The Behavioral Scientist in Public Health

During the past two decades a good many sociologists, anthropologists, and social psychologists have worked with departments of public health. Most of these have been on special projects. In the last 5 years several regular staff positions for behavioral scientists have been created within State health departments in California, Maryland, New York, and Pennsylvania and in large city health departments, such as those in Philadelphia and New York City.

The symposium reported here provides some facts about behavioral science in the Pennsylvania Department of Health and some discussion of the present and possible uses of behavioral science in public health. It was organized by Dr. Thomas McCorkle of the division of behavioral science, Pennsylvania Department of Health, and presented during Pennsylvania's annual health conference held at University Park, August 20–23, 1962.

Presented in brief, the series includes a description of Pennsylvania's behavioral science service, comments written by two physicians and a sociologist, and summaries of two field studies that illustrate the factfinding function as handled by an anthropologist and a sociologist.

A Behavioral Science Service

THOMAS MCCORKLE, PH.D.

brief To help health personnel deal with public apathy and the social and behavioral phenomena that hamper execution of public health programs, the Pennsylvania Department of Health in 1960 employed an anthropologist and a psychologist. With the assistance of a conference called for the purpose, it was determined that the behavioral scientists should function in research; participate in planning, training, and evaluation; and perform services related to the analysis and improvement of existing health programs. Early in 1961 the two new specialists were assigned to the office of the chief health officer, and in April 1962 a new division of behavioral science was established.

The behavioral scientists approached the task of forming the new unit bearing the assumptions that most public health activities are constructive and therefore it is legitimate to offer assistance toward their objectives; that some health officers will be willing to change approaches and methods and may also be willing to modify objectives; and that behavioral scientists are employed mainly to deal with groups of persons and only to a lesser extent with disease entities. Those employed within the new division consciously have shaped it to conform, so far as possible, with preexisting patterns of action in the health department.

To date the division most frequently has undertaken problem-oriented projects in cooperation with other units of the department. Projects have been initiated either by the behavioral scientists or by directors of other units. Problems are deemed suitable for division attention when they are a source of concern to any unit director and also present aspects susceptible to sociological, psychological, or anthropological approach.

In addition to problem solving, the unit is alert to undesirable psychosocial or cultural side effects in programs and is responsible for assembling systematic and reliable information about significant populations in the State—those populations large in numbers or presenting significant public health problems. Some specific activities of the new division have been these.

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1. Research into factors contributing to the loss by popular referendum of a county health department.

2. Setting up contracts for university-based studies of health behavior and felt needs in a rural vicinity and in a lower-class suburban population.

3. Delivering lectures before public audiences or as parts of educational programs arranged by other department units on such topics as cultural contexts conducive to problem drinking.

4. Developing a short course designed to help beginning sanitarians to locate those community leaders and groups that enter into decisions affecting environmental sanitation.

5. Providing consultation, and sometimes performing research, on such subjects as community organization, current social science knowledge about fluoridation controversies, beliefs and practices surrounding pregnancy and childbirth, maintenance of membership in voluntary organizations, and methods for evaluating a program in community sanitation.

The new unit is a behavioral science service rather than a division of research. With enlarged staff, this unit probably will become more active in research design and in continuing study of the sociocultural characteristics and thought and action patterns of several representative Pennsylvania populations.

Integrating the Behaviorist

William Steiger, M.D.

brief The behavioral scientist is needed in public health because health personnel, in general, have not been trained to deal with the irrational. However much the health professions would like to motivate persons to seek health care by means of logic and scientific evidence, the elements of fear, hatred, prejudice, and group mores in many of today's public health problems do not yield to logical arguments. The fluoridation controversy is an outstanding example of this.

Their lack of training in the irrational may also cause the biologically trained—physicians and nurses—to be wary of the sociologically and psychologically trained. This wariness can result in the isolation of the behavioral scientist minority within a health organization. If the behavioral scientists are to function effectively, the agency's leader has an obligation to treat them as insiders and partners. He also has a duty to protect them from inordinate demands and miraculous expectations. Setting up some order of priority in the problems assigned to the behaviorists is required so that they are not forced to resort to off-the-cuff generalizations which can have only limited validity for particular situations.

