situation will depend upon his estimation of the seriousness of his condition, the extent of his fear of death or permanent disablement, and the strength and degree of unity of his personality. Those patients dealt with in this study obviously have met this conflict situation satisfactorily enough to allow themselves to remain in the sanatorium environment. However, it is unfair to say that all of those patients who left the sanatorium against medical advice returned to their pre-sanatorium environment because they were unable to cope adequately with the sanatorium situation. Some of them left because of conditions at home, such as no one to care for their children.

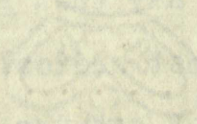
Inherent in the sanatorium situation is the basic conflict between life and death, recovery and permanent disablement. Anxiety concerning this conflict can be reduced by instruction of the patient by the sanatorium staff. To most sanatorium patients the therapeutic procedures and the routine are entire new, and they have little knowledge of the meaning of these procedures or the significance of their own symptoms. Therefore, the routine and unimportant happenings can hold unnecessary fear for the patient. The Albuquerque Indian Sanatorium has attempted to meet adjustment to this new psychological situation of the patient by telling him his diagnosis and by periodic reports on his condition. The patient

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...and ...
...will depend upon the ...
...condition, the extent of the ...
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...sensibility. These ...
...have not ...
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...needs and ...

has explained to him the character of the disease, and the necessity of the therapeutic measures undertaken to control the disease as regards his case. He is informed as to the reasons for the routine and the necessity of bed rest. As the Assistant Director of Nurses said: "We have to teach them how to live in the sanatorium, and how to live with tuberculosis."

In teaching the patient the necessity for complete relaxation through avoidance of overstimulation and in aiding him to adjust to his situation there is the danger of narrowing the patient's scope to the point where he is preoccupied with his physiological processes and his symptoms. In the Indian Sanatorium the scope of the patient's situation is increased by including him as an active agent in treatment procedures to the extent that his physical and mental capacities permit. Because he is given an understanding of the reasons for prescribed treatment, and cares for himself to the maximum of his ability he experiences more freedom and success and less conflict, as well as a feeling of competence in meeting his own problem.

Of the major adjustment problems voiced by the patients of the Albuquerque Indian Sanatorium the one problem the sanatorium has made no attempt and can make no attempt to solve is that of anxiety over conditions at home. For example, one is at a loss as to how to remedy the fact that a


has explained to him the character of the disease, and the necessity of the therapeutic measures undertaken to control the disease as regards his case. He is informed as to the reasons for the routine and the necessity of bed rest. As the Assistant Director of Hospitals said: "We have to train them how to live in the sanatorium, and how to live with tuberculosis."

In teaching the patient the necessity for complete relaxation through avoidance of overstimulation and in aiding him to adjust to his situation there is the danger of over-allowing the patient's scope to the point where he is preoccupied with his physiological processes and his symptoms. In the Indian Sanatorium the scope of the patient's situation is increased by including him as an active agent in treatment procedures to the extent that his physical and mental capacities parallel. Because he is given an understanding of the reasons for prescribed treatment, and cares for himself to the maximum of his ability he experiences more freedom and success and less conflict, as well as a feeling of competence in meeting his own problem.

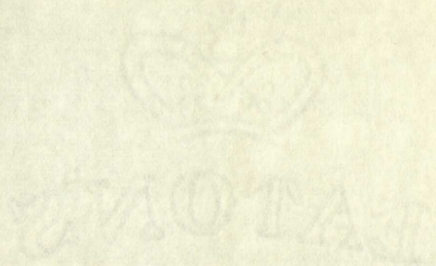
Of the major adjustment problems voiced by the patients of the Alameda Indian Sanatorium the one problem the sanatorium has made no attempt and can make no attempt to solve is that of anxiety over conditions at home. For example, one is at a loss as to how to remedy the fact that a



mother with small children is forced to leave the sanatorium before it is medically expedient to do so by the circumstance of having no reliable person to care for them. This example is used because it seems to be the most frequently stated reason for leaving the sanatorium by married female patients. Conditions at home are more often than not those stated for the male, either single or married, for his leaving, and center around some aspect of the economic or financial question. Some sanatoria surmount this obstacle presented by the females by maintaining children's wards for the purpose of keeping the children near the mother. Whether or not such a solution is feasible in the case of the Indian patients the investigator is not prepared to say, but it has been successful in other sanatoria.



mother with small children is known to have been
torium before it is medically expedient to do so. The
circumstances of having no reliable person to care for her.
This example is used because it seems to be the most fre-
quently stated reason for leaving the mother in custody
female patients. Conditions in some cases are often stated
those stated for the male, either alone or together. The
leaving, and each is ground upon the fact of the mother's
financial position. Some patients, however, are
presented by the female by certain children's needs for
the purpose of keeping the children near the mother. In such
or not such a solution is feasible in the case of the female
patients the investigator is not prepared to say, but it has
been successful in other instances.



CHAPTER V

SUMMARY, CONCLUSIONS, AND SUGGESTIONS

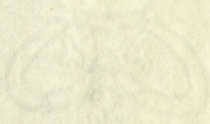
The data presented show that the tuberculous Indians interviewed who expressed adjustment problems are: mothers of small children, males with family and financial responsibilities, students whose education was interrupted, Indians highly active and independent before entrance to the sanatorium, and non-English speaking Indians.

From the problems of adjustment admitted by patients interviewed and from secondary data it was discovered that the most probable reasons for patients to leave without consent are:

1. concern over affairs at home and homesickness
2. financial worries and difficulties
3. dissatisfaction with sanatorium life and wanderlust
4. religious convictions and superstitions
5. dissatisfaction with progress of their case, misinterpretation of improvement, and the desire to die at home.

These last two reasons were not mentioned in the data presented from the interviews and are based upon opinions of the sanatorium staff. No significance is meant to be attached to the position of any of these reasons in the listing; they are not weighted as to incidence of occurrence or as to importance of one over another.

