1968

A Comparative Analysis of the Social Components of Illness of Second Generation Japanese-Americans and Mexican-Americans in the Chicago Area

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A COMPARATIVE ANALYSIS OF THE SOCIAL COMPONENTS OF ILLNESS OF SECOND GENERATION JAPANESE-AMERICANS AND MEXICAN-AMERICANS IN THE CHICAGO AREA

by

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A Thesis Submitted to the Faculty of the Graduate School of Loyola University in Partial Fulfillment of the Requirements for the Degree Master of Arts

February

1968

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CHAPTER I

INTRODUCTION

Purpose of the Study

Medical science has always helped alleviate the afflictions of the human body, but until recently its therapy has developed without much assistance from the behavioral sciences. The concern of this thesis, stated very broadly, is with the modern-day conjunction between sociology and medicine. The researcher will deal with the manner in which this combination leads not only to concepts of health and sickness expressed in socio-biological terms, but also, in its broadest application, results in theoretical possibilities of transcultural variations in these same socio-biological manifestations.

On the psychological level, any given individual is constantly exposed to dynamics of every-day life which entail adjustment and readjustment--a maintenance of homeostasis in the process of social interaction. Similarly, the physiological elements of any individual must maintain an organic equilibrium under conditions of stress. Should the individual be unable to deal with these constant multiple stresses, so that homeostatic maintenance is threatened, he suffers from an organic disorder which is physical and/or psychological.

Thus, social components of sickness cannot be separated from the biological and chemical factors. As one author puts it:

> The person is viewed as a focus in a field of social interaction which profoundly affects his attitudes, feelings, ideas, and bodily processes. His migraines, his ulcers, his sexual deviation, his hypertensions and heart ailments, even his injuries in accident involvements have social and emotional factors in their etiology, treatment, and preventions.[1]

Medical sociology, therefore, the study of the social components of illness, may be said to participate fully in the alleviation of physical ills.

In spite of advances in technique and accessibility of modern medicine, certain segments of the average community do not participate fully in its benefits. These problems will not be overcome as long as there exists ignorance or indifference on the part of the individuals involved. However, the results of sociological research can, nevertheless, go far in eliminating certain of these problems.

This thesis is an attempt to explore and compare in the empirical manner some implications of attitudes of particular ethnic groups--the second generation Japanese-Americans and the second generation Mexican-Americans in the Chicago area--toward medicine.

The empirical questions at issue in this thesis are:

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[1] A. R. Mangus, "Medical Sociology: A Study of the Social Components of Illness and Health," Sociology and Social Research XXXIX (January, 1955), 158-64.

1. Do Japanese-Americans and Mexican-Americans react differently from each other to pain experiences caused by disease and injury?

2. Do Japanese-Americans and Mexican-Americans react differently from each other to advances in modern medicine?

Review of Related Literature

In the area of the study of the social components of illness, some of the most important new insights have been provided by Gartly Jaco and Dorrian Apple.

In Jaco's Patients, Physicians and Illness[1] the topics range from social epidemiology to the social organization of the hospital, and includes: (1) the study of cultural and social factors in illness and mortality, (2) some aspects of health projects in various communities, (3) differences in certain aspects of medical care in terms of cultural differences, (4) the emotional and attitudinal phases of the patient, (5) the importance and influence of medical education on the socialization and professionalization of medical students, (6) the role of the physician, his specialization, and his projected image, and, (7) the social organization of the medical setting, along with the communication and function of the hospital therapists in the socio-medical environment.

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[1]Gartly Jaco (ed.), Patients, Physicians and Illness: Behavioural Science and Medicine, (New York: The Free Press, 1958).

The second above-mentioned author's text, Apple's Sociological Studies of Health and Sickness,[1] consists of articles on the social-cultural perspectives of medicine, the social machinery of medical organization, the cultural components of pain response, etiological patterns, psychological aspects of hospital workers, and the relationship between health care and socio-economic status. Additional areas include the influence of folk culture of medicine, social-cultural perspectives of medicine involving the value systems of families, attitudinal differences toward mental sickness (in terms of social-class differences), and cultural differences regarding rates of alcoholism.

In both these texts, then, study is not limited merely to problems of Western culture, but expands to areas which might be placed under the jurisdiction of modern comparative anthropology. This is, as has been already noted, one of the general interests of this thesis.

Several sociologists have discussed this role of behavioral sciences in medicine in substantive studies. The relationship between social sciences and medicine is described in an entire issue of Journal of Social Issues (1952).[2] Mangus has

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[1]Dorrian Apple (ed.), Sociological Studies of Health and Sickness, New York: McGraw-Hill Book Company, Inc., 1960)

[2]"Socio-Cultural Approaches to Medical Care," Journal of Social Issue, VIII (October, 1952), entire issue.

written about the importance of social factors in illness in an article.[1] Parsons and Leader also contributed to the understanding of the concept of "health and illness" and the ill person.

Of primary importance is the necessity of understanding the terms "health and illness" in order to comprehend the public's general attitude towards the realm of medicine. From an operational point of view, Parsons notes that "health is the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized, and illness is the state of imputed generalized disturbances of the capacity for normally expected tasks in role performance."[2] He goes on to illustrate the specific features of the sick person's role as (1) an incapacity in effecting the results of his decision-making, (2) an incapacity which is accepted as a legitimate basis for exemption from the normal role, and (3) an obligation to get well and seek competent help and to cooperate with it.

Leader explains that the sick person initially exhibits egocentricity, constriction of interests, emotional dependency, and tendency towards hypochondriasis, while during the convalescence stage the invalid acts much like the adolescent who yearns

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[1] Mangus, op. cit.

[2] Talcott Parsons, "Definition of Health and Illness in the Light of American Values and Social Structure," Jaco, op. cit., pp. 165-87.

for adult life but lacks self-assurance. The author states that "the convalescent phase of illness terminates with the parallel recovery from physical limitations and psychological regression."[1]

Another study in this area is that of David Mechanic.[2] He is interested in the significance of an individual's predisposition towards medical diagnosis and treatment; those who most often make use of medical facilities are likely to adopt the role of the invalid.

Along with these substantive studies, a number of methodological studies based upon empirical research have been done in the area of social and cultural variations which bear upon medicine. The present study is conducted on the basis of empirical research.

Cultural Perspectives

Medicine has values and rituals of its own which are, in areas of care treatment, often influenced by cultural factors. In understanding the connection between culture and social institution--medicine, therefore, it is important to examine the

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[1]Henry Leader, "Hos the Sick View Their World," Social Interaction and Patient Care, James K. Skipper and Robert C. Leonard (eds.), (Philadelphia: J. B. Lippincott Company, 1965), pp. 155-67.

[2]David Mechanic, "Stress, Illness Behaviour, and the Sick Role," American Sociological Review, XXVI (February, 1961), pp. 51-8.

conflicts which may arise between primitive and modern medicine. One study in this area, by Simmons,[1] indicates that there coexist both magical and empirical cures, each performing equivalent functions. In a primitive community there are some "sicknesses" which can only be cured by non-empirical medicine. Similarly, Gould's study[2] indicates, in an Indian village, "folk medicine" exists side by side with "scientific medicine." The former, suggests the author, acts as a panacea against the chronic non-incapacitating dysfunctions which regularly have plagued the villagers. These two studies indicate that there coexist "folk medicine" and "scientific medicine" in a rural area that is a community of another country.

In addition, cultural studies on different ethnic groups, although the number of studies are few, in different areas of this country are investigated by sociologists.

In a study of Spanish-speaking villagers in New Mexico and Colorado, Shulman found that "among the Spanish-Americans, unless pain or other dysfunctioning factors of life's activities were present, sickness was not recognized."[3] Those villagers

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[1]Ozzie Simmons, "Popular and Modern Medicine in Mestizo Communities of Coastal Peru and Chile," Apple, op. cit., pp. 69-87.

[2]Herald A. Gould, "The Implications of Technological Change for Folk and Scientific Medicine," Jaco, op. cit., pp. 197-213.

[3]Sam Schulman, "The Concept of Health Among Spanish-Speaking Villagers of New Mexico and Colorado," Journal of Health and Human Behaviour, IV (Winter, 1963), pp. 226-34.

have no understanding of the nature of sickness and health, and adopt a fatalistic attitude towards bodily well-being. Similarly, according to the work of Lyle Saunders,[1] the Mexican-Americans of the South-West manifest a simplified attitude towards pain and health, but he traces four different sources determining their knowledge of medicine: (1) folk medicine, originating in Spanish traditions, (2) American Indian folk medicine, (3) Anglo-folk medicine, and (4) scientific medicine. Unfortunately, however, the last-mentioned is of little importance, due to the scarcity of medical personnel, the cost of medical service, and the cultural-linguistic barriers which inhibit the spread of knowledge about such matters. In addition, relatives do not wish to be separated from the patient; folk-medicine treats certain ailments unknown to doctors; and above all, Anglo-scientific medicine does not provide enough satisfaction for the expectations of the general populace. In this thesis, of course, one of the primary objects of study is the group of Mexican-Americans dwelling in Chicago, having a different socio-cultural environment from the above-mentioned peoples.

Graham contributed to the understanding of the ethnic factors in health and illness by his survey of Medical Research

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[1]Lyle Saunders, Cultural Difference and Medical Care: The Cases of the Spanish-Speaking People of the South-West (New York: Russell Sage Foundation, 1954).

on Ethnic Factors in Health Status.[1] The author's report on prevalence of various health conditions includes color blindness, pneumonia, tuberculosis, cancer of the reproductive and gastro-intestinal organs, pernicious anemia, goitre, leprosy, and mental disorder. Lower rates of the above-mentioned diseases, particularly communicable diseases, and mental disorder, are found among the native born whites of native born parents than among other ethnic groups. He points out that the Irish have high rates of communicable disease and mental disturbances. The low rate of cancer of the reproductive organs among Jews and also the low rate of gastro-cancer among Italians are indicated as provocative findings. As to the relationship between the etiology and cultural factors, the same author states that "it would seem plausible that because of differences in folkways, which could predispose to protect against or welcome health disorders of various sorts, the several ethnic groups could vary in prevalence of each. Furthermore, 'marginal men' in this country, recently exposed to a new culture, or the product of cross-ethnic marriages, possibly could experience tensions which would lower their tolerance to several diseases."[2] The above study directs the attention to cultural factors in the realm of

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[1] Saxon Graham, Medical Research on Ethnic Factors in Health Status, A paper given at the meetings of The Eastern Sociological Society, New York City, April 3, 1955, pp. 1-12.

[2] Ibid.

health and medicine which is also one of the main concerns of the present thesis. However, whereas the former deals with the relationship between the etiology and cultural factors, the latter is concerned with the relationship between the attitudes towards medicine and cultural factors.

Response Toward Pain

Socio-cultural factors influence not only attitudes towards medical care, treatment, and personnel, but also have an effect on pain experience. For example, Mark Zborowski's[1] study on differences in response to pain experience show that culture significantly effects various responses. Selecting the sample for study from Jewish, Italian, Irish, and "Old American," he found that the first two ethnic groups, due to certain effects of the family environment, were more likely to be emotional about pain than were the latter two. However, Italians express emotion mostly with regard to the effects of the pain experience upon the immediate situation, while Jews express emotion in terms of worries and anxieties with regard to the source of the pain. One of the problems of the present study, which is the area of pain experience, is basically drawn from Zborowski's study. Although he studied the role of cultural patterns in attitudes toward pain experience, as this study does, he did an

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[1]Mark Zborowski, "Cultural Components of Responses to Pain," Jaco, op. cit., pp. 256-68.

observation on four different nationality stocks of the same race in the hospital setting. This thesis, however, uses two racially and culturally different groups in the manner of sociological study outside of the hospital setting.

Also within this field of interest is the social-psychological study by Lambert, Libman, and Poser[1] on the relationship of pain experience to religion. Here, Jewish and Protestant students were treated, in order to determine their pain tolerance thresholds. When both groups were told that they, as groups showed an intolerance of pain, and then were tested again the Jewish group showed a significant increase in their pain threshold. In another experiment, both groups were told that their own religious group had (1) more, and (2) less tolerance to pain than the other religious group. Both Jewish and Protestants who were told that they could tolerate less pain than the others subsequently increased their pain threshold. Of those who were told that they could tolerate more pain than others, the Protestant students increased subsequently their tolerance of pain, but the Jewish students showed no significant further change. On the whole, there was no reliable difference between the two groups, except that the Jewish students seemed to show a

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[1]Wallace E. Lambert, Eva Libman, and Ernest G. Poser, "The Effect of Increased Salience of a Membership Group on Pain Tolerance," Current Studies in Social Psychology, Ivan Steiner and Martin Fishbein (eds.), (New York: Holt, Rinehart and Winston, Inc., 1965), pp. 273-43.

general lower tolerance of pain experience. Their study was experimental, and subjects were chosen based upon religious differences. However, in this thesis, as already mentioned, the interview technique is employed, and subjects are not chosen in terms of religious differences, but rather on the basis of ethnic differences.

Social Perspectives

The following studies are important in formulating questions of the structured interview schedule of the present study specifically related to ideas and attitudes toward modern medicine and medicine in general.

Several studies have shown a relationship between social class and attitude towards illness and medical care. In Illness in Regionville[1] Koos examines the relationship between social class differences and sensitivity towards symptoms, and concludes that those of the "upper classes," having had more exposure to information about illness than individuals in the "lower classes," are likely to give more attention to pain. In another study, the author of Metropolis--What City People Think of their Medical Services[2] shows that the metropolitan

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[1] Earl Koos, "Illness in Regionville," Apple, op. cit., pp. 9-14.

[2] Earl Koos, "Metropolis--What City People Think of their Medical Services," American Journal of Public Health, XXXXV (December, 1955), pp. 1551-7.

individual, regardless of his class situation, realizes the importance of medical care. He "accepts...medical care, in general, without undue reaction against the cost, but with strong reservations regarding the emphasis upon technical medicine given without regard for human relationships."