Friction may arise in an agency because of the differences in training and performance required of the behaviorist and the physician. The behaviorist's forte is method, but the physician relies on a fund of factual knowledge. The Ph.D. is accustomed to time for a survey of the literature, consultation with experts, and dry runs before taking action. The M.D. must often act quickly on the basis of a few facts and a degree of intuition. The physician and the nurse may become impatient with the behaviorist, wanting him to act quickly; the behaviorist may be shocked at the assuredness of the physician's acts which may appear to be based on an unscientific mixture of facts and hunch.

Also, behaviorists, aside from those specializing in psychotherapy, are often not trained in the clinical setting. They are not service oriented and at times they have difficulty appreciating the service orientation of medicine.

In fitting behaviorists into the organizational structure, it should be remembered that the physician is the product of a relatively authoritarian setting while the behaviorist is trained in a highly democratic one. He relies on self-discipline and self-motivation; he is accustomed to expressing dissenting views freely, and his adjustment to a more rigidly structured work situation is not always easy. He expects, as a professional, that he will work without tight supervision, and he can create a problem for the administrator accustomed to measuring work by the number of hours, visits, or cases. As an administrator, supervising other behaviorists, he measures performance in such terms as depth and breadth of vision, creativity, initiative, logic of thought, and cleanliness of method.

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Integration of the biological and behavioral sciences in health will continue to grow. Some differences will blur in time, as they already have between psychiatry and psychology, social work and public health nursing. The integration of both kinds of scientists is required in order to focus all available skills and knowledge on the public's health.

Uses of the Behavioral Sciences

WILLIAM J. MEYER, M.D.

brief The basic dilemma of public health today is not lack of budgetary support, not the gaining of popular understanding of its services, not the recruiting of adequate staff, or even the difficulty of motivating people to develop better health habits. The fundamental need is to discover the rightful place of public health in the ecology of man and to put public health in that place so that its contribution to the relationship between mankind and society is constructive.

Recently public health has expanded its horizon to include most of the factors of social interaction that determine how completely man can realize his full potental for living. Within its sphere of action are many mental, social, and economic aspects of health and disease formerly thought to lie in other fields. Professional public health workers believe the change is fitting, that community efforts to create and maintain positive health must evolve within the total framework of the social structure.

However, many health workers fail to recognize that man is evolving a social structure less and less capable of satisfying his basic needs; in the stresses of everyday living many individuals find it impossible to obtain basic human satisfaction, and it is this maladjustment that interferes significantly with the health of the public. Public health, with its accelerating catholicity of interests, can be among the leaders in helping man to rectify this situation.

At present, one might easily argue that public health has been adding its moiety to the forces responsible for the maladjustment of man. Many public health workers are convinced that health in its physical, mental, social, and economic components is of paramount importance. They conclude that what improves the health of the public must be in the direction of the ultimate good, no matter what the cost in any currency to the individual and the social structure. Some ask why the public does not devour the services offered or grow suspicious that appropriating authorities are venal and lacking in understanding because they fail to give budgetary support to public health activities. Many fail to see that health is not of overriding importance to man; he proves it daily by putting his joys above his needs.

Recently there have been glimmerings of a change in the thinking of public health workers. If the glimmerings become a trend, perhaps public health can regain its leadership either by helping to make the social environment more responsive to man's needs or by helping man to adapt more fully to it. To do this requires that public health workers become professional rather than amateur students of mankind.

The best tutors in this field are the behavioral scientists. But if they are to assist public health in aiding man, their role must be to serve the public, not public health.