A description of some of the major adjustment problems that harass tuberculous Indians in the sanatorium situation has been presented. The existence of the adjustment



SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The data presented show that the respondents interviewed who expressed adjustment problems were mostly of small children, males with family and financial responsibilities, students whose studies were interrupted, and those highly active and independent before entering the institution; and non-English speaking students. From the present of adjustment studies by previous interviewed and from secondary data it was observed that the most probable reasons for adjustment problems were:

constant area

1. concern over affairs of home and home-keeping
2. financial worries and difficulties
3. dissatisfaction with general living conditions and surroundings
4. religious, racial, and social differences
5. dissatisfaction with progress of their studies
6. interpretation of improvement, and the desire to do at home.

These last two reasons were not mentioned in the data presented from the interviews and are based on the opinion of the senior staff. No significance is found to be attached to the position of any of these reasons in the list. They are all weighted as to incidence of occurrence or as to frequency of one over another.

A description of some of the major adjustment problems that have been experienced by students in the institution has been presented. The existence of the adjustment

problems indicated was described in interviews with the tuberculous sanatorium Indian in his sanatorium environment. The data show that Indians do not have more or fewer problems of adjustment than would be expected in any tuberculous patient and that none of the adjustment problems are what could be considered peculiar to the Indian alone.

An attempt has been made to point out where the sanatorium is aiding and failing to aid the patient in his struggle to resolve these problems, keeping in mind that not all of the problems originate in the sanatorium situation and the improbability of the sanatorium even being able to offer aid in these problem areas.

Aiding the tuberculous Indian to adjust to life in the sanatorium situation is in some instances being well done by the Albuquerque Indian Sanatorium, as has been shown. In other instances a program of aid is slowly evolving. It is thought by the investigator that if this evolutionary process is hastened and broadened in the areas of educational and vocational training and part time work for those patients who are physically able to participate in such a program, there would be a reduction in the anxiety of the patient caused by his problems which are undoubtedly important factors in the progress of the cure. The investigator is convinced that the focal point of resolution of the conflicts by most patients lies in the sanatorium's operation of an

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Along the tuberculous Indian to adjust to life in the sanatorium situation is in some instances being well done by the Algonquian Indian Sanatorium, as has been shown. In other instances a program of aid is slowly evolving. It is thought by the investigator that if this evolutionary process is hastened and broadened in the areas of educational and vocational training and part time work for those patients who are physically able to participate in such a program, there would be a reduction in the anxiety of the patient caused by his problems which are undoubtedly important factors in the progress of the cure. The investigator is convinced that the focal point of resolution of the conflicts by most patients lies in the sanatorium's operation of an

inclusive educational program, the institution of a vocational training program, and the inauguration of a work program. This three fold plan would have effectiveness not only for the sanatorium situation but also for the post sanatorium situation which is important in keeping the patient a quiescent case. Such a program, properly functioning, would directly reduce the problems of the males who are forced to leave the sanatorium because of financial obligations to their families; and, would also be a major aid to the Indian who is discharged in his adjustment to his post sanatorium environment. The problem of gaining employment (which is for the Indian beset with many obstacles exclusive of those added by the physical requirements of an arrested tuberculous) would be lessened somewhat by his ability to meet this situation armed with the training to perform a job in keeping with his physical limitations.

Suggestion is made to the effect that the Albuquerque Indian Sanatorium needs to enlarge its physical plant, extend its facilities, expand its staff, and increase its budget in order to serve more adequately the population it is meant to serve; to aid more adequately those it does serve in adjusting to the problems that their disease presents to them. The fact that the sanatorium at present has a waiting list of 15 patients, and has had to refuse admission to approximately 30 tuberculous Indians in the last fiscal year because



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training program, and the introduction of a new program.
This threefold plan would have effectiveness not only for
the sanatorium situation but also for the post-sanatorium
situation which is important in keeping the patient's progress
constant. Such a program, properly functioning, would dis-
cussly reduce the problems of the patient who are caused by
leave the sanatorium because of financial difficulties or
their families; and would also be a help to the patient
who is discharged in his adjustment to his post-sanatorium
environment. The problem of gaining employment which is the
the Indian's biggest with handicaps is exclusive of these causes
by the physical requirements of an extended rehabilitation
would be lessened somewhat by his ability to adjust his
nation armed with the training he gains in the sanatorium
with his physical limitations.
Suggestion is made to the extent that the Algonquin
Indian Sanatorium needs to enlarge its physical plant, extend
its facilities, expand its staff, and increase its equipment
in order to serve more adequately the population it is asked
to serve; to aid more adequately those it does serve in ad-
justing to the problems that their illness creates for them.
The fact that the sanatorium is treated as a waiting place
of 15 patients, and has had no refuse admission to patients
nearly 50 tuberculosis patients to the last three years because

of a lack of space; and the high incidence of those who leave the sanatorium against medical advice attests to the feasibility of the above suggestions.

The subject of this study obviously needs more, and more intense investigation and preferably by one who could converse with the patient in his own language. It is thought by the investigator that this language obstacle was responsible for the fact that the interviews did not yield more information concerning the patients' point of view concerning his problems of sanatorium life.

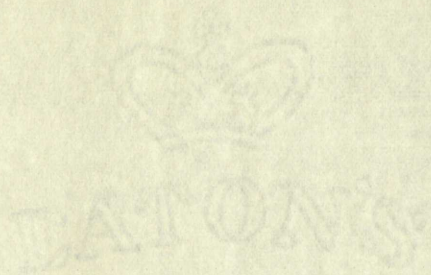
There is a need for more investigations which will lay a basis for the organization of medical and sanatorium procedures for an optimal social-psychological situation for the patient. This study has presented some of the more obvious suggestions for attaining this optimum situation. Necessary too, are companion investigations describing the optimal psychological situation for the "cure" of tuberculosis. With this knowledge it should be possible to devise practical methods of institutional organization for providing more adequate situations for the patients' adjustment to the sanatorium environment.

of a lack of space and the high incidence of those who
leave the hospital against medical advice presents to the
feasibility of the above suggestions.

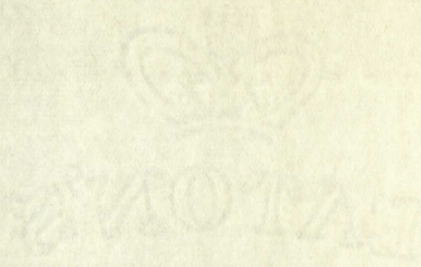
The subject of this study obviously needs more, and
more intense investigation and preferably by one who could
converse with the patient in his own language. It is thought
by the investigator that this language obstacle was respon-
sible for the fact that the interview did not yield more
information concerning the patient's point of view con-
cerning his problems of anesthetic life.