Another study in this area has been conducted by DeCicco and Apple,[1] examining the relationship between health care and such factors as place of birth, marital status, and economic level. Their findings have indicated that foreigners, unmarried people, and those in the lower economic classes tend to have relatively low rates of health care. This information seems to be somewhat corroborated by the findings of Weeks, Davis, and Freeman,[2] who have seen a relationship between high rate of income and high rate of medical care. They further try to explain the phenomenon of apathy towards medical care in terms of childhood experiences, cultural and situational backgrounds, and differences in personality. Finally, the intricate relationship of class factors in medicine is well pointed out by Ozzie Simmons,[3] who indicates that public health attempts to

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[1]Lena De Cicco and Dorrian Apple, "Health Needs and Opinions of Older Adults," Apple, op. cit., pp. 26-39.

[2]Ashley Weeks, Marjorie Davis, and Howard Freeman, "Apathy of Families Towards Medical Care," Jaco, op. cit., pp. 159-65.

[3]Ozzie Simmons, "Implications of Social Class for Public Health," Jaco, op. cit., pp. 107-12.

cure the diseases of the lower classes, according to middle-class values, and using individuals (doctors) who are generally considered to be upper-class.

In addition to this, two pieces of research have been done on the relationship between social factors and attitudes toward participation in preventive medicine. The study of Clausen, Seidenfeld, and Deasy[1] concerns parental decisions as regards the children's Polio Vaccine trials. The findings indicated that those mothers who gave consent tended to have a higher educational level than those who withheld their approval; moreover, their information level was considerably higher, not only from printed sources, but also from conversation with others. Similarly, there is shown to be a higher level of acceptance of psychiatric aid for children among those who have a higher level of education than others in the study by Raphael.[2]

There are several studies, in this area, concerning the relationship between social status and use of medical facilities. One researcher[3] has found that: (1) although rates of illness,

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[1]John Clausen, Morton Seidenfeld, and Leila Deasy, "Parent Attitudes Toward Participation of Their Children in Polio Vaccine Trials," Jaco, op. cit., pp. 119-29.

[2]Edna Raphael, "Community of Structure and Acceptance of Psychiatric Aid," American Journal of Sociology, LXIX (January, 1964), pp. 340-58.

[3]Saxon Graham, "Socio-Economic Status, Illness, and the Use of Medical Services," Jaco, op. cit., pp. 129-134.

according to class, are similar, those of the "upper classes" tend most often to consult a physician, (2) and they do tend more often to develop acute illness, (3) while among the "lower classes" there seems to be a greater tendency to chronic illness, although here the attendance of a physician tends to be adverse. Another work[1] has compared two communities with different socio-economic characteristics, in order to examine the incidence of hospitalized and non-hospitalized cases of psychosis. The researchers found that in the "higher-class" community there existed fewer cases of hospitalized psychosis, but the researchers attribute this not to an upper-class aversion to medical treatment, but rather to an understandable bias against the state medical hospital (known as the "snake-pit").

Some studies have also been done in the area of patients' attitudes towards doctors and hospitals, communications between doctors and patients, and the ramifications of the patients' knowledge of their illnesses. One group of researchers[2] in this area found that the patients they studied had little knowledge of disease, little desire to gain information about their

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[1]Bert Kaplan, Robert Reed, and W. Richardson, "A Comparison of the Incidence of Hospitalized and Non-Hospitalized Cases of Psychosis in Two Communities," American Sociological Review, XXI (October, 1956), pp. 472-9.

[2]Lois Pratt, Arthur Seligman, and George Reader, "Physicians' View of the Level of Medical Information among Patients," American Journal of Public Health, XXXXVII (October, 1957), pp. 1277-83.

diseases, and little conscious demand for a complete explanation from a doctor. The physicians, on the other hand, underestimated the patients' intelligence; although the doctors stressed the importance of the understanding of illness, they far too often tended to avoid discussion with the patients, who therefore received only sketchy explanations of the situation. This, suggest the researchers, is highly regrettable, for evidence indicates that the more thorough the explanation given to the patient, the more effective will be his participation with the physician.

Another study in this area, that of Coser,[1] deals with the concept of the hospital as a "home away from home," where patients are supposed to receive full attention and warm, sympathetic care. In examining the attitude of patients toward the doctors, he has found a co-relationship. The researcher classifies patients into three categories, "instrumental," "primary," and "mixed," according to the criteria they give for judging the worth of a doctor. The first type of patient is that which sees the doctor as a necessarily competent professional; the second type looks at him as a provider of kindness and love; in between these two falls the "mixed" category. The "instrumental" type of patient, the researcher decided, tends to enjoy people and activity more than the other type, and is more likely also to

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[1]Rose Lamb Coser, "A Home Away from Home," Apple, op. cit., pp. 154-72.

make suggestions concerning the improvement of the patients' comfort. The "primary" patient, on the other hand, is far more likely to accept hospital norms.

Another study was pursued by Redlich, and others,[1] concerning the attitudes held about psychiatry by neurotics of different social classes. Patients of a white-collar background, it developed, tend to complain of emotional difficulties, while those of semi- or unskilled heritage complain of "somatic" symptoms; moreover, the former had some knowledge of the nature of illness, prior to medical contact, while the latter group had almost none, and this proportion continued after medical contact, with more than half of the first group increasing their knowledge, as opposed to seventeen per cent of the others.

A recent study[2] along these lines attempted to determine if there is a relationship between schizophrenia and social class. Their findings showed that "it is the nature of the disease that determines the class position of the schizophrenia, at least by the measure of occupation and education, and...it is not the class position that influences the nature of the disease."

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[1] F. C. Redlich, A. B. Hollingshead, and Elizabeth Bellin, "Social Class Differences in Attitudes towards Psychiatry," Apple, op. cit., pp. 134-44.

[2] H. Warren Dunbar, Patricia Phillips, and Barbara Srinivasan, "A Research Note and Diagnosed Mental Illness and Social Class," American Sociological Review, XXI (April, 1966), pp. 223-7.

The problems that arise concerning the performance, toleration and rejection of psychiatric patients has been investigated by several behavioral scientists. Phillips,[1] for example, has found that younger and better educated people are more likely than others to recognize schizophrenic behavior as illness.

Shirley Angrist[2] has examined the relationship between social factors and the performance of mental patients. The high level performers tend to be married, with children, and from a middle-class background. High performance levels are related to high role expectations on the part of the patients themselves, and also to the role expectations of the significant others.

Definition of Culture

Man is a social animal. Each individual breathes and lives according to the culture of the society in which he is born and raised. In the process of socialization, his personality is produced through social interaction and communication with other men in society, as Clyde Kluckhohn explains it:

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[1]Derek L. Phillips, "Regulation of the Mentally Ill: The Influence of Behaviour and Sex," American Sociological Review, XXIV (October, 1964), pp. 670-87.

[2]Shirley Sarah Angrist, "The Social Factors in the Outcome of Mental Hospitalization," Unpublished Ph. D. dissertation, The Ohio State University, 1960.

> A person is an emergent entity of and in a certain physical, social, and cultural milieu. He cannot be properly represented in isolation from his locale, or from the culture of the group of which he is a member, or from his status (role) in the structure of that group. Basically, every person is a social person, an interdependent part of a system of human interaction.[1]

Since an individual is a unit of a collectivity of individuals who make up a society, he is bound to follow the patterns which that society has established. "The cultural patterns that are stereotyped forms of behavior upon which any society depends for its survival must be established as patterns of behavioral response on the part of its members."[2]

This concept of "culture" is basic to the theories of modern anthropology; it is used generally to designate the total way of life of a people, including those aspects of their environment which is self created.[3] This "culture" may be classified

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[1]Clyde Kluckhohn, Henry A. Murray, and David M. Schneider (eds.), Personality: In Nature, Society, and Culture (New York: Alfred A. Knopf, Inc., 1948), p. 6.

[2]Ralph Linton, The Cultural Background of Personality (New York: Appleton-Century-Cragrs, Inc., 1945), p. 24.

[3]There are many variations of definition within the scope of this general understanding of culture. Note: "Culture refers to man's entire social heritage, all the knowledge, beliefs, customs, and skills he acquires as a member of society." (Leonard Broom and Philip Selznick, Sociology /Evanston and Elmsford: Row, Pearson, and Co., 1958/, p. 43.) "Culture is the distinctive way of life of a group of people, their complete design for living." (Clyde Kluckhohn, Mirror for Man, /New York: McGraw-Hill Book Co., 1949/, pp. 17-36.) "Culture is the configuration of learned behaviour and results of behaviour whose component elements are shared and transmitted by the members of a particular society." (Linton, op. cit., p. 32).

as either material or psychological, the material elements of the culture being overt manifestations, the psychological elements existing as covert phenomena inferred from the former. In other words, although "real" culture consists of the actual behavior of a people, the covert aspects of this culture consists of the attitudes, values, and shared knowledge of this people which form the bases of their culturally influenced actions.

According to Ralph Linton[1] the overt aspects of culture play the principle roles in cultural transmission because each individual re-creates the covert aspects of the culture, as internalized values, through contact and experience with the overt elements. The young child, therefore, is surrounded by external cultural stimuli derivative from the common shared behavior surrounding adults. This gives him the necessary background to understand his social situations and relationships which exist between his environment and himself as an individual in his society. Thus the child learns the common behavior patterns of his society and creates thereby attitudes and values which determine his own behavior patterns.

American society, however, is by no means culturally homogeneous. But although there exist wide-spread different ethnic groups, there nevertheless dominates an Anglo-Saxon

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[1]Linton, op. cit.

common denominator, the basis for acculturation.[1] Therefore, of the major immigrant groups, (of non-Anglo-Saxon origin) we may distinguish between the people of "first generation"--those who have immigrated and then become acculturated--and the people of the "second generation"--the children of the original immigrants, who are raised according to two cultures, one of which is the culture of their parents, and one of which is the dominant culture of America. These second generation individuals are influenced by the dominant culture through contact with people outside the family, and this conflicts with or supplements the sub-cultural influence of his home life.

The research investigations in this study are concerned with two ethnically and racially different second generation minority groups in Chicago, Americans of Japanese and Mexican ancestry. Not only does Japanese culture differ radically from Mexican, but the two have few affinities with the dominant Anglo-Saxon traditions; the differences between the three are well suited for the purposes of this investigation.

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[1] "Acculturation is the process by which individuals whose primary learning has been in one culture take over traits from another; or sometimes the way in which whole groups incorporate traits from other cultures with which they have had contact." (Charles F. Marden and Gladys Meyer, Minorities in American Society /New York: American Book Company, 1962/, p. 35.

Hypotheses

The remainder of this thesis will be devoted to the postulation and examination of hypotheses drawn from the literature briefly mentioned above.

The hypotheses at issue in this thesis are as follows:

1. Because of differences in cultural background, dissimilarities are expected to exist between Japanese-Americans and Mexican-Americans regarding emotional responses toward pain caused by disease or injury.

2. Because of differences in cultural background, dissimilarities are expected to exist between Japanese-Americans and Mexican-Americans regarding their reactions to advances in modern medicine.

CHAPTER II

METHODS AND TECHNIQUES

Sources of Subjects for the Study

The subjects of the present research were selected on the following basis. All the subjects had to be married, former patients, and second-generation Americans of Japanese ancestry and second-generation Americans of Mexican ancestry. The number of the selected subjects in each group is fifty. Each of these groups consists of twenty-five males and twenty-five females.

An attempt was made to obtain lists of both Japanese-Americans and Mexican-Americans with the above qualifications from ethnic organizations to which these ethnic groups belong. Also, because of the nature of this study, the subjects must have been hospitalized before. Therefore, another source, medical institutions such as hospitals and clinics, were taken into consideration. However, there exists some hesitation on the part of these institutions to permit outsiders to look through medical records. There is, likewise, the difficulty for the researcher to determine whether or not obtained names identified ethnicity and whether or not these names indicated to which generation the patients belonged. These following

sources, therefore, were utilized in selecting samples: (1) membership lists of community and national organizations and (2) a list of people registered in a religious organization. A list was requested from the Chicago Chapter of Japanese American Citizens League which has approximately 750 members in the Chicago area. From this roster the names of people eligible for interview, 376 males and 146 females, were obtained. A request was made to a religious organization which has a number of Japanese-American members but the reply was received in such a way as conflicted with the sampling technique used in this study.

A list was likewise requested of the Mexican Community Committee of South Chicago and of South Deering Post No. 1238 of the American Legion; both organizations are composed mainly of Mexican-American members. The names of 127 male Mexican-Americans were obtained from both of these organizations; the wives of these men were also eligible for interview. Another request was made to a Catholic church named Our Lady of Guadalupe, the majority of which is composed of Mexican-Americans. Thirty-four names of married couples were obtained. Consequently, the total number of Mexican-Americans eligible for interview was 322.

Sampling Technique

A systematic random sampling was made to procure a hundred subjects. The names for each category were arranged in

alphabetic order with a number and every nth number was selected N varies in each category according to the number of the population. The first name in each category was selected randomly from a statistical table.

The concern of this research is with two groups totaling a hundred cases drawn from a single society at a single period and the primary basis for selecting cases is representational. Under this research design systematic random sampling was selected as a technique. In the case of male Japanese-Americans, every fifteenth name was selected. The number fifteen was obtained by dividing the total number of 376 by the universe number of twenty-five. For female Japanese-Americans, every fifth name was chosen. Using the same method as for male Japanese-Americans, the number five was obtained by dividing 146, which is the number of female Japanese-Americans eligible for interview by twenty-five. As far as male and female Mexican-Americans are concerned, every sixth name was selected. Six is the quotient of the dividend 161, which is the total number in each category and the divisor, twenty-five, which is the size of the universe. The first number in each category was chosen separately for fear that male and female subjects should be from the same household.

Sampling Procedure

After a random sampling was made, a telephone call requesting an interview was made to every selected subject.

Since some of the questions used for interview were related to hospitalization experiences, request was made on the basis of verification of ethnicity, generation, marital status, and hospitalization experiences followed by a request of an interview. Although the variables such as ethnicity, generation, marital status, were delimited before a random sampling was made, selected subjects were not always eligible for interview until it was discovered that they had been hospitalized before. Some wives of Mexican-Americans were not Mexican descendants. It was found also that some subjects were neither Japanese nor Mexican, were not second generation American, and had not married. Some who were eligible for interview with all the necessary variables refused to be interviewed with reasons such as being busy, leaving Chicago, or disinclination to being interviewed. A telephone call, thus, was made one after another to every nth selected subject, until the required number was secured.