How can behavioral scientists help in the field of public health? First, they should remain behavioral scientists, retaining their objectivity. Second, they must continue their studies of man as a social being and determine the proper place of health in the broadest meaning of that word in society. Third, they can show the health worker how to offer services that are tailored to meet needs and how to present them in a way acceptable to the public, including in the health worker's education the ability to help the consumer relate the health program to his ultimate, personal well-being. Fourth, the behavioral scientist can show the public health worker, functioning within the confines of his discipline, how to relate his thinking to man's total needs in all areas of living.

From his viewpoint, the behavioral scientist

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divides the dilemma of public health into two component parts: first, to establish a public health program aimed at helping man to realize his various potentials rather than satisfying some stereotyped professional concepts, and second, to orient the individual to his own best interests, to relate these interests to a comprehensive well-thought-out health program, and to persuade him to participate actively in obtaining the benefits to be derived from such a program.

To accomplish this, two things must be done. The first is the common practice of identifying population groups and changing their motivation regarding health and other problems of living. The second is to orient public health workers to the real needs of the public so thoroughly that the worker will not substitute his own attitude, with its overemphasis on traditional health concepts, for the more comprehensive one which will contribute most to the ecological health of man. The motivation of the public health worker must be changed as well as the public's.

Only when the motivations of the two groups complement each other can a public health program be built that makes sense to the man on the street. He will then become the partner, instead of the subject, in public health.

Social Scientist's Viewpoint

PETER K. NEW, PH.D.

brief As more social scientists work in the area of health, it is possible that points of view regarding the means by which social scientists work and the goals they wish to achieve may conflict with those of health practitioners.

Social scientists are often accused of doing research on the obvious. However, in doing so, they are able to place a very different perspective on some of the issues that society, represented by the public, is not aware of analytically. Social scientists hope to frame proper questions to elicit responses which might be used in the most efficient manner to attain certain desired goals. It is only through the practice of raising seemingly naive "points of order" and questioning the most obvious that a different perspective may be gained.

In the public health field, for example, we may know some of the reasons persons like to smoke; yet, when confronted with the fact that smoking may induce certain types of lung cancers, why do people continue to smoke or ignore all the evidence in spite of the information purposely directed at the public? In seeking answers to this question, the social scientist hopes to discover important basic issues underlying the effectiveness of information giving, attitude changes, communication problems, interaction principles—complex issues compared with age, sex, height, or weight.

Social scientists seek to generalize from certain pieces of information, sometimes much to the discomfort of many health workers or "pure" scientists. In generalizing, one loses a certain amount of information. In the older sciences, particularizing is important, if the sources of information are exact and precise. However, particulars lose their significance if we are not able to derive other uses from specific items of information.

It would be of limited value to present findings which could be used only in a particular locale or applied to a specific situation. The social scientist attempts to construct "models" in order to apply certain theories learned from one situation to other situations. Thus, a model of a hierarchically structured, single-line authority organization may be applied to the analysis of an army, a civil service organization, or even a nursing station. These models allow a certain amount of comparability. At the same time, they permit the investigator to discover possible deviances, which are indicative of certain "ills," and to understand the variations of each situation, some with real, or manifest, content and others which may be masked, or have latent meanings.

In developing models for research resulting in findings, social scientists take a certain amount of time in rumination and reflection to work through the maze. To persons not acquainted with the seemingly endless time it takes the social scientist to get to the point, this may

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be frustrating. The time lag between question and answer may necessarily have to be short for the service-oriented practitioner, whose keynote is immediacy, whereas for the research-oriented person, this process is long, since reflection is important. There may be another difference. The social scientist looks for some principles, however elusive these might be. Because of his training, he is imbued with the attitude that all avenues must be tried before he is satisfied with an answer, much less the answer. This takes an inordinate amount of time in most instances.

When a situation does arise that requires close coordination between the social scientist and a health practitioner on a particular topic, the immediacy in problem solving and the long range in research findings may clash. The social scientist may be frustrated if he is not given adequate time to develop his ideas thoroughly. In addition to being aware of the exigencies of the situation, a competent social scientist is also cognizant of the fact that unless basic principles are discovered which could be used again, the study and its findings may be limited.