There is a need for more investigations which will
lay a basis for the organization of medical and anesthetic
procedures for an optimal anesthetic-psychological situation for
the patient. This study has presented some of the more ob-
vious suggestions for attaining this optimum situation.
Necessary too, are comparative investigations describing the
optimal psychological situation for the patient of anes-
thesia. With this knowledge it should be possible to de-
velop practical methods of institutional organization for
providing more adequate situations for the patient's ad-
justment to the anesthetic environment.

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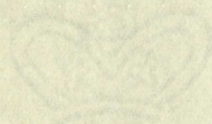
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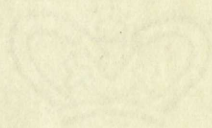
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APPENDIX

BERKSHIRE

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APPENDIX

TABLE I

MEAN AND MEDIAN AGE OF
ALBUQUERQUE INDIAN SANATORIUM PATIENTS
BY SEX AND YEAR

	1939		1949	
	Male	Female	Male	Female
Median age in years	18.5	18	24	24
Mean age in years	19.8	19.4	26	25.8

TABLE 1

REVENUE OF THE DISTRICT OF COLUMBIA
 AND TERRITORIES
 FOR THE YEAR 1939

1939				
Median age in years	Male	Female	Male	Female
15.8	18	21	1	1
Mean age in years	19.0	19.4	20	20.2

U.S. GOVERNMENT
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TABLE II

MARITAL STATUS OF ALBUQUERQUE
INDIAN SANATORIUM PATIENTS:
PERCENTAGES BY SEX AND YEAR

Number and Classification	1939			1949		
	Male 94	Female 93	Total 187	Male 63	Female 160	Total 223
Percent Married	79	15	13	25	53	45
Percent Single	88	78	82	66	36	45
Percent Widowed	1	3	2	6	7	6
Percent Divorced	2	4	3	3	4	4
Total	100	100	100	100	100	100

TABLE II

ANNUAL STATUS OF AMERICAN
INDIAN NATIVITY IN 1939
PROPORTION OF SEX AND AGE

Classification		1939		1939		1939		1939		1939	
Sex	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	
Married	5	12	13	22	21	42	1	7	1	1	
Single	85	18	85	30	85	42	1	7	1	1	
Divorced	1	2	2	5	1	7	1	7	1	1	
Total	91	30	100	100	100	100	100	100	100	100	

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TABLE III

RELIGIOUS PREFERENCE OF PATIENTS AT
ALBUQUERQUE INDIAN SANATORIUM:
PERCENTAGE BY SEX AND YEAR

Number and classification		1939			1949		
Sex Number	Male 94	Female 93	Total 181	Male 63	Female 160	Total 223	
Percent Catholic	52	67	60	53	47	49	
Percent Protestant	35	28	32	37	39	38	
Percent Pagan	13	3	7	10	14	13	
Percent none given	0	2	1	0	0	0	
Totals	100	100	100	100	100	100	

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TABLE 10

ESTIMATED 1964-65
ANNUAL 10-10-64
FEDERAL RESERVE

Number and classification									
Sex									
Number									
Age									
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TABLE IV

TRIBAL AFFILIATION OF
ALBUQUERQUE INDIAN SANATORIUM PATIENTS:
PERCENTAGE BY SEX AND YEAR

Number and classification		1939			1949		
Sex Number		Male 94	Female 93	Total 187	Male 63	Female 160	Total 223
Percent Navaho		46	25	35	67	50	56
Percent Pueblo		38	50	44	32	41	37
Percent others		16	25	21	1	9	7
Totals		100	100	100	100	100	100

TABLE IV

ALLEGEDLY IN THE MOUNTAIN REGION
INVESTIGATED BY S. J. AND L. H.

Harbor and Classification		1934		1935	
Sex	Number	Male	Female	Male	Female
Navaho	10	25	15	35	25
Pueblo	25	80	15	35	15
Others	15	25	21	1	9
Totals	100	100	100	100	100

TABLE V

DEGREE OF INDIAN BLOOD OF
ALBUQUERQUE INDIAN SANATORIUM PATIENTS:
PERCENTAGE BY SEX AND YEAR

Number and classification	1939			1949		
	Male	Female	Total	Male	Female	Total
Sex Number	94	93	187	63	100	223
Percent full blood	85	83	84	98	99	98
Percent mixed blood	14	15	14	2	0	1
Percent non Indian	16	25	21	1	9	7
Totals	100	100	100	100	100	100

TABLE VI

DISCHARGES OF PATIENTS FROM
ALBUQUERQUE INDIAN SANATORIUM:
PERCENTAGE BY TYPE OF DISCHARGE, SEX AND YEAR

Number and type of discharge		1939			1949		
Sex	Male	Female	Total	Male	Female	Total	
Number	84	85	169	25	101	126	
Discharged with medical advice							
	37	50	43	16	20	18	
Discharged against medical advice							
	39	36	38	80	70	72	
Discharge by death							
	24	14	19	4	10	10	
Totals	100	100	100	100	100	100	

TABLE VI

DISCHARGES BY TYPE OF DISCHARGE, 1933
 ALLEGEDLY FROM
 DISCHARGE BY TYPE OF DISCHARGE, 1933

Type of Discharge		1933		1934	
Sex	Number	Male	Female	Male	Female
Discharged with medical advice	37	25	12	20	17
Discharged against medical advice	39	26	13	20	19
Discharged by death	21	16	5	10	11
Total	100	100	100	100	100



TABLE VII

AVERAGE LENGTH OF STAY IN DAYS OF
ALBUQUERQUE INDIAN SANATORIUM PATIENTS DISCHARGED:
BY TYPE OF DISCHARGE, SEX AND YEAR

Number and type of discharge		1939		1949	
Sex Number		Male 84	Female 85	Male 25	Female 101
<hr/>					
Average daily length of stay before discharge with medical advice	960	876	526	294	
<hr/>					
Average daily length of stay before discharge against medical advice	338	452	261	218	
<hr/>					
Average daily length of stay before death	328	871	362	58	
<hr/>					