Method of Gathering Data

The source of data in the present study was gathered through the use of the structured interview schedule consisting of seventy-six questions, some of which are subdivided. The structured interview schedule was based mainly upon the theoretical aspects of the sociology of medicine and partly upon the sample questions used by the National Opinion Research Center on

medical care. The basic sources of data were new data collected by this researcher through interviews. The number of properties used in this research is limited to one, that is attitudes, and the method of handling this single property is by means of the measurement of variables on the basis of statistical analysis.

Appendix I presents the explanation of questions in the structured interview schedule and Appendix II presents the structured interview schedule.

Procedure of Interview

The structured interview schedule had been pretested among ten Japanese-Americans and ten Mexican-Americans in the Chicago area.

Interviews were made mainly on week-day evenings and week-end afternoons for working subjects and week-day afternoons for non-working subjects. The first interview was initiated in December, 1966, and the last one ended in April, 1967. Because of the location of the residences of the interviewees and of the lack of free time they could spare, the span of the interviews involved a considerably long duration.

Interviews were mainly operated at an interviewee's residence except for a few which were conducted at the interviewer's residence and the interviewee's office. One interview lasted approximately forty minutes--some thirty minutes, and some close to an hour. Entry and rapport were easily

established between the interviewer and interviewees of both Japanese-Americans and Mexican-Americans. As a whole, the interviewees were understanding and showed an interest and willingness to cooperate with the researcher. Although one question relating to income was regarded by the researcher as quite personal and as less likely to be answered, most of the interviewees did not even hesitate to give information on the question. Furthermore, it was recognized that some interviewees were interested in the educational and cultural background of the researcher and expressed hospitality to entertain her not as a complete stranger who conducts interviews but as a guest who is studying in a foreign land. Some invited her to tea or to dinner, and some offered her a ride home.

As far as the language barriers were concerned, all the interviews conducted were in English, without any actual difficulty of communication, because the second-generation Americans of both groups use English as a daily speaking language. Since some terms used in interviews were technical, however, the researcher was requested to explain terminology; or she deliberately explained some questions when she discovered that they were misunderstood.

Limitations of Study

1. With reference to the universe from which the samples were drawn, it is recognized that the list of two groups of Japanese-Americans and Mexican-Americans was incomplete due

to the inability to secure all the names of two groups who are eligible for the study.

2. With reference to the universe from which the samples were drawn, it is recognized that samples used in this study were not representative of both groups in a pure sense, because subjects were secured only from lists of organizations and those who did not participate in these organizations were excluded from sampling procedure.

3. With reference to the sampling procedure for the samples interviewed by way of a telephone call, it is recognized that it was not strictly scientific, because those who did not own telephones were excluded from sampling.

CHAPTER III

SOCIAL CHARACTERISTICS OF JAPANESE-AMERICANS AND MEXICAN-AMERICANS

This chapter attempts to investigate the social characteristics of Japanese-Americans and Mexican-Americans studied in this research together with the social background of the respondents' parents.

The present study is restricted to married subjects. Of the Japanese, four per cent are widowed and the remainder are currently living with their spouses. Two per cent of the Mexicans are divorced, another two per cent of them are separated, and the rest are married.

An age difference is found between these two groups. Fifty-six per cent of the Mexicans are under thirty-nine years of age, whereas only sixteen per cent of the Japanese come under this category. Forty-four per cent of the Japanese and forty-two per cent of the Mexicans are between the ages of forty and forty-nine. Forty per cent of the Japanese against only two per cent of the Mexicans are older than fifty years. The Japanese group is older than the Mexican group as a whole.

The statistical facts presented in Table 2 indicate that the number of children is greater among the Mexicans than among

TABLE 1.--Age of respondents

Age	Japanese	Mexican	Totals
20-24	0	0	0
25-29	0	3 (6)	3
30-34	3 (6)	10 (20)	23
35-39	5 (10)	15 (30)	20
40-44	11 (22)	11 (22)	22
45-49	11 (22)	10 (20)	21
Over 50	20 (40)	1 (2)	21
Totals	50 (100)	50 (100)	100

the Japanese. Thirty per cent of the Japanese have no more than one child, whereas only four per cent of the Mexicans are classified in this category. Fifty-six per cent of the Japanese against forty-four per cent of the Mexicans have two or three children. Fourteen per cent of the Japanese against fifty per cent of the Mexicans have four or more than four children. It is considered by this writer that this is affected by their religious background and socio-economic background.

TABLE 2.--Number of children of respondents

	Japanese	Mexican	Totals
None	5 (10)	1 (2)	6
One	10 (20)	1 (2)	11
Two	18 (36)	10 (20)	28
Three	10 (20)	12 (24)	22
Four or more	7 (14)	26 (52)	33
Totals	50 (100)	50 (100)	100

It was found that ninety-six per cent of the Mexicans against only six per cent of the Japanese are Catholic. Furthermore, fifty-six per cent of the Japanese against four per cent of the Mexicans are affiliated to the Protestant religion. Among the Japanese the number of Protestants exceeds that of Buddhists though Buddhism is the dominant religious faith in Japan. None of the Japanese are believers in Shintoism which is another major religion in Japan. Among the Mexicans the only religious affiliates are Christians.

TABLE 3.--Religion of respondents

	Japanese	Mexican	Totals
Buddhist	18 (36)	0	18
Shintoist	0	0	0
Protestant	28 (56)	2 (4)	30
Catholic	3 (6)	48 (96)	51
Other	0	0	0
None	1 (2)	0	1
Totals	50 (100)	50 (100)	100

The educational attainment, the type of work curriculum followed in high school and the major in college are given in Tables 4, 5, and 6 respectively. A big gap is found between the two groups with reference to an educational attainment. Among the Japanese the proportion of respondents who received a post-high school education is greater than that of respondents who attained only a high school education or lower than high school

education. In contrast, only eight per cent of the Mexicans have a post-high school education and the remainder attained as high as or lower than high school education.

TABLE 4.--Educational attainment of respondents

	Japanese	Mexican	Totals
Some elementary	0	4 (8)	4
Completed elementary	1 (2)	4 (8)	5
Some high school	2 (4)	21 (42)	23
Completed high school	15 (30)	17 (34)	32
Some college	17 (34)	4 (8)	21
Completed college	9 (18)	0	9
Some graduate or professional	3 (6)	0	3
M.A.	2 (4)	0	2
Ph.D.	0	0	0
M.D. or D.D.S.	1 (2)	0	1
Totals	50 (100)	50 (100)	100

The curriculum followed by those who attended high school are classified into academic, technical, business, and other. It is found that forty-five per cent of the Japanese as opposed to only twenty-one per cent of the Mexicans followed an academic college preparatory course. Instead, forty-five per cent of the Mexicans followed a technical course which has led them in later years to occupations in which a technical skill is required. Eight out of every nine Japanese females and ten out of every twelve Mexican females followed business courses.

TABLE 5.--Curriculum in high school followed by respondents

	Japanese	Mexican	Totals
Academic	37 (76)	9 (21)	46
Technical	1 (2)	19 (45)	20
Business	9 (18)	12 (29)	21
Other	2 (4)	2 (5)	4
Totals	49 (100)	42 (100)	91

Figures of both groups concerning the major in college, whether the degree was completed or not, are presented in Table 6. Among the Japanese who have studied in college, the largest concentration is found in a business major and the second largest concentration is found in a natural science.

TABLE 6.--Major in college of respondents

	Japanese	Mexican	Totals
Liberal arts	1	1	2
History	1	0	1
Social science	1	0	1
Natural science	5	1	6
Engineering	3	2	5
Mathematics	1	0	1
Business	10	0	10
Fine arts	2	0	2
Education	2	0	2
Home economics	3	0	3
Stenography	1	0	1
Totals	30	4	34

Table 7 describes the variety of occupations pursued. Seven Japanese hold a professional occupation. None of the Mexicans do so. Whereas a concentration of Japanese males is found in non-manual occupations, the majority of Mexican males have a manual occupation. The statistical fact that Mexican females have a greater tendency to stay at home as a housewife than Japanese females is due to such factors as lower educational attainment, larger numbers of dependent young children. The most popular occupations among Japanese females are clerical, involving forty per cent of them compared to eight per cent of the Mexican females. The popularity of clerical occupations among Japanese females may be explained by their educational attainment, that is, eight of them followed a business course in high school and five of them majored in business in college. Six Mexican females are factory workers, while no Japanese females are found in this area of occupation, though five of the latter possess a vocational occupation such as seamstress and barber.

Occupation and income are related significantly. Table 8 shows the annual income of the respondents' families. Income of family indicates the joint income of both spouses if they are both making some kind of income or the income of one of the spouses if only he or she is receiving an income. Seventy-six per cent of the Japanese respondents are classified as annual income holders of more than $10,000 compared to twenty-two

TABLE 7.--Occupation of respondents

	Japanese		Mexican		
	Male	Female	Male	Female	Totals
Professional[a]	6	1	0	0	6
Proprietor, manager, or official[b]	10	0	1	0	11
Semi-professional[c]	3	3	2	4	12
Clerical or sales[d]	5	10	2	2	19
Civil service[e]	0	0	2	0	2
Craftsman or foreman[f]	1	0	4	0	5
Operator	0	0	13	3	17
Unskilled	0	0	1	3	4
Vocational[g]	0	5	0	0	5
Housewife	-	6	-	13	19
Totals	25	25	25	25	100

[a]Includes a school teacher, a chemist, and an engineer.

[b]Includes a store keeper and a self-employed.

[c]Includes a nurse, an accountant, and a community representative.

[d]Includes an insurance agent broker.

[e]Includes a post officer and a police officer.

[f]Includes a printing press superviser.

[g]Includes a seamstress and a barber.

per cent of the Mexican respondents, fifty-two per cent of whom fall in the category of annual income between $8,000 to $9,999.

TABLE 8.--Annual income of respondents' families

	Japanese	Mexican	Totals
Less than $1,999	0	0	0
$2,000 - $4,999	2 (4)	1 (2)	3
$5,000 - $7,999	2 (4)	12 (24)	14
$8,000 - $9,999	8 (16)	26 (52)	34
$10,000 - $14,999	19 (38)	11 (22)	30
More than $15,000	19 (38)	0	19
Totals	50 (100)	50 (100)	100

In addition to their own social background, respondents were asked to give information on their parents' background. Since the present study is concerned with second generation Americans, it was considered that some information on respondents' parents may contribute to formulating social characteristics of the subjects studied.

While all the Japanese respondents answer that their parents were of Japanese nationality, one Mexican female indicates that one of her father's parents was non-Mexican and two Mexican females state that their mothers had a non-Mexican parent.

The majority of the parents of the respondents had been in this country for forty years or more. This is true of forty-one fathers and thirty-four mothers of the Japanese, and thirty-four fathers and thirty-six mothers of the Mexicans. The length of a stay in this country by respondents' parents, who were immigrants, does not necessarily coincide with the age of

respondents who were born in this country, due to such factors as that some parents have returned to their native land after a certain duration of time in this country and that some are deceased.

TABLE 9.--Length of a stay in this country, by parents

	Japanese		Mexican		
	Father	Mother	Father	Mother	Totals
0 - 9	0	1	3	0	4
10 - 19	2	5	4	1	12
20 - 29	4	5	2	7	18
30 - 39	3	3	4	3	13
40 or more	41	35	34	36	146
Unknown	0	1	3	3	7
Totals	50	50	50	50	200

TABLE 10.--American citizenship, by parents

	Japanese		Mexican		Totals
	Father	Mother	Father	Mother	
Yes	16	13	15	13	63
No	34	37	35	35	135
Uncertain	0	0	0	2	2
Totals	50	50	50	50	200

How many of the respondents' parents became naturalized American citizens? The number of naturalized citizens is as follows: sixteen fathers and thirteen mothers of Japanese

respondents and fifteen fathers and thirteen mothers of Mexican respondents. Two Mexican respondents are unable to give information on their mothers' naturalization. It is recognized that the number of naturalized parents of both groups is almost identical.

Eighteen per cent of the Japanese and twenty-three per cent of the Mexicans are unable to inform the interviewer of their parents' educational attainment since this seemed an irrelevant question to put to their parents. Seven per cent of the Japanese parents against none of the Mexican parents attained a higher than high school education. It is found that the parents of a half of the Japanese subjects have completed high school and/or have had some high school education. On the contrary, the parents of only five per cent of the Mexican respondents have similar educational backgrounds. There exists a marked contrast between Japanese parents and Mexican parents in relation to non-formal or only partial elementary education. Only ten per cent of the parents of Japanese respondents and as high as fifty-nine per cent of Mexican respondents have a non-formal or only partial elementary education.

The last occupations of respondents' fathers are also studied. The findings are as follows. Out of the fathers of Japanese respondents, twenty-six per cent are engaged in business owning a restaurant, a laundry, and a grocery store, and thirty-four per cent are farmers. The number of fathers of Mexican

TABLE 11.--Educational attainment, by parents

	Japanese		Mexican		
	Father	Mother	Father	Mother	Totals
Some elementary	2	5	17	21	45
Completed elementary	9	6	5	8	28
Some high school	7	2	1	2	12
Completed high school	19	22	1	1	43
Some college	0	1	0	0	1
Completed college	4	1	0	0	5
Other[a]	1	0	0	0	1
None	0	3	10	11	24
Unknown	8	10	16	7	41
Totals	50	50	50	50	200

[a]Includes a degree in Law.

respondents who are in business or who are farmers is very small. However, seventy-four per cent of Mexican respondents are laborers, working in steel mills and railroads. Table 12 describes various types of occupations of the fathers of the respondents of the two groups.