Social scientists working in the field of health should realize their obligations to the health workers, even though the behaviorists see the whole area of health as providing a "laboratory milieu" in which to test various hypotheses and ideas. The social scientist no longer can afford the luxury of hiding behind the veil of scientism, not making any pronouncements; he must enter the real world. He is under some obligation not only to translate his findings but also to make recommendations. However, he should not be urged to go to extremes lest he lose his usefulness in becoming a totally action person.

At the same time, a public health practitioner is also under some obligation to understand that there are some basic issues at hand which take a long time to uncover. He needs to reflect on some of these issues and allow his imagination to soar beyond the immediate. Because health needs are changing rapidly, there is a necessity to understand the basic principles, which should be questioned constantly and modified in the light of new knowledge.

To summarize, social scientists bring with them certain perspectives with which they are able to question the obvious in order to reach possible new solutions. In doing so, the types of data and information which are gathered should be comparable so that we may at once discover deviances as well as deviations, both clues to the health and illness of the society. The material which social scientists must gather to answer these questions may take some time; nevertheless, they do attempt to seek basic principles. Finally, the social scientist is under some obligation to make recommendations in the health field, and the health worker may also be obliged to reflect on the long-range consequences of research and studies in the use and development of behavioral science materials in the field of public health.

Community-Migrant Relationship

ERNEST M. G. KUHINKA, PH.D.

brief A sociological study of community-migrant relationship sought to analyze the attitudes and reactions of residents of Franklin County, Pa., toward seasonal migrant workers.

In this investigation, certain social features common to what has been called "community" were selected. A community is said to exist when interaction between individuals has the purpose of meeting individual needs and obtaining common goals. In all societies physical, psychological, and social needs are met through the creation of social systems. Individual members of the population group have a sense of identification with one another and act together to solve common problems.

Within this frame of reference Franklin County was understood as a community where individuals feel that they belong and where these feelings are emphasized at the moment when a foreign element is introduced into the area. The foreign element in this case was seasonal migrant farm workers.

Desired information was collected by inter-

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views using questionnaires. The interviews were conducted with growers, local citizens such as clergymen and newspaper reporters, and local and county officials. A total of 181 persons were contacted.

The findings concerning community attitudes toward the migrant showed that the influence of the migrant upon the community has remained about the same during the last several years. Mechanization and permanent settlement of migrants did not change local ideas about the labor relationship, but many respondents implied that the services offered to the migrants had improved slightly.

The majority of community respondents thought of the migrants as a labor force only; a minority felt a need for more interest in increased assistance to migrants. Large numbers of the respondents offered some guesses about government policy and responsibility but seldom could they define codes, available services, and financial assistance.

Among the community attitudes expressed was a desire for stronger police control in order to eliminate excessive drinking, physical assault, and other deviant behavior patterns of the migrants. However, the majority of community members believed that every citizen, migrant or local resident, should have the same privileges and duties.

Of the subgroups (growers, local citizens, local officials, and county officials) the local citizens were the most consistent supporters of the idea of improving the status of the seasonal migrant laborer. It appears that State agencies have provided ample facilities and opportunities to improve the status of the migrant workers via the many services offered, but the final results can be only as effective as the willingness of the local community to allow or to participate in action.

Proper understanding of the community-migrant relationship is a dual problem, and knowing both aspects would greatly facilitate bringing the two groups together under a common aegis. It is probable that community-migrant relationships will never reach the summit of ideal democratic living, but there is no reason to believe that the citizens of the county studied lack interest in the problems of the migrant.

Cultural Patterns in a Rural Area

LOUISE E. SWEET, PH.D.

brief Describing the culture and health behavior of the people of a rural locality in western Pennsylvania was an assignment attacked through techniques developed by anthropologists. Emphasis was placed on customary ways of meeting such health problems as sanitation, sickness, and accidents. Attention was also to be given to the possible roles of several former nurses in this locality.

