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

By

Mary Van Franklin

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E. A. Castetter

DEAN

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BY

Mary Van Franklin

Thesis committee

Minnie Jacquint Miller

CHAIRMAN

Walter J. Keston

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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 occurence 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

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[1]Roger 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 Navahos[2] 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

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

[3]There 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.

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 hypothecated 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

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[4]Based on the Dictionary of Sociology definition of adjustment.

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

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."

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[6] Ibid., 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 fellowman. 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-

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

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

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

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

[4]Ibid., 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.

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

[6]Loc. 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

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

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 Kendal 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]

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[8] Loc. cit.

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

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

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.

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 marginal[10] 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

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

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

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

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

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

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

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[12] Ibid., p. 106.

cases.

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

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.

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[13]George A. Lundberg, Social Research (New York: Longmans, Green and Company, 1948), 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 sub groups 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

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.

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

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 tendering 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

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 housekeeping 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

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 advise 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.

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[1]See Appendix for tables.

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

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:

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

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:

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[3]Note menus presented in the Appendix.

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."

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.

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[4]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."

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[5]At 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:

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 theywould 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

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

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 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,

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

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

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[7] Ibid., p. 129.

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

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

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:

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[8] Ibid., 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 Burhoe[10] 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

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[9] Ibid., p. 139.

[10] Ibid., p. 146.

patients. It used to be thought that so-called diversional activities such as occupational therapy and recreation[11] 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

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

speak, read, and write 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

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

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

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.

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

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 progfam, 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

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.

BIBLIOGRAPHY

BIBLIOGRAPHY

A. BOOKS

Barker, Roger G., 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.

Bernard, L. L., editor, The Fields and Methods of Sociology. New York: Ray Long and Richard R. Smith, Inc., 1934.

Bingham, Walter Van Dyke, and Bruce Victor Moore, How To Interview. New York: Harper and Brothers Publishers, 1941.

Cooledge, Dane, and Mary Roberts Coolidge, The Navajo Indians. Cambridge, Massachusetts: The Riverside Press, Houghton-Mifflin Company, 1930.

Fry, C. Luther, The Technique of Social Investigation. New York: Harper and Brothers, 1934.

Linton, Ralph, Acculturation in Seven American Indian Tribes. New York: D. Appleton-Century Company, Incorporated, 1940.

Lundberg, George A., Social Research. New York: Longmans, Green and Company, 1948.

Macgregor, Frances Cooke, Twentieth Century Indians. New York: G. P. Putnam's Sons, 1941.

Young, Pauline V., Interviewing in Social Work. New York: McGraw-Hill Book Company, Inc., 1935.

Young, Pauline V., Scientific Social Surveys and Research. New York: Prentice-Hall, Inc., 1939.

B. PERIODICAL ARTICLES

Bogardus, E. S., "Personal Experience and Social Research," Journal of Applied Sociology, Vol. VIII, 1923-24.

Buell, B., "Interviews, Interviewers, Interviewing," Family, Vol. VI, 1924-26.

Burgess, E. W., "What Social Case Records Should Contain To Be Useful for Social Interpretation," Social Forces, Vol. VI, 1925.

Cavan, Ruth Shonle, "Interviewing for Life History Material," American Journal of Sociology, Vol. 35, July-May, 1929-30.

Hallowell, A. Irving, "Anthropology and the Social Worker's Perspective," Family, Vol. 5-6.

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

Myrick, Helen L., "Psychological Processes in Interviewing," Family, Vol. VII, 1926.

Queen, S. A., "Social Interaction in the Interview," Social Forces, Vol. VI, 1928.

C. GOVERNMENT BULLETINS

U. S. Commissioner of Indian Affairs, Statistical Supplemental Report for 1939.

_____, Statistical Supplemental Report for 1944.

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 II

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

Number and Classification	1939			1949		
Sex	Male	Female	Total	Male	Female	Total
Number	94	93	187	63	160	223
Percent Married	9	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 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

TABLE IV

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

Number and classification	1939			1949		
Sex	Male	Female	Total	Male	Female	Total
Number	94	93	187	63	160	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 V

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

Number and classification	1939			1949		
Sex	Male	Female	Total	Male	Female	Total
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