Methodology

In this chapter the social characteristics of respondents are analyzed, with special emphasis given to the different social backgrounds of the two groups. Although the present study is concerned with cultural differences, these social differences must also be taken into consideration as variables which influence the respondents' formulation of attitudes toward

TABLE 12.--Last occupation, by fathers

	Japanese	Mexican	Totals
Professional[a]	1 (2)	0	1
Proprietor, manager, or official	13 (26)	3 (6)	16
Semi-professional	1 (2)	0	1
Clerical or sales	4 (8)	0	4
Craftsman or foreman	4 (8)	6 (12)	10
Laborer	3 (6)	37 (74)	40
Vocational[b]	4 (8)	0	4
Farmer	17 (34)	2 (4)	19
Service[c]	2 (4)	0	2
Unknown	1 (2)	2 (4)	3
Totals	50 (100)	50 (100)	100

[a]Includes a minister.

[b]Includes a gardener.

[c]Includes a cook.

pain and modern medicine. In the following analysis of these varying different attitudes, therefore, although the findings (in Chapters IV, V, and VI) indicate that the variations between the two groups are the product of cultural differences, there exists a strong probability that social background variables are the determining factors. Although the researcher's data at first glance indicate attitudinal differences according to ethnicity, it is nevertheless important to examine these differences with regard to variations in the respondents' age and level of education. This will be attempted in Chapter VII. Until then, however, it is impossible to derive from the

evidence (in Chapters IV, V, and VI) a clear picture of the causes underlying the apparent attitudinal differences of the two ethnic groups under consideration.

CHAPTER IV

HYPOTHESIS I: A COMPARISON OF ATTITUDES OF JAPANESE-AMERICANS AND MEXICAN-AMERICANS TOWARD PAIN

In this chapter, attitudes of the two ethnic groups toward pain will be explored and compared. It is hypothesized that "because of differences in cultural background, dissimilarities are expected to exist between Japanese-Americans and Mexican-Americans regarding emotional responses toward pain caused by disease and injury."

Mark Zborowski[1] has found that reaction to pain is related to cultural background. He singles out two attitudes toward pain--pain expectancy and pain acceptance. By pain expectancy he means anticipation of pain as being unavoidable in given situations; and by pain acceptance he means willingness to experience pain. The perception of the necessity of pain and the willingness to accept it differ among different cultures.

The questions used in the present study are based upon Zborowski's observational study of attitudes toward pain among Italians, Jewish, Irish, and "Old American" patients.

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[1]Mark Zborowski, Jaco, op. cit., pp. 256-268.

This chapter will explore various facets of the pain experience as this is perceived by Japanese-Americans and Mexican Americans who have been hospitalized in the recent past. The questions (59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, and 76) deal with various aspects of the pain experience on the part of the patient and the transmission of cultural attitudes toward pain.

Pain Experience Among Former Patients of Japanese and Mexican Origin

Question 59 in the present study asks: Which do you think concerns you most when you have pain, the physical pain experience itself, or the significance of pain in relation to your health, welfare, and welfare of the family? The responses to this question are presented in Table 13.

TABLE 13.--Responses of Japanese-Americans and Mexican-Americans in the Chicago area to question 59: Which do you think concerns you most when you have pain? The physical pain experience itself or the significance of pain in relation to your health, welfare, and the welfare of the family?

	Japanese	Mexican	Totals
Physical pain itself	21	28	49
Significance of pain in relation to your health, welfare, and welfare of the family	28	20	48
Uncertain	1	2	3
Totals	50	50	100

X^2 - 2.58 (degree of freedom - 1) more than .10

There are no significant differences between the two groups. Zborowski[1] found that Italian patients seemed to be mainly concerned with the immediacy of the pain experience and were disturbed by the actual pain sensation which they experienced in a given situation, while the concern of patients of Jewish origin was focused mainly upon the symptomatic meaning of pain and upon the significance of pain in relation to their health, welfare, and eventually to the welfare of their families.

With regard to expectation of pain, significant differences are found between the two groups of the Japanese and the Mexicans. Although both groups show a higher percentage of accepting pain than rejecting it, chi square analysis indicates that the Japanese group tends to perceive pain as being necessary more often than the Mexican group.

TABLE 14.--Responses of the two groups to question 60: Do you think that having pain is necessary?

	Japanese	Mexican	Totals
Yes	41 (82)	30 (60)	71
No	9 (18)	19 (38)	28
Uncertain	0	1 (2)	1
Totals	50 (100)	50 (100)	100

X^2 - 5.78 (degree of freedom - 1) less than .025

[1] Ibid.

At the .05 level there exist significant differences. Different reasons are given by the respondents as to why they think it necessary or unnecessary to have pain. As Table 15 shows, the large number of the respondents feel that pain is necessary because it is a sign of illness.

TABLE 15.--Reasons why having pain is necessary and unnecessary, given by the respondents

	Japanese	Mexican	Totals
Necessary, because pain is a sign of illness	40	23	63
Necessary, because pain is a part of life	1	7	8
Unnecessary, because pain is not a sign of illness	4	4	8
Unnecessary, because pain is intolerable	1	3	4
Unnecessary, because pain always exists	4	1	5
Unnecessary, because drugs can kill pain	0	4	4
Unnecessary, because pain does not exist if people take care of themselves	0	5	5
Totals	50	47	97

Zborowski's[1] study points out that both the Italians and the Jews feel free to talk about their pain, complain about it, and manifest their sufferings by groaning, moaning, and crying, whereas "Old Americans" hardly emphasize free expressions of emotion by words, sound, and gestures. Do the Japanese differ from the Mexicans with regard to emotional responses to the experience of pain?

TABLE 16.--Responses of the two groups to question 61: Do you show your sufferings by groaning, moaning, or crying?

	Japanese	Mexican	Totals
Yes	10	21	31
No	40	29	69
Totals	50	50	100

X^2 - 5.40 (degree of freedom - 1) less than .025

While the majority of the respondents from both groups do not show their sufferings in an emotional manner, the Mexicans have a greater tendency to express emotion at the time of pain experience than do the Japanese.

Generally, the person who expresses his pain by gestures does not always manifest it in front of medical personnel as he hesitates to do so. Although many of the respondents from both

[1] Ibid.

groups do not express emotion by groaning, moaning, or crying in the presence of medical personnel, the Mexicans tend to do so more than the Japanese. This finding supports the previous research finding of Zborowski that there exists a relationship between ethnicity and emotional expression of pain in the presence of medical personnel.

TABLE 17.--Responses of the two groups to question 62: Is it natural to show pain by groaning, moaning, or crying in front of a doctor or nurse?

	Japanese	Mexican	Totals
Yes	8	22	30
No	41	28	69
Uncertain	1	0	1
Totals	50	50	100

X^2 - 9.38 (degree of freedom - 1) less than .005

The differences are found between the Japanese and the Mexicans at the level of .05.

As the manifestation of pain experience by groaning, moaning, and crying is behavior of free expression of emotion, so is the verbal complaint of pain experience. Zborowski's[1] findings depict that "Old Americans" define the quality of pain and localize it to medical personnel in an unemotional way whereas the Italians complain of pain sensations to them.

[1] Ibid.

The majority of both Japanese and Mexicans feel free to complain of pain to medical personnel as Table 18 presents. In this, there is no significant difference.

TABLE 18.--Responses of the two groups to question 63: Do you feel free to complain of your pain to a doctor or a nurse?

	Japanese	Mexican	Totals
Yes	46	47	93
No	4	3	7
Totals	50	50	100

The respondents were also asked whether they feel free to complain a great deal to members of their families.

TABLE 19.--Responses of the two groups to question 64: Do you think it natural to complain a great deal to your family?

	Japanese	Mexican	Totals
Yes	7	9	16
No	43	41	84
Totals	50	50	100

Neither the Japanese nor the Mexicans feel free to complain of pain to members of the family. No significant differences between the two groups are discovered. While both groups

complain of pain to medical personnel, the majority do not admit that they complain a great deal to members of the family.

In Zborowski's[1] study the Jews and Italians are described as not being ashamed of calling for help and of expecting sympathy and assistance from other members of their immediate social environment while "Old Americans" are depicted as being withdrawn from society. In the following Tables 20, 21, and 22, the respondents' attitudes toward the expectation of help and sympathy from members of the family and of their presence and assistance are studied.

TABLE 20.--Responses of the two groups to question 65: Do you think it natural to call for help from your members of family?

	Japanese			Mexican			
	Male	Female	Total	Male	Female	Total	Totals
Yes	18	12	30	18	18	36	66
No	7	12	19	7	7	14	33
Uncertain	0	1	1	0	0	0	1
Totals	25	25	50	25	25	50	100

As Table 20 shows, the majority of the respondents feel that it is natural to call for help from members of the family. (However, of all the respondents, the Japanese females feel the least that to do so is natural).

[1] Ibid.

TABLE 21.--Responses of the two groups to question 66: Do you think it natural to expect sympathy from your members of family?

	Japanese			Mexican			
	Male	Female	Total	Male	Female	Total	Totals
Yes	18	8	26	14	15	29	55
No	7	17	24	11	10	21	45
Totals	25	25	50	25	25	50	100

TABLE 22.--Responses of the two groups to question 67: When you are in pain, do you prefer to be left alone or to be cared for by others?

	Japanese	Mexican	Totals
Alone	35	35	70
With other people	14	15	29
Uncertain	1	0	1
Totals	50	50	100

No differences are also found between the two groups with regard to their expectations of sympathy from members of the family; (however, the majority of the Japanese females do not think it natural to expect sympathy from members of their families). The proportion of respondents who feel it natural to expect sympathy from members of the family is slightly greater than that of the respondents who feel it natural to call for help.

The numbers of the respondents from the two groups who prefer being left alone to being cared for by other are identical. An interesting contrast in the findings from the responses to the questions 65, 66, and 67 is that the majority of the two groups prefer being left alone to being cared for by other members of the family in spite of their expecting help and sympathy from them.

How is the emotional expression of pain related to the pain relief? Do people react to pain emotionally because it will be effective for the relief of pain? If the emotion expressions are regarded as effective for the relief of pain, they will be more acceptable. The respondents' belief in emotional expressions as an effective impulse for the relief of pain is examined.[1] The statistical analysis of Table 23 does not show significant differences between the two groups.

TABLE 23.--Responses of the two groups to question 68: Do you think that emotional expressions are helpful for the relief of pain experience?

	Japanese	Mexican	Totals
Yes	17	20	37
No	29	29	58
Uncertain	4	1	5
Totals	50	50	100

X^2 - .38 (degree of freedom - 1) more than .5

[1]It is interesting to note here that relatively many respondents of the Japanese group think that emotional expression is effective for the relief of pain while only a small proportion of these actually show their sufferings in an emotional manner.

With reference to this item, the differences are not found at the level of .05.

The patients who express attitudes of anxiety as to the meaning of their pain are more health-conscious and are aware of pain as a possible symptom of a dangerous disease. As Zborowski[1] notes, Jewish patients and "Old American" patients are more concerned with the meaning of pain than Italian patients who are rather concerned with the actual pain.

TABLE 24.--Responses of the two groups to question 69: Does the relief from pain give you security?

	Japanese	Mexican	Totals
Yes	37	44	81
No	11	6	17
Uncertain	2	0	2
Totals	50	50	100

X^2 - 2.67 (degree of freedom - 1) more than .1

The majority of the respondents of the two groups feel secure after pain is relieved. The finding denotes that there is no significant difference at the level of .05 between the Japanese and the Mexicans.

Do the Japanese differ from the Mexicans with regard to the attitudes towards the apprehension of pain?

[1] Ibid.

TABLE 25.--Responses of the two groups to question 70: When in pain which causes you more discomfort --physical effects of pain experience or worry or anxiety?

	Japanese	Mexican	Totals
Physical effects of pain experience	22	30	52
Worry or anxiety	25	19	44
Uncertain	3	1	4
Totals	50	50	100

X^2 - 1.51 (degree of freedom - 1) more than .25

In Zborowski's[1] study the Italian's attitude toward pain is characterized as present-oriented whereas the Jewish attitude is explained as future-oriented. As the previous table shows, half of the Japanese show a future-oriented anxiety of pain, whereas the larger proportion of the Mexicans exhibit a present-oriented apprehension of pain. But there is no statistical difference between the two groups.

The Transmission of Cultural Attitudes Toward Pain from the Japanese and the Mexican Respondents to their Children

Zborowski points out that the family environment affects the individual's response to pain: "Attitudes toward pain and expected reactive patterns are acquired by the individual

[1] Ibid.

members of the society from the earliest childhood along with other cultural attitudes and values which are learned from the parents, parent-substitutes, siblings, peer groups, etc. Each culture offers to its members an ideal pattern of attitudes and reactions, which may differ for various sub-cultures in a given society, and each individual is expected to conform to this ideal pattern."[1] On the basis of his observation, the Japanese and the Mexican parents' attitudes towards their children in pain are examined.

TABLE 26.--Responses of the two groups to question 71: Do you expect your children to be hurt in sports and games?

	Japanese	Mexican	Totals
Yes	49	48	97
No	1	2	3
Totals	50	50	100

The overwhelming majority of both groups indicate that they expect their children to be hurt in sports and games.

Zborowski[2] observed that both Jewish and Italian parents show over-protective and over-concerned attitudes towards their children in pain, and especially the latter manifest their

[1] Ibid.

[2] Ibid.

verbal expression of emotion and feeling of sympathy towards them, whereas the "Old American" patients encourage their children to take pain "like a man" and not to act like a crying baby. The following three questions--72, 73, and 74 are related to the respondents' attitudes toward their children in pain.

TABLE 27.--Responses of the two groups to question 72: When your children are injured as a result of play, do you show attitudes of worry or concern?

	Japanese	Mexican	Totals
Yes	28	38	66
No	21	12	33
Uncertain	1	0	1
Totals	50	50	100

X^2 - 4.55 (degree of freedom - 1) less than .05

TABLE 28.--Responses of the two groups to question 73: Should this occur, would you console them by giving any verbal expression of emotion, such as "poor child"?

	Japanese	Mexican	Totals
Yes	16	27	43
No	34	23	57
Totals	50	50	100

X^2 - 4.96 (degree of freedom - 1) less than .05

TABLE 29.--Responses of the two groups to question 74: In the same case, do you stimulate their ability to resist pain, telling them to act grown up?