ALPHABETICALLY BY NAME OF THE
MANUFACTURER

Number and type of blades	
Sex	
Number	
Average depth length of wing before dissection with special device	
Average depth length of wing before dissection against motion device	
Average depth length of wing before dissection	

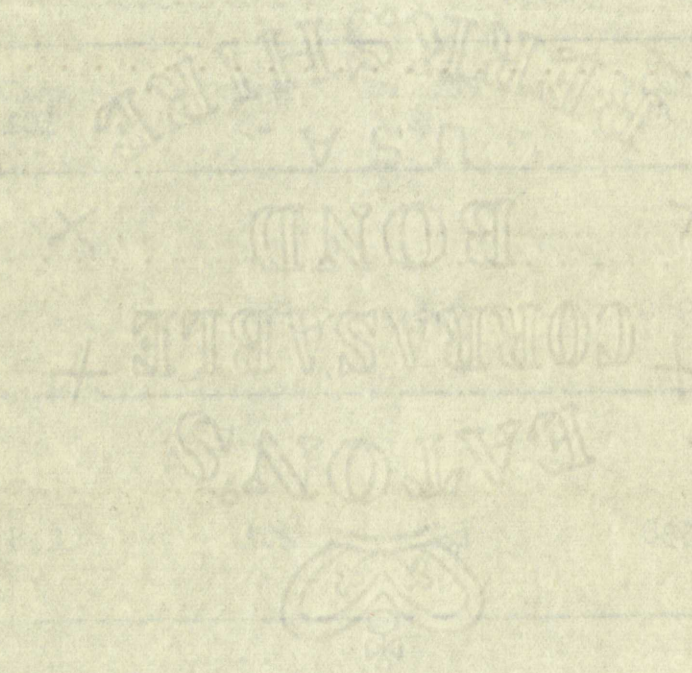


TABLE VIII

COMPARATIVE AGES OF SAMPLE AND UNIVERSE OF
ALBUQUERQUE INDIAN SANATORIUM PATIENTS BY SEX

Number and classification	Sample		Universe		
	Male	Female	Male	Female	
Sex Number 61	23	38	Number 96 38	58	
Mean age in years	27	27.5	23.8	24.6	
Median age in years	26.3	25	24	23	

TABLE IX

COMPARATIVE SEX DISTRIBUTION OF SAMPLE AND UNIVERSE OF
ALBUQUERQUE INDIAN SANATORIUM PATIENTS BY SEX

Number and classification		Sample		Universe	
Sex Number	61	Male	Female	Number	96
Percent of total		38	62	40	60

TABLE X

COMPARATIVE MARITAL STATUS OF SAMPLE AND UNIVERSE OF
ALBUQUERQUE INDIAN SANATORIUM PATIENTS:
PERCENTAGE BY SEX

Number and classification	Sample			Universe		
Sex Number	Male 23	Female 38	Total 61	Male 38	Female 58	Total 96
Percent married	26	29	27	24	44	35
Percent single	65	63	64	66	48	55
Percent widowed	9	3	5	5	4	5
Percent divorced	0	5	4	5	4	5
Totals	100	100	100	100	100	100

TABLE XI

COMPARATIVE RELIGIOUS PREFERENCE OF SAMPLE AND UNIVERSE OF
ALBUQUERQUE INDIAN SANATORIUM PATIENTS:
PERCENTAGE BY SEX

Number and classification	Sample			Universe		
Sex Number	Male 23	Female 38	Total 61	Male 38	Female 58	Total 96
Percent Catholic	56	50	52	50	41	45
Percent Protestant	44	50	48	37	45	41
Percent Pagan	0	0	0	13	14	14
Totals	100	100	100	100	100	100

TABLE

COMPARATIVE RECORD OF THE
ALLEGEDLY "LIVE" AND "DEAD"
RECORDS OF THE

Name		Age		Sex		Status	
1. John Doe		25		Male		Alive	
2. Jane Smith		30		Female		Dead	
3. Bob Johnson		22		Male		Alive	
4. Mary White		28		Female		Dead	
5. Tom Green		35		Male		Alive	
6. Alice Brown		20		Female		Dead	
7. Charlie Black		27		Male		Alive	
8. Betty Gray		32		Female		Dead	
9. Frank White		24		Male		Alive	
10. Helen Black		29		Female		Dead	
11. George Brown		31		Male		Alive	
12. Mary Green		26		Female		Dead	
13. John White		23		Male		Alive	
14. Alice Black		33		Female		Dead	
15. Tom Gray		21		Male		Alive	
16. Betty White		34		Female		Dead	
17. Frank Black		25		Male		Alive	
18. Helen White		30		Female		Dead	
19. George Brown		32		Male		Alive	
20. Mary Green		27		Female		Dead	
21. John White		24		Male		Alive	
22. Alice Black		35		Female		Dead	
23. Tom Gray		22		Male		Alive	
24. Betty White		31		Female		Dead	
25. Frank Black		26		Male		Alive	
26. Helen White		33		Female		Dead	
27. George Brown		30		Male		Alive	
28. Mary Green		28		Female		Dead	
29. John White		25		Male		Alive	
30. Alice Black		32		Female		Dead	
31. Tom Gray		23		Male		Alive	
32. Betty White		34		Female		Dead	
33. Frank Black		27		Male		Alive	
34. Helen White		31		Female		Dead	
35. George Brown		29		Male		Alive	
36. Mary Green		26		Female		Dead	
37. John White		24		Male		Alive	
38. Alice Black		33		Female		Dead	
39. Tom Gray		22		Male		Alive	
40. Betty White		35		Female		Dead	
41. Frank Black		28		Male		Alive	
42. Helen White		32		Female		Dead	
43. George Brown		30		Male		Alive	
44. Mary Green		27		Female		Dead	
45. John White		25		Male		Alive	
46. Alice Black		34		Female		Dead	
47. Tom Gray		23		Male		Alive	
48. Betty White		31		Female		Dead	
49. Frank Black		26		Male		Alive	
50. Helen White		33		Female		Dead	
51. George Brown		30		Male		Alive	
52. Mary Green		28		Female		Dead	
53. John White		25		Male		Alive	
54. Alice Black		32		Female		Dead	
55. Tom Gray		24		Male		Alive	
56. Betty White		35		Female		Dead	
57. Frank Black		27		Male		Alive	
58. Helen White		31		Female		Dead	
59. George Brown		29		Male		Alive	
60. Mary Green		26		Female		Dead	
61. John White		24		Male		Alive	
62. Alice Black		33		Female		Dead	
63. Tom Gray		22		Male		Alive	
64. Betty White		34		Female		Dead	
65. Frank Black		28		Male		Alive	
66. Helen White		32		Female		Dead	
67. George Brown		30		Male		Alive	
68. Mary Green		27		Female		Dead	
69. John White		25		Male		Alive	
70. Alice Black		34		Female		Dead	
71. Tom Gray		23		Male		Alive	
72. Betty White		31		Female		Dead	
73. Frank Black		26		Male		Alive	
74. Helen White		33		Female		Dead	
75. George Brown		30		Male		Alive	
76. Mary Green		28		Female		Dead	
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269. John White		25		Male		Alive	
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271. Tom Gray		24					