As a resident for 2 years in the locality, I enjoyed the advantage of entree and rapport with a number of households on a friendly and informal basis, and I was aware of the general features of the locality. Since the people of this vicinity understood and appreciated historical studies and since the population included a number of four-generation family lines and a number of elderly people, I took advantage of the change-over-time perspective that this stable core of local residents permitted. It formed the basis of all interviews.

I gathered data through standard ethnographic procedures. I observed family and social activities—farm and housework, club and church meetings, weddings, showers, a farm auction, shopping trips, and visiting. I took notes or simply listened through long casual conversations, sometimes asking planned questions with an outline of topics in hand. Visits to households were repeated, especially to those most productive of information or with past or present health problems.

Since farming is the dominant economic activity in this locale, the geographic features of the area were noted, and the settlement pattern and scale of farming operations were investigated and compared roughly with neighboring locales. Comparable data throughout the vicinity on farm and household equipment and furnishing, family composition and occupation, and family experience over time with problems of sickness, accident, and childbirth were recorded. I kept a brief diary during the summer months; how the families met various ad-

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versities from the failure of the early hay crop owing to drought to several cases of illness or accident. A glossary of the local vocabulary and dialect was collected, and these items contributed to evaluation of the conservative and deep-rooted character of the core families of the vicinity. Genealogies of several families were taken down and the whereabouts of kinsmen ascertained.

Marriages in these families emphasized the intense localization of the neighborhood in its interwoven kinship ties. The autobiographical accounts revealed the narrow range of educational and occupational experience of those who have remained within the vicinity. The conversations during the many social gatherings and the repetition at each meeting of the same topical patterns further brought out the day-to-day concerns and the intellectual levels of interest of the community as well as the modes of circulating locally relevant news and information. The health of one's neighbors, on whom one depends, is a continuing topic of interest, and concern focuses upon the course of treatment. The ways and extent to which the two or three nurses retired by marriage functioned in the community were observed.

The findings of this study belied initial impressions. A vicinity that at first seemed relatively homogeneous and stable proved to have considerable heterogeneity, breakdown, and deculturation. There is a rather marked line between rural households that have been able to adapt to the economic and technological changes that have taken place over the past quarter century and those that are for various reasons falling behind. In respect to sickness and chronic disability, the nonadaptable households are faced with the withdrawal of medical services from nearby villages to towns and urban centers and with the difficulties of transportation, fixed appointment schedules of medical practitioners, and the costs of treatment or care. The significance of the few women with professional training and experience in nursing seems rather negligible, and the availability for general help and home care of invalids of two or three widows, women who might once have functioned in roles approximating that of midwives, has been far more relevant to local custom and need.

Uniform Accounting by Voluntary Agencies

Uniform accounting and reporting of income and expenditures by voluntary health and welfare agencies is the goal of a 3-year project of the National Health Council and the National Social Welfare Assembly. The membership of the two organizations comprises most of the major national voluntary agencies in the United States.

The National Health Council has developed a guide, "Accounting and Financial Reporting Procedures for Voluntary Health Agencies," which was published in November 1962. The guide establishes classifications for reporting income and expenditures. A major recommendation of the guide is consolidated reporting by national offices and their State and local affiliates. In the past, national, State, and local units generally made separate reports to the public. The guide also includes basic reporting and accounting forms.

The National Health Council is enlisting the participation of appropriate member agencies in putting the recommended procedures into operation.

The National Social Welfare Assembly is developing accounting and reporting procedures for voluntary social welfare agencies. The work is closely coordinated with that of the National Health Council.

The joint project is being financed by member agencies, the Rockefeller Foundation, and the Avalon Foundation.

The council and assembly have urged municipal and State regulatory bodies and legislators to become familiar with the project, particularly the recommended procedures. Regulatory bodies are increasingly active in matters relating to control of organizations that solicit funds from the public for health and welfare purposes. The council and assembly feel that uniform procedures established on a national basis can contribute greatly to the simplification of any future reporting regulations.

Copies of the guide to accounting and reporting procedures are available at $4.75 each from the National Health Council, 1790 Broadway, New York 19, N.Y.