	Japanese			Mexican			
	Male	Female	Total	Male	Female	Total	Totals
Yes	17	9	26	11	9	20	46
No	8	14	22	14	16	30	52
Uncertain	0	2	2	0	0	0	2

X^2 - 1.44 (degree of freedom - 1) more than .25

It is discovered that there exist significant differences between the two groups with regard to attitudes toward children who are hurt as a result of participation in sports and games at the level of .05. The Mexicans are more likely to show attitudes of worry or concern to their children than are the Japanese; and they are more likely to manifest verbal expression of emotion such as "poor child" to console their children than are the Japanese. Although differences are found between the two groups in relation to the verbalization of emotional expression to children in pain at the level of .05, in contrast, no significant differences are found between the Japanese and Mexicans concerning the verbal stimulation of their children's ability to resist pain. It is concluded that the parents who tend to verbalize their emotion to their children in pain do not always verbalize their ability to resist pain.

As Table 30 shows, the majority of both groups expect their children to come to them and complain of pain.

TABLE 30.--Responses of the two groups to question 75: Do you expect your children to come to you crying and complaining of pain?

	Japanese			Mexican			
	Male	Female	Total	Male	Female	Total	Totals
Yes	19	21	40	25	20	45	85
No	6	4	10	0	5	5	15
Totals	25	25	50	25	25	50	100

No differences are found between the Japanese and the Mexicans. Although the majority of the respondents tend to expect emotional responses from their children if they are in pain, there exist unanimous expectation of this on the part of the Mexican males. The type of behavior which the respondents expect from their children who are in pain is sought in an open-end question. As Table 31 presents, large numbers of the respondents of both groups explain that they expect their children to be emotional. Also a relatively large number of respondents of the two groups expect their children to explain pain calmly.

TABLE 31.--Responses of the two groups to question 76: What type of behavior do you expect from your children if they are in pain?

	Japanese	Mexican	Totals
Be emotional	32	42	74
Act in such a way as to get attention from parents	3	0	3
Explain calmly	11	8	19
Be stoical	4	0	4
Totals	50	50	100

Summary

Findings of this chapter are as follows:

These are the findings of attitudes toward pain experiences of the former patients of the Japanese and Mexican origin.

1. Whereas the majority of the Japanese think that the significance of pain in relation to their health, welfare, and the welfare of the family concerns them most when they are in pain, the majority of the Mexicans think that the physical pain itself concerns them most. Significant differences are not found between the two groups.

2. Although the majority of the respondents of both groups think that having pain is necessary, the Japanese are more likely to think so mainly because pain is a symptom of a dangerous disease than are the Mexicans.

3. Although the majority of the respondents of both groups do not show their sufferings by groaning, moaning, or crying, the Japanese are less likely to show their sufferings in an emotional manner than are the Mexicans.

4. Although the majority of the respondents of both groups do not think that it is natural to show pain by groaning, moaning, or crying in the presence of medical personnel, the Japanese are less likely to show their sufferings in an emotional manner in the presence of medical personnel than are the Mexicans.

5. The majority of the respondents of both groups feel free to complain of their pain to a doctor or a nurse.

6. The majority of the respondents of both groups do not think it natural to complain a great deal to their family.

7. The majority of the respondents of both groups think it natural to call for help from their members of family when they are in pain.

8. The majority of the respondents of both groups think it natural to expect sympathy from their members of family when they are in pain.

9. The majority of the respondents of both groups prefer being left alone to being cared for by others when they are in pain.

10. The majority of the respondents of both groups do not think that emotional expressions are helpful for the

relief of pain experience.

11. The majority of the respondents of both groups think that the relief from pain gives them security.

12. Whereas the majority of the Japanese think that worry or anxiety causes them more discomfort when they are in pain, the majority of the Mexicans think that physical effects of pain experience causes them more discomfort.

These are the findings of the transmission of cultural attitudes toward pain from the Japanese and the Mexican respondents to their children.

1. The majority of the respondents of both groups expect their children to be hurt in sports and games.

2. Although the majority of the respondents of both groups show attitudes of worry or concern to their children when they are injured as a result of play, the Mexicans are more likely to do so than are the Japanese.

3. Whereas the majority of the Japanese do not console their children who are injured as a result of play and sports by giving some verbal expression of emotion such as "poor child," the majority of the Mexicans verbalize their emotion to their children. The Japanese are less likely to console their children who are injured by giving some verbal expression of emotion than are the Mexicans.

4. Whereas the majority of the Japanese stimulate their children's ability to resist pain, telling them to act

grown up, the majority of the Mexicans do not do so. Significant differences are not found.

5. The majority of the respondents of both groups expect their children to come to them crying and complaining of pain.

The fact found in this chapter that five out of eighteen items support Hypothesis I indicates that there exist more similarities than dissimilarities in the attitudes of the two groups. However, although the data apparently discloses that the Japanese show less emotional responses toward pain than the Mexicans, they do not necessarily follow that ethnicity is the cause of this attitudinal difference between the two groups. Such an assumption would be possible only if such social factors as age and education proved to be influential.

CHAPTER V

HYPOTHESIS II: A COMPARISON OF ATTITUDES OF JAPANESE-AMERICANS AND MEXICAN-AMERICANS TOWARD ADVANCES IN MODERN MEDICINE

In this chapter, attitudes of the two ethnic groups toward advances in modern medicine are examined and compared. The data are analyzed in accordance with Hypothesis II that, "because of differences in cultural background, dissimilarities are expected to exist between Japanese-Americans and Mexican-Americans regarding their reactions to advances in modern medicine."

The questions used in the examination of Hypothesis II are modeled after the several studies done by sociologists on attitudes toward medicine in relation to the social factors such as socio-economic class, education, age, sex, marital status, and residential area.

This chapter will scrutinize different aspects of acceptance of modern medicine expressed by the respondents of the two ethnic groups. The questions (29, 37, 43, 44, 47, 48, 49, 50a, 50b, 50c, 50d, 50e, 50f, 50g, 50h, 52, 53a, 53b, 53c, 53d, 53e, 53f, 54, 55, 56, and 57) are related to the various attitudes toward acceptance of modern medicine exhibited by the Japanese-Americans and Mexican-Americans in Chicago.

Lyle Saunders' study[1] on Spanish-speaking people in the South West describes their lack of knowledge of medicine which leads to their fear for the unknown modern instruments used in a clinic or a hospital. How do the respondents of the Japanese and the Mexicans who live in Chicago feel about the instruments used in a doctor's office or in a hospital?

TABLE 32.--Responses of Japanese-Americans and Mexican-Americans in the Chicago area to question 29: Do the instruments in the doctor's office or in the hospital cause fear in you?

	Japanese			Mexican			
	Male	Female	Total	Male	Female	Total	Totals
Yes	0	5	5	0	4	4	9
No	25	20	45	25	21	46	91
Totals	25	25	50	25	25	50	100

Although there exist no significant differences between the two groups of the Japanese and the Mexicans, differences are found between the two sexes. Chi square analysis (X^2 is 9.9 at the level of .05) indicates that the female respondents from both groups are more likely to be afraid of modern instruments than are the male respondents from both groups. Reasons for fear are asked of nine female respondents: two of these answer, "Something sharp is frightening," one of these answers, "I do

[1]Saunders, op. cit.

not care for needles," two answer, "Instruments are unknown and there is a fear of the unknown," and three answer, "Instruments hurt me." One respondent gives no answer.

In relation to the above question, the respondents' dependence upon folk medicine such as herbs or animal parts is examined. As Saunders[1] points out, among the Spanish-speaking population in the South West, folk medicine assumes an important role as a remedy for illnesses. In the present study those who use folk medicine are regarded as less likely to accept the advances of modern medicine.

TABLE 33.--Responses of the two groups to question 52: Do you depend upon herbs or animal parts when you are sick?

	Japanese	Mexican	Totals
Yes	1	9	10
No	49	41	90
Totals	50	50	100

X^2 - 7.12 (degrees of freedom - 1) less than .01

Although the majority of the respondents from both groups do not show dependence upon folk medicine, statistical analysis indicates that there is significant difference between the two groups.

[1]Saunders, op. cit.

In the study by Pratt, Seligmann, and Reader[1] the effectiveness of the doctor-patient relationship is stated as a fundamental consideration in evaluating adequacy of medical care. The level of a patient's participation with a doctor is related to the level of a patient's expectation from a doctor. The following question examines the respondents' level of participation with a doctor: whether they take the initiative to request the physician to do something for them and to direct the physician's attention to something, or assume that the physicians should direct conversation and activity and they should do whatever they are directed by the physicians.

TABLE 34.--Responses of the two groups to question 37: Do you think that as a patient you should always quietly do whatever the physician says or directs you to do while you are under his care?

	Japanese	Mexican	Totals
Yes	40	45	85
No	10	5	15
Totals	50	50	100

As the above table presents, the majority of the respondents from both groups think that the patient should passively participate with a doctor while they are under his care.

[1]Lois Pratt, Arthur Seligmann, and George Reader, Jaco, op. cit., pp. 222-229.

No significant differences between the two groups are found. The reasons for the above answers given by the respondents are presented below in Table 35.

TABLE 35.--The reasons for the question 37

	Japanese	Mexican	Totals
They think so, because a doctor is a professional who does his best for patient's benefit	20	30	50
They think so, because it is a matter of confidence in a doctor	15	9	24
They think so, because cooperation is necessary for recovery	3	5	8
They do not think so, because a doctor can be wrong	1	2	3
They do not think so, because a patient has a right to say and ask what is going on	9	3	12
Totals	48	49	97

The majority of the respondents think that they should always quietly do whatever they are told or directed by the physician because the physician is a professional who does his best for the patient's benefit and also because they have confidence in the physician.

Pratt, Seligmann, and Reader[1] found that patients who received some explanation from the physician tend to participate

[1]Pratt, Seligmann, and Reader, Jaco, op. cit., pp. 222-9.

with a physician more than did the patients who were not given any explanation. The following question investigates the respondents' expectation from a physician on information about the patient's condition.

TABLE 36.--Responses of the two groups to question 44: Do you think a good physician should give the patient full information about his condition and explain it carefully?

	Japanese	Mexican	Totals
Yes	29	36	65
No	5	1	6
Uncertain	16	13	29
Totals	50	50	100

There is no statistically significant difference between ethnicity and expectation from a doctor for information about the patient's condition. Although more than half of the respondents from each group think that the physician should give full information about the patient's condition, a large number of them think that whether the physician should give full information or not depends on the case. The reasons for the previous question are presented in the next table, Table 37.

A study done by Coser[1] on the patient's attitudes towards hospitals and doctors depicts that the patients who are

[1]Rose L. Coser, Apple, op. cit., pp. 154-172.

TABLE 37.--The reasons for question 44

	Japanese	Mexican	Totals
Yes, because a patient can take care of himself and make future plans	8	6	14
Yes, because truth gives peace of mind	9	4	13
Yes, because a patient has a right to know about his condition	10	21	31
Yes, because it is a mutual understanding between a doctor and a patient	0	5	5
No, because a patient is not in a condition to judge what is told by a doctor	1	0	1
No, because the shock is too big	1	1	2
No, because it should not be full but adequate information	3	0	3
Uncertain, because it depends upon a patient and/or a illness	10	11	21
Uncertain, because it depends upon a doctor	1	1	2
Uncertain, because it depends upon a case but he likes to know	5	1	6
Totals	48	50	98

classified as <u>instrumental</u> expect a doctor to have a professional and scientific competence while the patients who are classified as <u>primary</u> expect a doctor to provide them with kindness and love.

TABLE 38.--Responses of the two groups to question 43: Which do you expect a doctor to be? Professional man? Or dispenser of protection and love?

	Japanese	Mexican	Totals
Professional man	39	44	83
Dispenser of protection and love	6	6	12
Both	5	0	5
Totals	50	50	100

In modern medicine a doctor is recognized as a professional man who has enough confidence in his scientific field where personal relationship is regarded as a secondary purpose and indifference of emotional involvement is encouraged. Therefore, it is expected that the respondents who regard a doctor as a professional man are more likely to accept modern medicine. The majority of the respondents of both groups expect a doctor to be a professional and no differences between the two groups are found. In spite of the efforts made by the researcher to let the respondents make a choice as to their view of what should be a doctor's role, Japanese respondents were unable to do so.

The respondents' attitudes toward a symptomatic concern is measured on the basis of the assumption that those who are more health-conscious as to the meaning of symptoms are more likely to check the diagnosis and the treatment of one doctor

against the opinions of other specialists in the field even when pain is relieved.

TABLE 39.--Responses of the two groups to question 47: Generally, even when your pain is relieved, do you tend to check the diagnosis and treatment of one doctor against the opinions of other specialists in the field?

	Japanese	Mexican	Totals
Yes	23	27	50
No	27	23	50
Totals	50	50	100

This finding does not show a correlation between ethnicity and the cross-checking of the diagnosis and the treatment in comparison to Zborowski's[1] findings that Jewish patients are more inclined to cross-check with other doctors than the Italian patients. The reasons for agreement and disagreement with question 47 are given by the respondents. As Table 40 indicates, many respondents do check the diagnosis and treatment of one doctor against the opinions of other specialists in the field, because they like to make sure or deny what is told by one doctor, whereas many other respondents do not cross-check, because they have full confidence in a doctor.

[1]Mark Zborowski, Jaco, op. cit., pp. 256-278.

TABLE 40.--The reasons for question 47

	Japanese	Mexican	Totals
Yes, because he likes to make sure or deny what is told by a doctor	7	13	20
Yes, because he likes to get more information	5	4	9
Yes, because he can cure illness more quickly (doctors make errors)	3	7	10
Yes, because he can remove doubts about dissatisfaction	8	3	11
No, because he has full confidence in a doctor	21	17	38
No, because there is no use after pain is relieved	5	3	8
No, because the doctor he has is always right	0	3	3
Totals	49	50	99

Stern[1] points out the role of specialization in medicine: "Progress in medicine has been accelerated by specialization which facilitates conceptional refinements and develops the manipulative accuracy, speed, and skill which are impossible when the energies of the physician are diffused." Due to the advances of medicine, specialization is also encouraged, and its existence and use is evaluated highly.