TABLE XII

COMPARATIVE TRIBAL AFFILIATION OF SAMPLE AND UNIVERSE OF
ALBUQUERQUE INDIAN SANATORIUM PATIENTS:
PERCENTAGE BY SEX

Number and classification	Sample			Universe		
	Male 23	Female 38	Total 61	Male 38	Female 58	Total 96
Percent Navaho	65	55	60	76	68	71
Percent Pueblo	35	37	36	24	28	26
Percent others	0	8	4	0	4	3
Totals	100	100	100	100	100	100

T. 211. XII

COMPARATIVE TABLE OF THE
ABORIGINAL INDIAN
POPULATION IN 1901

Number and Classification of Tribes									
Sex	Male	Female	Total	Male	Female	Total	Male	Female	Total
Number	10	10	20	10	10	20	10	10	20
Language	10	10	20	10	10	20	10	10	20
Religion	10	10	20	10	10	20	10	10	20
Profession	10	10	20	10	10	20	10	10	20
Education	10	10	20	10	10	20	10	10	20
Totals	100	100	200	100	100	200	100	100	200

100

TABLE XIII

PERCENTAGE OF DIFFERENCE
BETWEEN SAMPLE AND UNIVERSE

A		
Age	Male 3 years H	Female 3.5 years H
B Marital Status		
Percent married	2 H*	15 L*
Percent single	1 L	15 H
Percent widowed	4 H	1 L
Percent divorced	5 L	1 H

TABLE XIII
(continued)

C Religious Preference		
	Male	Female
Percent Catholic	6 H	9 H
Percent Protestant	7 H	5 H
Percent Pagan	13 L	14 L
D Tribal Affiliation		
Percent Navaho	11 L	13 L
Percent Pueblo	11 H	9 H
Percent others	0	4 H
E Sex		
	2 L	2 H

* H - Higher than the Universe
 * L - Lower than the Universe

C. Ball-Jones, Professor

Sale

Percent

Capital

Percent

Professors

Percent

Professors

D. Michael, Professor

Percent

Professors

Percent

Professors

Percent

Professors

Percent

Professors

2.5

E. - Higher Education

F. - Lower Education

Feb. 22-28, 1948

MENU CARD

ALBUQUERQUE INDIAN SANATORIUM

week

	BREAKFAST	DINNER	SUPPER
S.	bananas cornflakes toast & jam cocoa	baked ham w/pineapple glazed sweet potatoes green beans salad ice cream	soup potato salad cold sliced meat comb. salad cookies & apples
M.	grapejuice oatmeal scrambled eggs cocoa	roast beef & gravy mashed potatoes buttered peas salad apple crisp	fried eggs spanish rice comb. salad rice pudding
T.	stewed apricots dry cereal hotcakes syrup cocoa	stewed beef & noodles baked squash buttered cabbage salad cobbler	pinto beans fried bread hash brown potatoes shredded lettuce sliced onions oranges
W.	oranges hot cereal fried eggs toast cocoa	steak & gravy riced potatoes green beans hot rolls salad pie	baked turkey scalloped corn comb. salad fruit jello
T.	mixed fruit juice dry cereal hardboiled eggs toast cocoa	weiners sauerkraut scalloped potatoes salad chocolate cake	boston baked beans Boston brown bread fried cabbage comb. salad apricot tarts
F.	stewed prunes hot cereal hot biscuits cocoa	braised ribs barbecue sauce steamed potatoes buttered carrots pineapple up-side- down cake	salmon croquettes white sauce buttered peas comb. salad. pumpkin custard
S.	applesauce dry cereal fried eggs toast cocoa	beef stew w/veg. buttered cabbage carrot sticks cornbread apricot whip	fried bologna fried potatoes cabbage slaw sliced peaches

ALBUQUERQUE INDIAN SANATORIUM

BREAKFAST

DINNER

SUPPER

S.
chilled figs
rice flakes
boiled eggs
toast
cocoa

pork chops-gravy
oven brown potatoes
fresh green beans
cranberry sauce
salad
ice cream

pinto beans
fried potatoes
harvard beets
sliced onions
pie

M.
fruit juice
oatmeal
toast-butter
cocoa

stew w/veg.
buttered cabbage
steamed potatoes
corn muffins
salad
baked custard

hot hamburger sand-
wiches w/gravy
buttered rice
crisp green salad
plums

T.
cantaloupe
ralston
fried eggs
toast
cocoa

roast beef-gravy
riced potatoes
creamed corn
celery sticks
apricot whip w/
nuts

hash-gravy
left overs
sliced onions
cabbage slaw
grapes

W.
applesauce
branflakes
hotcakes
syrup-butter
cocoa

meat loaf-gravy
baked potatoes
buttered asparagus
salad
cobbler

fried eggs
creamed peas
comb. salad
raw turnips
peaches

T.
grapefruit juice
cream of wheat
French toast
jam
cocoa

roast pork-gravy
parsley potatoes
baked squash
cranberry sauce
apple crisp

pinto beans
fried potatoes
carrot sticks
roast chili
cantaloupe

F.
stewed raisins
pep
hot biscuits
jam
cocoa

mock chicken legs
country gravy
corn on cob
scalloped potatoes
salad
watermelon

clam chowder
cold sliced meat
creamed asparagus on
toast
shredded lettuce
oranges