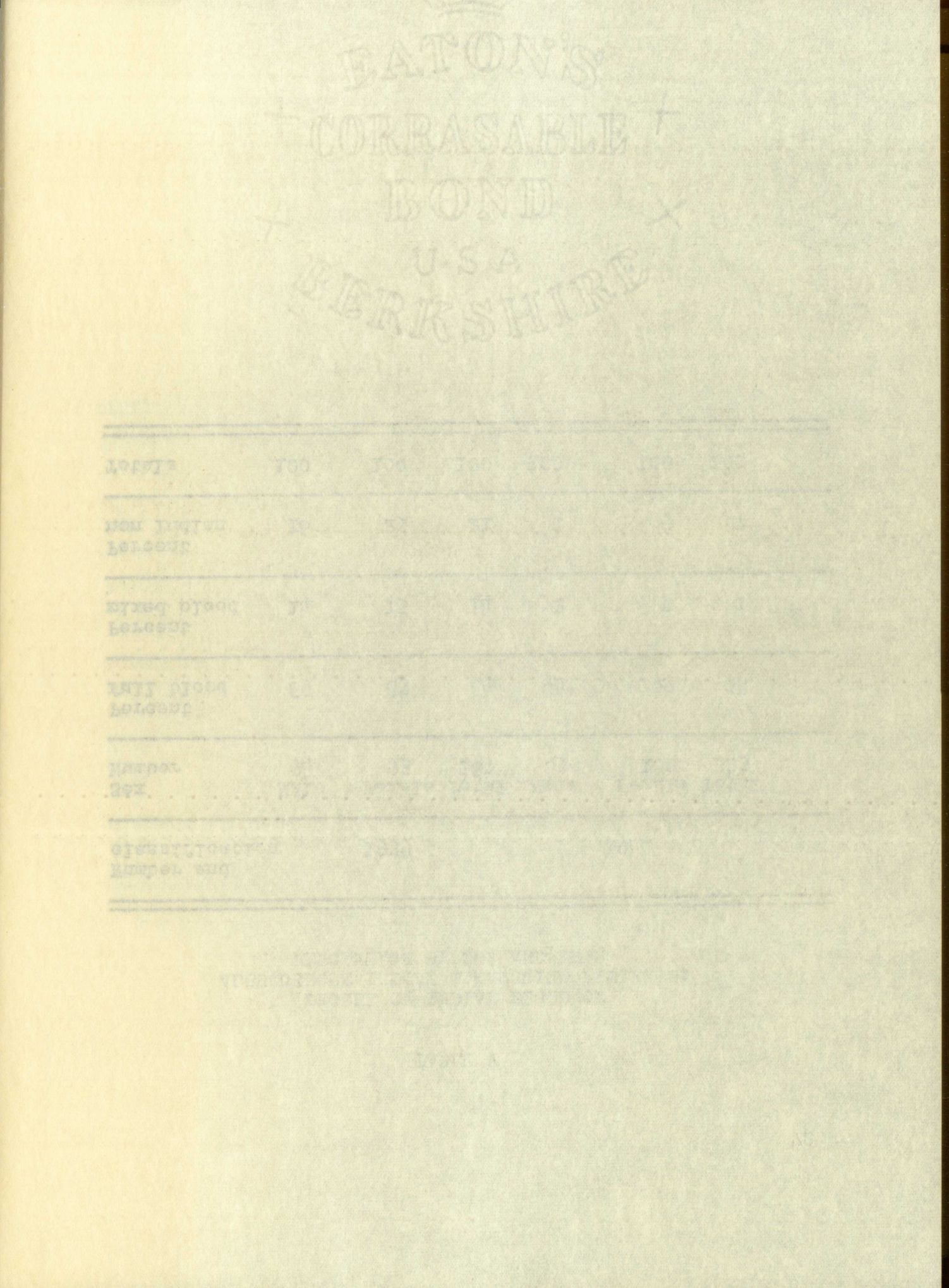
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TABLE VI

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

Number and type of discharge	1939			1949		
Sex Number	Male 84	Female 85	Total 169	Male 25	Female 101	Total 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 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	Male	Female	Male	Female
Number	84	85	25	101
Average daily length of stay before discharge with medical advice	960	876	526	294
Average daily length of stay before discharge against medical advice	338	452	261	218
Average daily length of stay before death	328	871	362	58

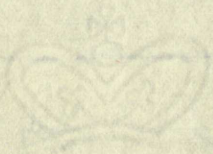

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TABLE VIII

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

Number and classification	Sample		Universe	
Sex	Male	Female	Male	Female
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	Male	Female	Male	Female
Number	61		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 X

COMPARATIVE MARITAL STATUS OF NEGRO AND WHITE CO-EDS
AT SOUTHERN UNIVERSITY, AGRICULTURAL
AND MECHANICAL COLLEGE

Number and classification	Sample			Universe	
Sex . . . . . Male . Female . Total . Male . Female . Total					
Number	63	36	61	36	36
Persons married	26	29	27	36	36
Persons single	65	63	66	56	55
Persons widowed	9	3	5	4	5
Percent divorced	0	5	4	5	4
Totals	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	Male	Female	Total	Male	Female	Total
Number	23	38	61	38	58	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 XII

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

Number and classification	Sample			Universe		
Sex	Male	Female	Total	Male	Female	Total
Number	23	38	61	38	58	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

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

Feb. 22-28,1948 MENU CARD

eek ALBUQUERQUE INDIAN SANATORIUM

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

Week Sept.12-18,1948 MENU CARD

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

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 potatoes 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
orange		
cream of wheat		
S. toast		
jam		
cocoa		
chilled fruit juice		
bran flakes		
M. fried eggs		
toast		
cocoa		
apricots		
rations		
syrup		
T. cocoa		
hot cakes		
tomato juice		
krumbles		
fried eggs		
W. toast		
cocoa		
stewed prunes		
cracked corn		
T. scrambled eggs		
toast		
cocoa		
mixed fruit juice		
oatmeal		
F. fried eggs		
toast		
cocoa		
orange		
cornmeal mush		
S. jam		
toast		
cocoa		

MENU CARD

Week June 19-29, 1949 — ALBUQUERQUE INDIAN SANATORIUM

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


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