[1]Bernard J. Stern, "The Specialist and General Practitioner," Jaco, op. cit., pp. 352-360.

TABLE 41.--Responses of the two groups to question 48: In your opinion, is there any advantage in consulting a specialist rather than a general practitioner?

	Japanese	Mexican	Totals
Yes	49	49	98
No	1	0	1
Uncertain	0	1	1
Totals	50	50	100

Table 41 shows that the overwhelming majority of the respondents from both groups recognize the advantage in consulting a specialist rather than a general practitioner. There are no significant differences found between the Japanese and the Mexicans.

In relation to the previous question, whether the respondents prefer to have their family doctor (if they have one) examine them before contacting a specialist is asked. Lately there exists a tendency not to have a family doctor who is a general practitioner because of the scarcity of general practitioners and because of the tendency among lay people to consult with specialists directly. Those who prefer to consult with a specialist are considered to be more likely to accept the advances in modern medicine. As Table 42 shows, both groups of the Japanese and the Mexicans have great inclination toward the

preference of consulting a family doctor before contacting a specialist. There exist no significant differences between the two groups.

TABLE 42.--Responses of the two groups to question 49: Would you prefer to have your family doctor (if you have one) examine you before contacting a specialist?

	Japanese	Mexican	Totals
Yes	42	47	89
No	8	3	11
Totals	50	50	100

These previous two questions indicate that both groups of the Japanese and the Mexicans realize the value and importance of specialized medicine but prefer having a family doctor examine them before contacting a specialist to consulting a specialist directly.

The immediacy of consulting a doctor after various symptoms of illness are revealed is tested to the respondents. It is considered that the sooner a consultation with a doctor takes place, the more a respondent is likely to be health-conscious and to accept the advances in modern medicine. Tables 43, 44, 45, 46, 47, 48, 49, and 50 show the statistical analyses of responses of the respondents to various symptoms in terms of the immediacy to see a doctor. The questions are

directly taken from the questions on medical care used by the National Opinion Research Center.[1]

TABLE 43.--Responses of the two groups to question 50a: If you have a symptom of a cough any time during the day or night which lasts for three weeks, do you see a doctor immediately?

	Japanese	Mexican	Totals
Yes	44	41	85
No	6	9	15
Totals	50	50	100

The majority of the respondents of the Japanese and the Mexicans do consult a doctor immediately in this instance. There are no significant differences between the two groups.

TABLE 44.--Responses of the two groups to question 50b: If you have a symptom of getting tired for weeks at a time for no special reason, do you see a doctor immediately?

	Japanese	Mexican	Totals
Yes	43	42	85
No	7	8	15
Totals	50	50	100

[1]Note: The questionnaire was borrowed by the researcher from a statistician of the National Opinion Research Center.

The majority of the respondents of the two groups also see a doctor immediately after getting tired for weeks at a time for no special reason. There exist no differences between the Japanese and the Mexicans.

TABLE 45.--Responses of the two groups to question 50c: If you have a symptom of skin rash or breaking out on any part of the body, do you see a doctor immediately?

	Japanese	Mexican	Totals
Yes	33	36	69
No	17	14	31
Totals	50	50	100

Skin rash as a symptom does not urge as large a number of the respondents as the other two above-mentioned symptoms to see a doctor immediately. Statistically significant differences are not found between the two groups.

TABLE 46.--Responses of the two groups to question 50d: If you have a sympton of diarrhea (loose bowel movement) for four or five days, do you see a doctor immediately?

	Japanese	Mexican	Totals
Yes	43	46	89
No	7	4	11
Totals	50	50	100

Diarrhea for four or five days is also a symptom which urges the respondents of both groups to see a doctor immediately. No significant differences exist between the Japanese and the Mexican respondents.

TABLE 47.--Responses of the two groups to question 50e: If you have a symptom of shortness of breath even after light work, do you see a doctor immediately?

	Japanese	Mexican	Totals
Yes	33	39	72
No	16	11	27
Uncertain	1	0	1
Totals	50	50	100

Shortness of breath even after light work, in spite of being a serious symptom from a medical point of view, encourages a relatively small number of the respondents to consult a doctor as soon as possible. A correlation ethnicity and seriousness about the symptom is not found.

TABLE 48.--Responses of the two groups to question 50f: If you have a symptom of unexplained loss of over ten pounds in weight, do you see a doctor immediately?

	Japanese	Mexican	Totals
Yes	40	39	79
No	10	11	21
Totals	50	50	100

Unexplained loss of over ten pounds in weight is regarded as an important measurement of health by the respondents of both groups. No significant differences are found.

TABLE 49.--Responses of the two groups to question 50g: If you have a symptom of repeated pains in or near the heart, do you see a doctor immediately?

	Japanese	Mexican	Totals
Yes	47	47	94
No	3	3	6
Totals	50	50	100

The most seriously recognized symptom by both groups is repeated pain in or near the heart. The great majority of the Japanese and the Mexicans feel that this symptom is serious. The above table shows no significant differences between the two groups.

TABLE 50.--Responses of the two groups to question 50h: If you have a symptom of sore throat or running nose with a fever as high as 100° F for a day or more, do you see a doctor immediately?

	Japanese	Mexican	Totals
Yes	20	34	54
No	30	16	46
Totals	50	50	100

X^2 - 7.88 (degree of freedom - 1) less than .005

Among all the above-mentioned symptoms, the smalles proportions of the respondents see a doctor immediately with a symptom of sore throat or running nose with a fever as high as 100° F for a day or more. The symptom itself is the least serious and the most common among all the symptoms presented here. Chi square analysis indicates that the Mexicans are more inclined to see a doctor with the symptom than are the Japanese.

The reasons for not having seen a doctor at the time of illness are asked of the respondents: "People sometimes do not see a doctor with some reasons when perhaps they should. Thinking back over your own experience, which of those reasons have ever kept you from seeking a doctor when perhaps you should have?" The reasons are: (1) You did not know any really good doctor; (2) You did not want to spend the money on a doctor unless you had to; (3) It might be painful--the doctor might hurt you; (4) You were too busy to see a doctor; (5) The doctor might find something really wrong with you; (6) You did not think the doctor could help you any. The respondents who think that no reason has ever kept them from seeing a doctor when they should are considered to be more health-conscious and more serious about illness. Questions 53a, 53b, 53c, 53d, 53e, and 53f are taken from the questions used on medical care by the National Opinion Research Center.

Table 51 describes that among the two groups, the proportion of the respondents who have failed to see a doctor with

some reasons are larger than the proportions of the respondents who have always seen a doctor when they should.

TABLE 51.--The respondents who failed to see a doctor and the respondents who always saw a doctor.

	Japanese	Mexican	Totals
Failed to see a doctor	30	27	57
Never failed to see a doctor	20	23	43
Totals	50	50	100

TABLE 52.--Responses of the two groups to question 53a: You did not see a doctor because you did not know any really good doctor.

	Japanese	Mexican	Totals
Yes	8	8	16
No	42	42	84
Totals	50	50	100

Only a small number of the respondents give the reason of not having seen a doctor because they did not know any really good doctor. This is considered to be a relatively sound reason compared to others, because the selection of a good doctor is an important factor for a good medical treatment. No significant differences between the two groups are found.

TABLE 53.--Responses of the two groups to question 53b: You did not see a doctor because you did not want to spend the money on a doctor unless you had to

	Japanese	Mexican	Totals
Yes	1	15	16
No	49	35	84
Totals	50	50	100

X^2 - 14.60 (degree of freedom - 1) less than .005

Fifteen Mexicans against one Japanese have not seen a doctor because they did not want to spend the money on a doctor unless they had to. Here, it is recognized that socio-economic elements influence the attitudes toward medical treatment. Statistical analysis indicates the differences existing between the two groups.

TABLE 54.--Responses of the two groups to question 53c: You did not see a doctor because it might be painful--the doctor might hurt you

	Japanese	Mexican	Totals
Yes	0	4	4
No	50	46	96
Totals	50	50	100

X^2 - 4.16 (degree of freedom - 1) less than .05

Of the respondents who have not seen a doctor because a doctor might hurt them, only four Mexicans against no Japanese are found; there exist correlations between ethnicity and fear of pain in the medical treatment.

TABLE 55.--Responses of the two groups to question 53d: You did not see a doctor because you were too busy to see a doctor

	Japanese			Mexican			
	Male	Female	Total	Male	Female	Total	Totals
Yes	15	6	21	6	7	13	34
No	10	19	29	19	18	37	66
Totals	25	25	50	25	25	50	100

A relatively large number of the Japanese males have not seen a doctor because they were too busy as compared to the number of the Japanese females, and Mexican males and females; no significant differences are found between the two groups.

TABLE 56.--Responses of the two groups to question 53e: You did not see a doctor because the doctor might find something really wrong with you

	Japanese	Mexican	Totals
Yes	8	10	18
No	42	40	82
Totals	50	50	100

Escapist attitudes from reality of not having seen a doctor because a doctor might find something really wrong with the respondents are not expressed by many respondents. No significant differences are discovered between the two groups.

TABLE 57.--Responses of the two groups to question 53f: You did not see a doctor because you did not think that the doctor could help you any

	Japanese	Mexican	Totals
Yes	2	3	5
No	48	47	95
Totals	50	50	100

Only a small number of the respondents express a fatalistic point of view, giving the reason of not having seen a doctor because the doctor could not help them any. Hereupon, no statistically significant differences are found between the two groups.

Graham's study[1] on the relationship of socio-economic status, illness, and use of physicians and hospitals reveals that the proportions of people who see a doctor for routine physical examination decline with class rank. The majority of the respondents of the present study express the favorable attitudes toward medical check-ups. They find the check-ups necessary

[1]Graham, Jaco, op. cit., pp. 129-134.

mainly because illness can be prevented from progressing and because good health is maintained by medical check-ups.

TABLE 58.--Responses of the two groups to question 56: What is your opinion on medical check-ups?

	Japanese	Mexican	Totals
It is good, because illness can be prevented from progressing	28	31	59
It is good, because good health is maintained	21	17	39
It is good, but he is scared to know his serious illness	0	1	1
It is not necessary	1	1	2
Totals	50	50	100

In comparison with the number of respondents who recognize the importance and the necessity of medical check-ups, the number of the respondents who have them in reality is smaller. There is no significant difference between the two groups. Table 59 indicates whether or not the respondents do, in fact, have medical check-ups and Table 60 presents the frequency of regular check-ups if the respondents have them.

TABLE 59.--Responses of the two groups to question 57: Do you have a regular medical check-up?

	Japanese	Mexican	Totals
Yes	33	26	59
No	17	24	41
Totals	50	50	100

TABLE 60.--Frequency of a regular medical check-up by the respondents of the two groups

	Japanese	Mexican	Totals
Once in half a year	3	2	5
Once a year	22	20	42
Once in two years	5	2	7
Once in more than two years	3	2	5
Totals	33	26	59

Table 60 shows that the majority of the respondents who have a regular check-up do this once a year.

How much interest do the respondents have in advances in modern medicine and health? Do they read the health columns in newspapers on health? It is regarded that those who read the articles on health are often more likely to accept the advances in modern medicine which are explained in the articles by a medical professional. The following two questions are taken from the questions used on medical care by the National Opinion Research Center. Table 61 shows that the majority of the respondents read health columns in newspapers often or occasionally. No significant differences exist between the Japanese and the Mexicans in terms of frequency of reading health columns in newspapers.

TABLE 61.--Responses of the two groups to question 54: Do you read the health columns in newspapers and newspaper articles about health?

	Japanese	Mexican	Totals
Frequently	21	18	39
Only occasionally	23	28	51
Hardly ever	6	4	10
Totals	50	50	100

In relation to the previous question, another question is asked of the respondents whether the respondents have read articles about health and medicine in magazines in the previous month of the interview.

TABLE 62.--Responses of the two groups to question 55: Have you read any magazine columns or articles about health and medicine in the last month?

	Japanese	Mexican	Totals
Yes	33	25	58
No	17	25	42
Totals	50	50	100

The larger number of the respondents read articles on health and medicine in the month prior to the interview. There is no significant difference between the Japanese and Mexican respondents.

Summary

Findings of this chapter are as follows:

1. The majority of the respondents of both groups do not think that the instruments in the doctor's office or in the hospital cause fear in them.

2. Although the majority of the respondents in both groups do not depend upon herbs or animal parts when they are sick, the Japanese are less likely to depend upon herbs or animal parts than are the Mexicans.

3. The majority of the respondents of both groups think that as a patient they should always do quietly whatever the physician says or directs them to do while they are under his care.

4. The majority of the respondents of both groups think that a good physician should give the patient full information about his condition and explain it carefully.

5. The majority of the respondents of both groups expect a doctor to be a professional man.

6. Whereas the majority of the Japanese do not tend to check the diagnosis and treatment of one doctor against the opinion of other specialists in the field when their pain is relieved, the majority of the Mexicans tend to check them. Significant differences are not found.

7. The majority of the respondents of both groups think that there is some advantage in consulting a specialist rather than a general practitioner.

8. The majority of the respondents of both groups prefer to have their family doctor examine them before consulting a specialist.

9. The majority of the respondents of both groups see a doctor immediately if they have a symptom of a cough any time during the day or night which lasts for three weeks.

10. The majority of the respondents of both groups see a doctor immediately if they have a symptom of getting tired for weeks at a time for no special reason.

11. The majority of the respondents of both groups see a doctor immediately if they have a symptom of skin rash or breaking out on any part of the body.

12. The majority of the respondents of both groups see a doctor immediately if they have a symptom of diarrhea for four or five days.

13. The majority of the respondents of both groups see a doctor immediately if they have a symptom of shortness of breath even after light work.

14. The majority of the respondents of both groups see a doctor immediately if they have a symptom of unexplained loss of over ten pounds in weight.

15. The majority of the respondents of both groups see a doctor immediately if they have a symptom of repeated pains in or near the heart.

16. Whereas the majority of the Mexicans see a doctor

immediately if they have a symptom of sore throat or running nose with a fever as high as 100° F for a day or more, the majority of the Japanese do not. The Mexicans are more likely to see a doctor immediately with this symptom than are the Japanese.