S.
bananas
corn flakes
toast-jam
cocoa

roast mutton-gravy
oven fried potatoes
green beans
salad
whipped jello

fried eggs-bacon
harvard beets
comb. salad
apples

BREAKFAST	DINNER	SUPPER
8.	chilled fish rice flakes boiled eggs toast cocon	roast chicken oven broiled potatoes fresh green beans cranberry sauce sliced chicken apple ice cream
M.	fruit juice cottage toast-butter cocon	steak & veg. buttered cabbage steamed potatoes corn muffins sliced baked custard
T.	cranberry raisin fried eggs toast cocon	roast beef-gravy fried potatoes steamed corn celery sticks apple pie milk
W.	apple sauce bran flakes potatoes eggs-butter cocon	meat loaf-gravy baked potatoes buttered squash sliced cobbler
T.	egg-fruit juice cream of wheat French toast jam cocon	roast pork-gravy baked potatoes baked squash cranberry sauce apple crisp
F.	steamed raisins pep hot biscuits jam cocon	roast chicken legs country gravy corn on cob scalloped potatoes sliced watermelon
8.	bananas corn flakes toast-jam cocon	roast mutton-gravy oven broiled potatoes green beans sliced apple whipped jelly

Week 12/5-11, 1948

MENU CARD

ALBUQUERQUE INDIAN SANATORIUM

	BREAKFAST	DINNER	SUPPER
S.	oranges cream of wheat toast jam cocoa	roast pork-gravy glazed sweet potatoes buttered broccoli salad cranberry sauce pie	pinto beans green chili bacon-buttered macaroni green salad apples
M.	chilled fruit juice bran flakes fried eggs toast cocoa	braised mutton-gravy oven brown potatoes buttered beets salad rice pudding	pasole buttered peas carrot salad grapes
T.	apricots ralston syrup cocoa hot cakes	roast beef-gravy steamed rice buttered asparagus salad cobbler	sliced bologna-mustard baked potatoes fruit salad carrot sticks apricot tarts
W.	tomato juice krumbles fried eggs toast cocoa	roast beef & gravy mashed potatoes fresh spinach salad apple crisp	pinto beans fried potatoes fried bread sliced onions chopped lettuce plums
T.	stewed prunes cracked corn scrambled eggs toast cocoa	braised mutton-gravy candied sweet pota- toes green beans salad jelly roll	sliced beef fried hominy celery sticks cookies
F.	mixed fruit juice oatmeal fried eggs toast cocoa	braised ribs-gravy oven brown potatoes boiled cabbage salad tapioca pudding	cheese sandwiches steamed rice-gravy sliced pickles chilled tomatoes bananas
S.	oranges cornmeal mush jam toast cocoa	meat loaf-gravy pinto beans buttered macaroni sliced tomatoes canned plums	boiled eggs fried potatoes peanut butter-jelly comb. salad apples

Breakfast		Dinner		Supper	
Oranges		Roast pork & apples		Roast pork & apples	
Cracked corn		Gravy		Gravy	
Hot cakes		Buttered bread		Buttered bread	
Apples		Apples		Apples	
Cocoa		Cocoa		Cocoa	
M.		T.		W.	
Chilled fruit juice		Roast pork & apples		Roast pork & apples	
Brain flakes		Gravy		Gravy	
Fried eggs		Buttered bread		Buttered bread	
Toast		Apples		Apples	
Cocoa		Cocoa		Cocoa	
T.		W.		T.	
Apples		Roast pork & apples		Roast pork & apples	
Refined		Gravy		Gravy	
Syrup		Buttered bread		Buttered bread	
Cocoa		Apples		Apples	
Hot cakes		Cocoa		Cocoa	
W.		T.		F.	
Tomato juice		Roast pork & apples		Roast pork & apples	
Krumpholtz		Gravy		Gravy	
Fried eggs		Buttered bread		Buttered bread	
Toast		Apples		Apples	
Cocoa		Cocoa		Cocoa	
T.		F.		S.	
Steamed prunes		Roast pork & apples		Roast pork & apples	
Cracked corn		Gravy		Gravy	
Assembled eggs		Buttered bread		Buttered bread	
Toast		Apples		Apples	
Cocoa		Cocoa		Cocoa	
F.		S.		S.	
Mixed fruit juice		Roast pork & apples		Roast pork & apples	
Oranges		Gravy		Gravy	
Fried eggs		Buttered bread		Buttered bread	
Toast		Apples		Apples	
Cocoa		Cocoa		Cocoa	
S.		S.		S.	
Oranges		Roast pork & apples		Roast pork & apples	
Cornmeal mush		Gravy		Gravy	
Apples		Buttered bread		Buttered bread	
Toast		Apples		Apples	
Cocoa		Cocoa		Cocoa	