17. The majority of the respondents of both groups did not fail to see a doctor for the reason that they did not know any really good doctor.

18. Although the majority of the respondents of both groups did not fail to see a doctor for the reason that they did not want to spend the money on a doctor unless they had to, the Japanese are less likely to have failed to see a doctor for this reason than are the Mexicans.

19. Although the majority of the respondents of both groups did not fail to see a doctor for the reason that they were afraid of pain in the process of medical treatment, the Japanese are less likely to have failed to see a doctor for this reason than are the Mexicans.

20. The majority of the respondents of both groups did not fail to see a doctor for the reason that they were too busy to see a doctor.

21. The majority of the respondents of both groups did not fail to see a doctor for the reason that the doctor might find something really wrong with them.

22. The majority of the respondents of both groups did not fail to see a doctor for the reason that the doctor could

not help them any.

23. The majority of the respondents of both groups think that medical check-ups are good, because illness can be prevented from progressing.

24. The majority of the respondents of both groups have a regular medical check-up once a year.

25. The majority of the respondents of both groups read the health columns in newspapers and newspaper articles about health frequently or occasionally.

26. The majority of the Japanese and half of the Mexicans have read articles about health and medicine in magazines in the previous month of the interview.

The above findings show that only four out of twenty-six items support Hypothesis II, and the cause of the attitudinal differences found in these four items cannot be determined to be ethnicity unless social factors such as age and education proved to be influential.

The majority of the respondents from both groups express a great degree of acceptance of the advances in modern medicine. It might be possible to consider that the main reason for this is due to the fact that the respondents are selected from the population of a metropolis where the advances in various fields are firstly introduced, and where these advances are followed and exploited by its dwellers. Through a mass communication system, urban dwellers quickly grasp the various aspects of

modern science, and their knowledge of newly introduced techniques and materials leads them to accept advances in modern science easily.

CHAPTER VI

A COMPARISON OF ATTITUDES OF JAPANESE-AMERICANS AND MEXICAN-AMERICANS TOWARD MEDICINE IN GENERAL

This chapter investigates the attitudes of Japanese-Americans and Mexican-Americans toward various aspects of medicine in general without reference to the two hypotheses.

The respondents, who have been hospitalized in the recent past, are asked about their hospital experiences and their selection of the physician before their last hospitalization. The respondents' attitudes toward medical care and hospital care are explored together with their general ideas on physicians and hospitals.

The questions (25, 25A, 26, 27, 28, 30, 31, 32, 33, 34, 35, 36, 38, 38A, 38B, 39, 39A, 39B, 40, 41, 42, 45, 46, 51, and 58) are related to various aspects of attitudes toward medicine in general; such as, attitudes toward medical care, hospital care, health insurances, and socialized medicine.

Last Hospitalization Experiences of the Former Patients of Japanese and Mexican Origin

The date and the duration of the last hospitalization together with the name of the hospital and the name of the illness are asked of the respondents.

TABLE 63.--Responses of Japanese-Americans and Mexican-Americans in the Chicago area to question 31a: When were you last treated in the hospital? Please specify date.

	Japanese	Mexican	Totals
1962-1967	18	30	48
1957-1961	8	11	19
1952-1956	9	4	13
1947-1951	6	4	10
1942-1946	5	1	6
1937-1941	3	0	3
Before 1936	1	0	1
Totals	50	50	100

Table 64 presents the type of illness the respondents had at the last hospitalization. Illnesses are largely classified into medical and surgical diseases, subdivided into acute and chronic diseases, and then subdivided into mild, moderate, and severe disease. Mild disease does not cause pain and is not life threatening, moderate disease is major illness but does not involve mortality, serious but fairly easily controlled, though pain and disease itself can develop to severeness, and severe disease causes severe pain and is life threatening. As is shown in Table 64, the majority of the respondents had surgical acute and chronic diseases with moderate severeness.

The duration of the hospitalization is presented in Table 65. The majority of the respondents from both groups were confined in the hospital for four days to two weeks.

TABLE 64.--Responses of the two groups to question 31b: When were you last treated in the hospital? Please specify your illness.

	Japanese	Mexican	Totals
Medicine acute mild	2	1	3
Medicine acute moderate	3	5	8
Medicine acute severe	1	0	1
Medicine chronic mild	3	3	6
Medicine chronic moderate	2	4	6
Medicine chronic severe	1	0	1
Surgery acute mild	4	3	7
Surgery acute moderate	22	15	37
Surgery acute severe	1	5	6
Surgery chronic mild	2	4	6
Surgery chronic moderate	9	9	18
Surgery chronic severe	0	1	1
Totals	50	50	100

TABLE 65:--Responses of the two groups to question 31c: When were you last treated in the hospital? How long were you in the hospital?

	Japanese	Mexican	Totals
Less than 3 days	4	9	13
4 to 7 days	19	16	35
8 to 14 days	20	14	34
2 weeks to 1 month	5	4	9
More than 1 month	2	5	7
More than 6 months	0	1	1
More than 1 year	0	1	1
Totals	50	50	100

Types of hospitals are classified into (1) private hospitals, (2) Governmental hospitals, including Veterans' Administration hospitals, county hospitals, and hospitals attached to state universities, and (3) Army, Navy, or Marine hospitals and hospitals in relocation centers during the last war. The majority of the respondents were confined in private hospitals.

TABLE 66.--Responses of the two groups to question 31d: When were you last treated in the hospital? Please specify the name of the hospital.

	Japanese	Mexican	Totals
Private hospitals	44	43	87
Governmental hospitals	0	2	2
Army, Navy, or Marine hospitals and Camp hospitals during the war	6	5	11
Totals	50	50	100

The statistical analysis of the respondents' opinions on the number of visits by the doctor at their last hospitalization indicates that the majority of the respondents were satisfied with the number of visits by the doctor. There are no statistical differences between the two groups.

Of the four respondents who think that the number of visits by the doctor were not enough to take care of the kind of pain or discomfort they were experiencing, one Japanese states that the pain did not leave soon, one Japanese states that she

needed more personal attention, and one Japanese and one Mexican state that the doctor should have come more often.

TABLE 67.--Responses of the two groups to question 32: Were the number of visits by your doctor, in your opinion, enough to take care of the kind of pain or discomfort you were experiencing?

	Japanese	Mexican	Totals
Yes	47	49	96
No	3	1	4
Totals	50	50	100

TABLE 68.--Responses of the two groups to question 32: Please specify the number of visits by your doctor.

	Japanese	Mexican	Totals
More than once a day	7	4	11
Once a day	40	41	81
Less than once a day	3	5	8
Totals	50	50	100

Table 68 shows that the majority of the respondents from both groups specify the visits by the doctor as once a day.

The overwhelming majority of the respondents of the Japanese and the Mexicans had confidence in the doctor who treated them. There are no differences found between the Japanese and the Mexicans.

TABLE 69.--Responses of the two groups to question 33: Did you have confidence in the doctor who treated you or did you harbor any doubts?

	Japanese	Mexican	Totals
Confidence	49	48	97
Doubts	1	2	3
Totals	50	50	100

Out of three respondents who harbored some doubts about the doctor, one Mexican gives the reason that the reputation of the doctor was not so good, one Mexican gives the reason that the doctor was not familiar with him, and one Japanese gives the reason that the doctor diagnosed his illness incorrectly.

The following three tables present the degrees of satisfaction expressed by the respondents of both groups with the doctor in terns of nature of symptoms, prognosis, and relief.

TABLE 70.--Responses of the two groups to question 34a: When the doctor visited you, did he give you the kind of satisfaction you wanted in terms of the nature of symptoms?

	Japanese	Mexican	Totals
Yes	47	49	96
No	3	1	4
Totals	50	50	100

TABLE 71.--Responses of the two groups to question 34b: When the doctor visited you, did he give you the kind of satisfaction you wanted in terms of the nature of prognosis?

	Japanese	Mexican	Totals
Yes	47	46	93
No	3	4	7
Totals	50	50	100

TABLE 72.--Responses of the two groups to question 34c: When the doctor visited you, did he give you the kind of satisfaction you wanted in terms of the nature of relief?

	Japanese	Mexican	Totals
Yes	48	48	96
No	2	2	4
Totals	50	50	100

Tables 70, 71, and 72 indicate that the great majority of the respondents were satisfied with the doctor in terms of the nature of the symptoms, prognosis, and relief. There exist no differences between the two groups concerning their satisfaction with the doctor.

The respondents were asked whether they directed the physician's attention to some aspect of illness. Pratt,

Seligmann, and Reader[1] point out that the effective doctor-patient relationship is associated with the level of patient's participation with the doctor.

TABLE 73.--Responses of the two groups to question 36: When you were in the hospital, did you direct the physician's attention to some aspect of your illness?

	Japanese	Mexican	Totals
Yes	13	9	22
No	36	41	77
Uncertain	1	0	1
Totals	50	50	100

X^2 - .93 (degree of freedom - 1) more than .25

No statistically significant differences are found between the two groups. As Table 74 presents, the majority of the respondents did not direct the physician's attention to some aspect of illness because there was no necessity to do so.

As to the medical care the respondents received from the doctor, the previous tables show that the majority of the respondents were satisfied with the doctor.

Table 75 presents the respondents' perception of the doctor's personal interest in them at their last hospitalization.

[1]Pratt, Seligmann, and Reader, Jaco, op. cit., pp. 222-9.

TABLE 74.--Explanation of the two groups on question 36: When you were in the hospital, did you direct the physician's attention to some aspect of illness?

	Japanese	Mexican	Totals
No, there was no necessity	36	41	77
Yes, about after effect of injection	2	0	2
Yes, about disability of breathing, eating and sleeping	2	4	6
Yes, about outcome of operation such as pain and excess bleeding	5	4	9
Yes, about pain or rash on other parts of the body	4	0	4
Yes, about the pain the doctor could not diagnose	0	1	1
Totals	49	50	99

TABLE 75.--Responses of the two groups to question 35: Did you feel that the doctor took a personal interest in you?

	Japanese	Mexican	Totals
Yes	44	45	89
No	6	5	11
Totals	50	50	100

The majority of the respondents from the two groups felt that the doctor took a personal interest in them against the finding by Koos[1] on metropolis residents who criticized that

[1]Koos, op. cit., pp. 1551-1557.

modern technical-centered medical practice lacks any human warmth. Ten out of eleven respondents who did not feel that the doctor took a personal interest in them give reasons. Three Japanese state that the doctor did not pay them special attention, two Japanese and three Mexicans state that the doctor was too busy, one Mexican states that the doctor had more serious cases than his own, and one Mexican states that the doctor did not come to see him often.

The selection of the doctor prior to the last hospitalization is asked of the respondents.

TABLE 76.--Responses of the two groups to question 38: Prior to hospitalization, how did you choose your doctor?

	Japanese	Mexican	Totals
Family doctor	14	18	32
Specialist other than family doctor	15	8	23
Specialist recommended by family doctor	8	11	19
Doctor recommended by hospital	4	5	9
No particular doctor	9	8	17
Totals	50	50	100

All the respondents of both groups who had selected the doctor prior to their hospitalization except the respondents who had a doctor recommended by the hospital or who were assigned to the doctor were treated by the same doctor after their

hospitalization. The reasons of the respondents' choice of the doctor are given.

TABLE 77.--Responses of the two groups to question 38b: What was the reason of your selection of the doctor?

	Japanese	Mexican	Totals
The doctor has been a family doctor for a long time	8	9	17
The doctor lives in the neighborhood	2	0	2
The doctor is good	10	5	15
The doctor speaks the same language (belongs to the same ethnic group)	4	3	7
The doctor has a manner and interest in patients	0	1	1
Reputation of the medical institution the doctor belongs to is good	3	3	6
The doctor is recommended by another doctor whose opinion is trustworthy	7	11	18
No special reason (first trial of the doctor)	2	4	6
Totals	36	36	72

With regard to the experiences the respondents had with the doctor at the last hospitalization their satisfactory responses are manifested according to the previous tables. In addition, the respondents are asked whether they wish to return to the hospital in which they were previously confined and to same doctor by whom they were treated.

TABLE 78.--Responses of the two groups to question 40a: Should you become ill, would you like to return to the hospital in which you were previously confined?

	Japanese	Mexican	Totals
Yes	30	46	76
No	20	4	24
Totals	50	50	100

X^2 - 14.12 (degree of freedom - 1) less than .005

Although the larger number of the respondents from both groups express that they wish to return to the same hospital, there are significant differences between the two groups. A fairly large number of the respondents who do not wish to return to the same hospital explain their reasons.

TABLE 79.--Reasons of the respondents who do not want to return to the same hospital to which they were previously confined

	Japanese	Mexican	Totals
The hospital is too far or not existing	8	2	10
The hospital has a bad accomodation or a bad atmosphere	9	1	10
The hospital has a low rating among all the hospitals	1	0	1
Another hospital is more preferable	2	1	3
Totals	20	4	24

Also, a fairly large number of the respondents express that they do not wish to return to the same doctor. There exist no differences between the Japanese and the Mexicans.

TABLE 80.--Responses of the two groups to question 40b: Should you become ill, would you like to return to the same doctor?

	Japanese	Mexican	Totals
Yes	34	41	75
No	16	9	25
Totals	50	50	100

X^2 - 2.62 (degree of freedom - 1) more than .1

The reasons given by the former patients who do not wish to return to the same doctor are presented in Table 81.

TABLE 81.--Reasons of the respondents who do not want to return to the same doctor by whom they were previously treated

	Japanese	Mexican	Totals
The doctor is not available (moved, retired, or dead)	10	7	17
The doctor is too old or not good	2	2	4
The doctor is not the family doctor	3	0	3
Any doctor is the same	1	0	1
Totals	16	9	25

As to returning to the same hospital, the majority of the reasons are divided into inaccessibility of the hospital and bad accommodations in the hospital, while as to returning to the same doctor, the majority of the reasons are concentrated in unavailability of the doctor.

Only eleven respondents from both groups felt that their bodies were used for teaching purposes when they were treated previously.

TABLE 82.--Responses of the two groups to question 39: Have you ever felt that a particular doctor who was treating you was using your body for teaching purposes?