MENU CARD

Week June 19-29, 1949

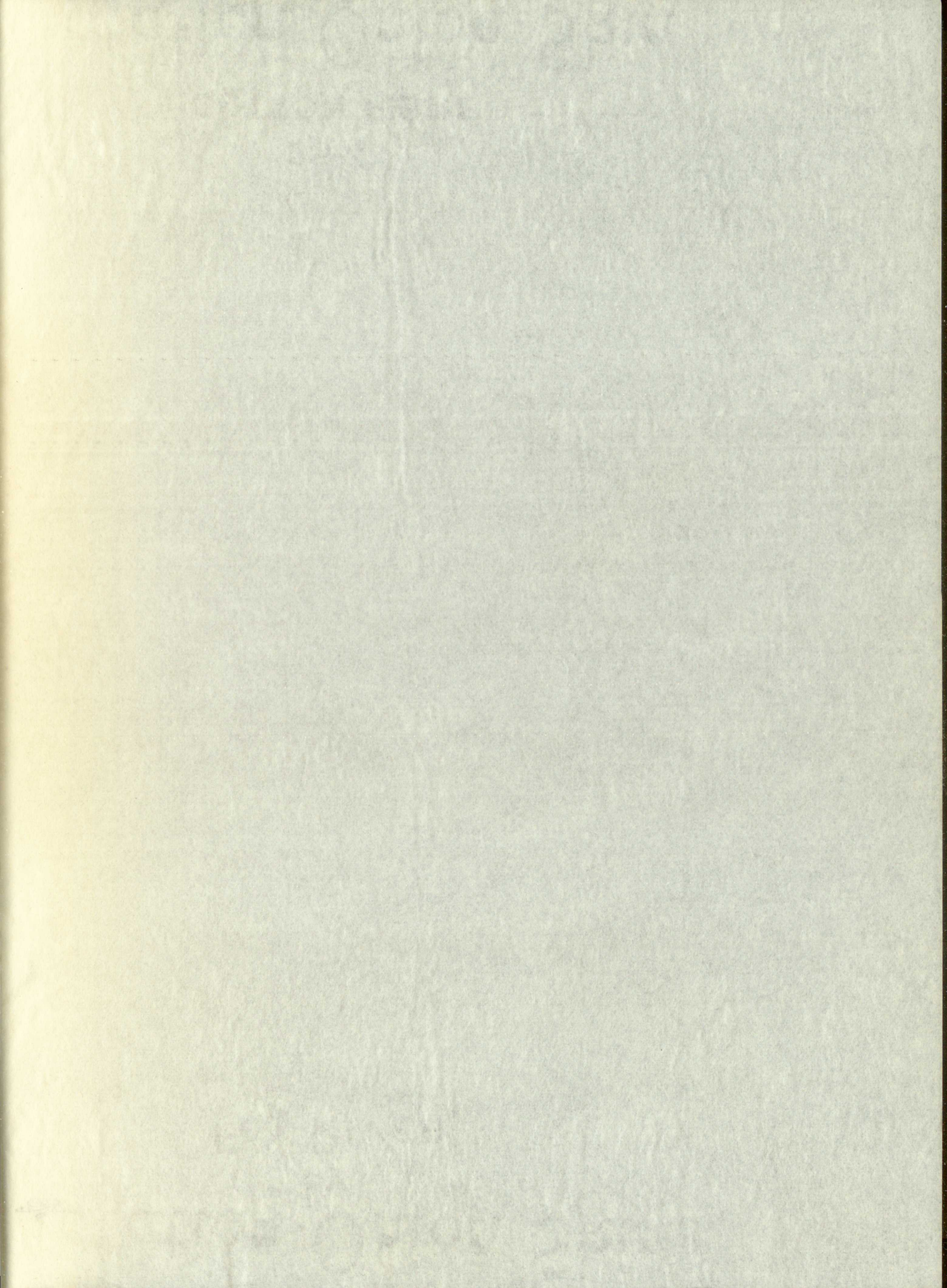
ALBUQUERQUE INDIAN SANATORIUM

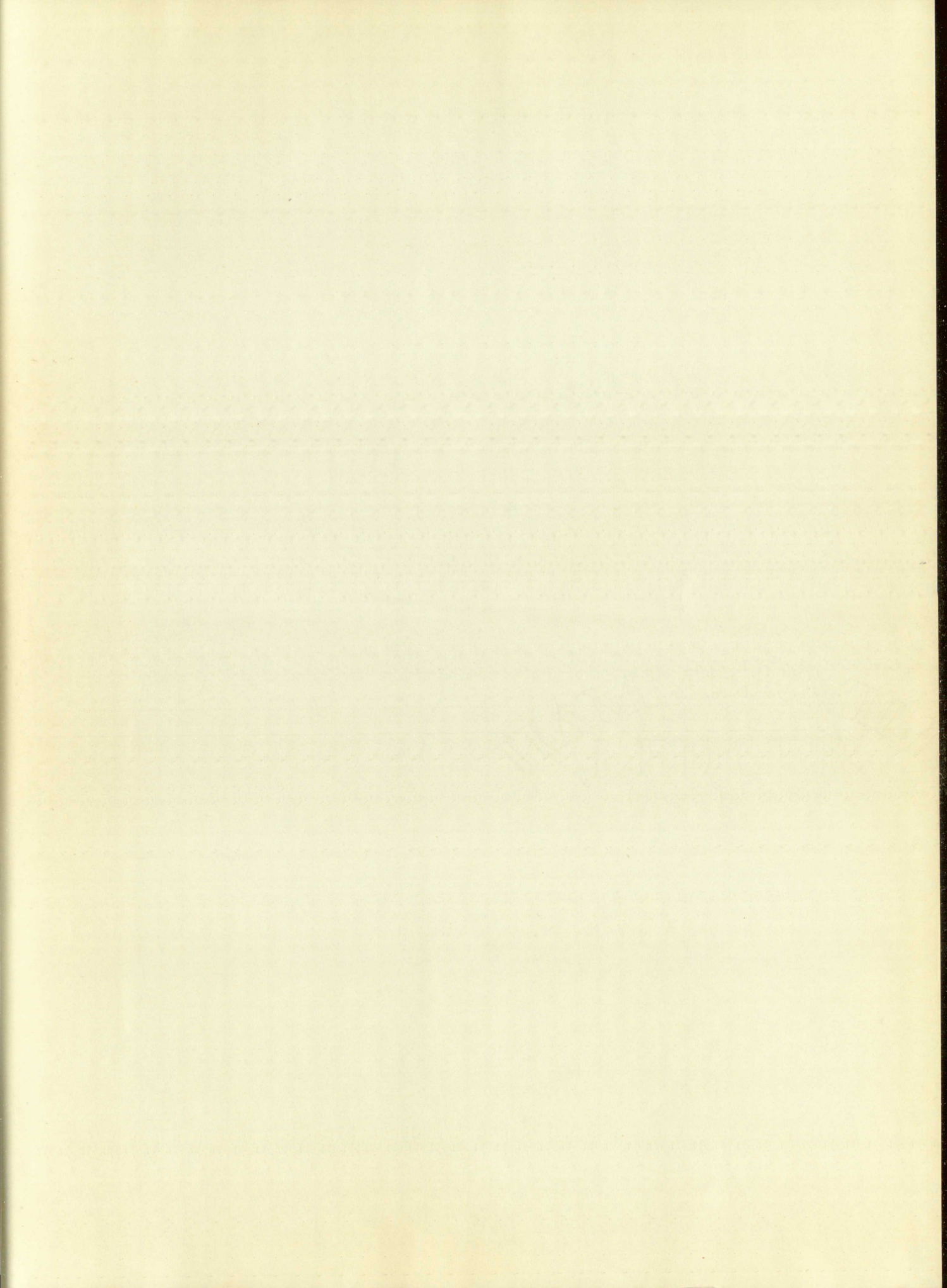
	BREAKFAST	DINNER	SUPPER
S.	bananas cornflakes toast jam & butter cocoa	fresh pork steaks candied yams buttered cauliflower ice cream-cookies	pinto beans potato salad cabbage & carrot salad sliced pickles apples
M.	fruit juice dry cereal boiled eggs toast cocoa	roast mutton-gravy ovenbrown potatoes buttered corn fried onions pie	macaroni & cheese buttered spinach creamed peas salad peanut butter cookies
T.	chilled prunes oatmeal toast blackberry jam cocoa	braised beef-gravy steamed potatoes broccoli spice cake	lima beans fried potatoes sliced onions green salad pears
W.	tomato juice krumbles fried eggs toast cocoa	weiners-sliced onions scalloped potato baked squash pudding	potato soup-crackers grilled sandwiches (cheese) fried hominy celery sticks oranges
T.	stewed apricots hot cereal scrambled eggs toast cocoa	pork chops-gravy riced potatoes boiled cabbage pumpkin pie	veg. stew yellow chili steamed rice shredded lettuce apples
F.	fruit juice dry cereal fried eggs toast cocoa	roast mutton-gravy baked potatoes buttered beets gingerbread	hash creamed corn buttered carrots salad fruit cup
S.	bananas cream of wheat hot cakes-syrup cocoa	beef stew steamed potatoes green salad cobbler	pinto beans fried potatoes apple & celery salad peaches

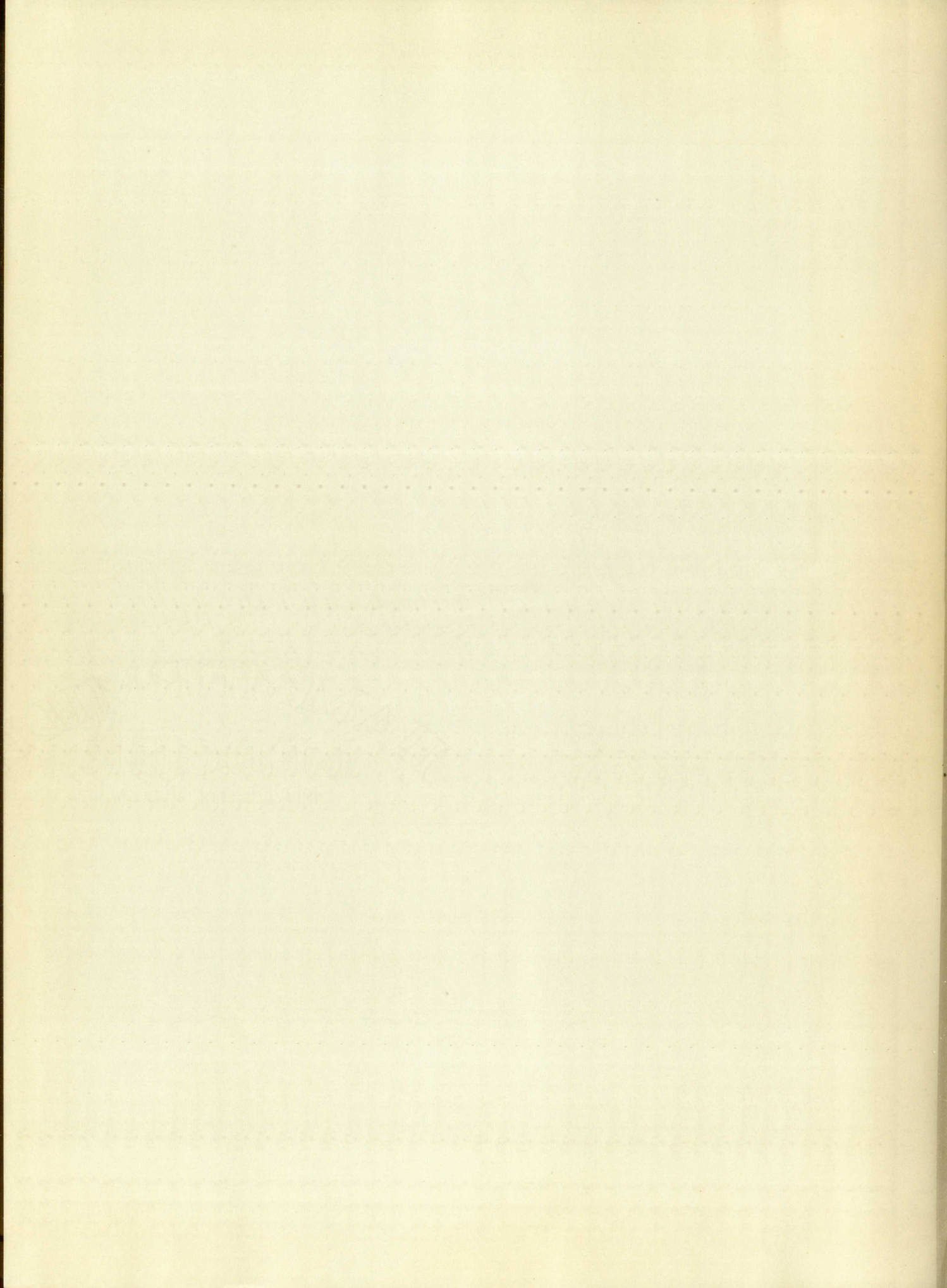
BREAKFAST

- 8. Bananas
cereal
toast
jam & butter
cocoa
- W. Fruit juice
dry cereal
boiled eggs
toast
cocoa
- T. Chilled tomatoes
cereal
toast
hot chocolate
cocoa
- W. Tomato juice
boiled eggs
toast
cocoa
- T. Stewed apples
hot cereal
boiled eggs
toast
cocoa
- F. Fruit juice
dry cereal
fried eggs
toast
cocoa
- 8. Bananas
cereal
hot cakes-syrup
cocoa









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must be paid for at the current rate of typing.

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