	Japanese	Mexican	Totals
Yes	5	6	11
No	45	44	89
Totals	50	50	100

TABLE 83.--Responses of the two groups to question 39a: If yes, were you entirely satisfied with your treatment?

	Japanese	Mexican	Totals
Yes	4	6	10
No	1	0	1
Totals	5	6	11

TABLE 84.--Responses of the two groups to question 39b: If yes, did you resent the secondary purpose?

	Japanese	Mexican	Totals
Yes	1	0	1
No	4	6	10
Totals	5	6	11

The respondents, with the exception of one Japanese female, whose bodies were used for teaching purposes were satisfied with their medical treatment and did not resent the secondary purpose.

General Ideas on Hospitals, Patients, and Doctors of the Former Patients of Japanese and Mexican Origin

The dislike of the Japanese and the Mexicans for the impersonal atmosphere and for the separation from the family in a hospital are asked of the respondents. While the respondents are confined in a hospital do they mind or dislike the impersonal atmosphere of the hospital where efficiency rather than personal attention is encouraged, and do they mind or dislike the separation from family because of the fact that they, being patients, are surrounded by the secondary groups of people, who are different from the primary groups of people such as members of the family?

TABLE 85.--Responses of the two groups to question 30a: Do you dislike impersonal atmosphere of the hospital?

	Japanese	Mexican	Totals
Yes	3	3	6
No	47	47	94
Totals	50	50	100

The majority of the respondents of the two groups express that they do not mind or dislike the impersonal atmosphere of the hospital.

TABLE 86.--Responses of the two groups to question 30b: Do you mind separation from family in the hospital?

	Japanese	Mexican	Totals
Yes	9	22	31
No	41	28	69
Totals	50	50	100

X^2 - 7.90 (degree of freedom - 1) less than .005

There are significant differences between the Japanese and the Mexicans in terms of their dislike of separation from family while they are confined in a hospital. The Mexicans are more likely to mind or dislike the separation from the family than are the Japanese.

What ideas do the respondents have on a "good hospital patient"? Every respondent gives one or more ideas on a good hospital patient. As Table 87 shows, a large number of the respondents think that a patient should follow the order and regulations and should demand as little and ask as little attention as possible.

TABLE 87.--Responses of the two groups to question 42: Who is a good hospital patient?

	Japanese	Mexican	Totals
One who cooperates with medical staff and gives little trouble	12	10	22
One who follows order and regulations	24	22	46
One who demands as little and asks as little attention as possible	20	15	35
One who trusts a doctor and gives him a chance to offer enough help	5	1	6
One who respects hospital staff and is considerate of them with appreciation	3	5	8
One who gives honest answers to the doctor and does not keep every thing in mind	2	2	4
One who considers other patients and gets aleng with them	5	5	10
One who acts normally and understands the situation	4	4	8
One who controls the pain and does not become emotional	3	1	4
One who is patient, pleasant, relaxed, calm, and quiet	4	15	19
Totals	82	80	162

One or more suggestions for improvement of the patient's comfort in a hospital are made by each of twenty-seven Japanese respondents and seventeen Mexican respondents. Table 88 indicates that many respondents suggest more help and personal attention to patients.

TABLE 88.--Responses of the two groups to question 41: Are there any suggestions that you would care to make for a possible improvement of the patient's comfort in a hospital?

	Japanese	Mexican	Totals
Efficiency and courtesy of medical staff to a patient	5	2	7
More help and more personal attention	12	6	18
More explanation from a doctor	2	1	3
Better judgement of nurses	1	1	2
Confidence and better care by nurses and nurses' aides	1	1	2
More privacy	1	0	1
More comfortable regulations, such as later waking hour and more visiting hours	5	3	8
More comfortable atmosphere, such as air conditioning and selection of the color of walls	2	3	5
Better accommodation such as more rooms, better food, seclusion of serious patients' rooms, and more bath rooms	4	3	7
Better communication system such as interphone	1	0	1
More efficiency of medical treatment by electric equipment	1	0	1
Totals	35	20	55

What ideas do the respondents have on doctors in general? Whereas the majority of the respondents feel that doctors are generally dedicated to their profession and have a sincere interest and desire to help people, a fairly large number of the respondents believe that some doctors are careless in attitudes toward and treatment of the sick.

TABLE 89.--Responses of the two groups to question 45: Do you feel that doctors are generally dedicated to their profession and have a sincere interest and desire to help people?

	Japanese	Mexican	Totals
Yes	46	46	92
No	3	3	6
Uncertain	1	1	2
Totals	50	50	100

TABLE 90.--Responses of the two groups to question 46: Do you believe that any doctors are careless in attitude and treatment towards the sick?

	Japanese	Mexican	Totals
Yes	19	21	40
No	27	25	52
Uncertain	4	4	8
Totals	50	50	100

The reasons why the respondents believe that some doctors are careless in attitude and treatment toward the sick are questioned.

TABLE 91.--Reasons for believing that some doctors are careless in attitude and treatment towards the sick

	Japanese	Mexican	Totals
Some doctors refuse house calls	1	1	2
Some doctors diagnose incorrectly, jump to conclusions without enough examination	5	5	10
Some doctors are inconsistent in explanations and give unsatisfactory information	0	4	4
Some doctors have attitude of doing a special favor for a patient and do not care for him as a patient	0	2	2
Some doctors are irresponsible in the way that they leave a patient while they are taking a vacation	2	1	3
Some doctors are over-interested in money	1	1	2
Some doctors are prejudiced against patients according to race and class	0	1	1
There must be some careless doctors but they were not encountered through the last experience	5	4	9
Totals	14	19	33

Health Insurance of the Former Patients of Japanese and Mexican Origin

Since medical treatment demands such a high expense, health insurance is recognized as being helpful to those who must undergo medical treatment. How much value do the respondents place on purchasing health insurances for fear that they

should be reluctant to receive necessary medical care in case of encountering some serious illnesses and injuries? Except for one respondent from each group, the greatest majority of the respondents of the Japanese and Mexicans own some kind of health insurances. Types of health insurances are specified by the respondents.

TABLE 92.--Responses of the two groups to question 25 and 25A: Do you have health insurance? If yes, please specify.

	Japanese	Mexican	Totals
Hospital and surgical	0	1	1
Hospital, surgical and medical	17	37	54
Hospital, surgical and other(s)	1	0	1
Hospital, surgical, medical and other(s)	31	11	42
No insurance	1	1	2
Totals	50	50	100

Means of purchasing health insurance is examined. Although the majority of both groups purchase their health insurance through the occupation they or their spouses hold, the Mexicans show a more marked tendency to do so than the Japanese.

TABLE 93.--Responses of the two groups to question 26: Has any health insurance you own been purchased through your company?

	Japanese	Mexican	Totals
Yes	31	44	75
No	12	0	12
Both	6	5	11
Totals	49	49	98

X^2 - 9.18 (degree of freedom - 1) less than .005

Means of the medical payment is asked of the respondents, the majority of whom answer that insurance and their savings pay every medical cost involved.

TABLE 94.--Responses of the two groups to question 27: Should you become ill, how would you meet the medical costs involved?

	Japanese	Mexican	Totals
Insurance	7	6	13
Insurance and savings	42	43	85
Other(s)	0	1	1
No answer	1	0	1
Totals	50	50	100

Opinions on socialized medicine are asked of the respondents. A fairly large number of the Japanese and the majority of the Mexicans are classified as "uncertain," because they are not aware of the term itself or its meaning. Differences are found between the two groups.

TABLE 95.--Responses of the two groups to question 28: Are you in favor of socialized medicine?

	Japanese	Mexican	Totals
Yes	15	7	22
No	22	10	32
Uncertain	13	33	46
Totals	50	50	100

X^2 - 16.00 (degree of freedom - 1) less than .005

Explanations of approval or disapproval for socialized medicine are given by the respondents. Although the reasons for approval of socialized medicine are given with variety, the reason for disapproval is represented by, "The needy are able to get medical attention."

TABLE 96.--Reasons for being in approval or disapproval of socialized medicine

	Japanese	Mexican	Totals
Favor, because the needy are able to get the medical attention	13	5	18
Favor, because medical cost is kept down	1	2	3
Favor, because all doctors are same	1	0	1
Favor, because everybody should have his responsibility to pay his medical expenses	4	1	5
Disfavor, because many are able to pay medical expenses	2	3	5
Disfavor, because medicine should be free enterprise (socialized medicine will bring socialism)	6	1	7
Disfavor, because private care is better	1	0	1
Disfavor, because there is no selection of the doctor	4	1	5
Disfavor, because doctors will not work hard	0	1	1
Disfavor, because it will break up doctor-patient relationship	3	1	4
Disfavor, because doctors are unable to get enough gain which causes shortage of doctors	2	1	3
Disfavor, because people are limited to benefits	0	1	1
Totals	37	17	54

Attitudes of the Japanese-Americans and Mexican-Americans Toward Medical Aid in Home Situations

Some people feel that it is necessary to see a doctor even if they think that they are able to cure sickness or injury by home therapy. The majority of the respondents, however, feel that it is not necessary to see a doctor if they think they can cure the illness or injury by home therapy. There are no differences found between the two groups.

TABLE 97.--Responses of the two groups to question 51: If you think that you can cure sickness or injury by home therapy, is it necessary to go to the doctor?

	Japanese	Mexican	Totals
Yes	6	11	17
No	44	39	83
Totals	50	50	100

X^2 - 1.78 (degree of freedom - 1) more than .25

A relatively large number of the respondents of both groups call for pain relief using drugs.

TABLE 98.--Responses of the two groups to question 58: When you have pain, do you call for relief?

	Japanese	Mexican	Totals
Yes	34	32	66
No	16	18	34
Totals	50	50	100

Tables 97 and 98 show some tendency of both groups to depend upon drugs or other kinds of medical aids available at the home situation without the doctor's care.

Summary

Findings of this chapter are as follows:

These are the findings of the last hospitalization experiences of the former patients of Japanese and Mexican origin:

1. The majority of the respondents of both groups were satisfied with the number of visits by the doctor.

2. The majority of the respondents of both groups had confidence in the doctor.

3. The majority of the respondents of both groups were satisfied with the doctor in terms of the nature of symptoms, prognosis, and relief.

4. The majority of the respondents of both groups did not direct the doctor's attention to some aspect of illness because there was no necessity to do so.

5. The majority of the respondents of both groups felt the doctor took a personal interest in them.

6. The majority of the respondents of both groups selected the doctor prior to their hospitalization mainly because of their full confidence in the doctor or full confidence

in the opinion of another doctor who recommended the doctor.

7. The Mexicans are more likely to go back to the hospital where they were previously confined than are the Japanese.

8. The majority of the respondents of both groups wish to return to the same doctor by whom they were previously treated.

9. The majority of the respondents of both groups were not used for teaching purposes at their medical treatment.

These are the findings of general ideas on hospitals, patients, and doctors of the former patients of Japanese and Mexican origin:

1. The majority of the respondents of both groups do not mind or dislike the impersonal atmosphere of the hospital.

2. The Mexicans are more likely to mind or dislike the separation from the family in a hospital than are the Japanese.

3. The majority of the respondents of both groups regard a "good hospital patient" as one who follows the order and regulatimns and the one who demands and asks as little attention as possible.

4. A fairly large number of the respondents of both groups make suggestions for the improvement of the patients' comfort which are represented by more help and more personal attention.

5. The majority of the respondents of both groups feel feel that doctors are generally dedicated to their profession and have a sincere interest and desire to help people.

6. A relatively large number of the respondents of both groups believe that some doctors are careless in attitudes toward the sick, and point out that some doctors err without careful examination of patients.

These are the findings of health insurance of the former patients of Japanese and Mexican origin:

1. The majority of the respondents of both groups own at least hospital, surgical, and medical insurance, which do not pay every medical cost involved.

2. The Mexicans are more likely to purchase their health insurance only through the occupation they or their spouses hold than are the Japanese.

3. The Japanese are more likely to have opinions about socialized medicine than are the Mexicans.

These are the findings of attitudes of Japanese-Americans and Mexican-Americans toward medical aid in home situations:

1. The majority of the respondents of both groups do not think that it is necessary to go to the doctor if they can cure sickness or injury by home therapy.

2. The larger number of the respondents from both groups call for relief by using some drugs when they have pain.

CHAPTER VII

AN EXAMINATION OF SIGNIFICANT FINDINGS WITH REFERENCE TO THE TWO HYPOTHESES BY TWO TEST VARIABLES OF AGE AND EDUCATION

This chapter is an attempt to investigate the question of whether social factors have an influence on the significant differences found between the two groups with reference to the two hypotheses. In Chapter IV and Chapter V an attempt was made to test these two hypotheses which were supported by nine out of forty-two items. However, as was discussed in Chapter III, the Japanese respondents and Mexican respondents exhibited marked differences from each other in their social backgrounds. Therefore, in order to test how much influence social backgrounds have on the formulation of the different attitudes of the Japanese and Mexican respondents, two social factors--age and education--are chosen as test variables.

Table 1 presents the age distribution of the respondents. As the table shows, the distribution patterns are dissimilar. The respondents of each group are divided into two categories according to the differences in age: (1) the respondents who are over forty years of age, and (2) the respondents who are under forty years of age. Differences of age between the two

groups are marked, as is shown in the table. Only eight respondents are classified in the first category and forty-two in the second among the Japanese, while twenty-two and twenty-eight respondents are classified in these respective categories among the Mexicans.

TABLE 1.--Age of respondents

	Japanese	Mexican	Total
20-24	0	0	0
25-29	0	3 (6)	3
30-34	3 (6)	10 (20)	13
35-39	5 (10)	15 (30)	20
40-44	11 (22)	11 (22)	22
45-49	11 (22)	10 (20)	21
Over 50	20 (40)	1 (2)	21
Totals	50 (100)	50 (100)	100

Table 4 shows that the two groups also differ in educational attainment. The respondents are divided into three categories according to differences in educational attainment: (1) the respondents who have completed college or have attained a higher than college education, (2) the respondents who have completed high school or have attained some college education, and (3) the respondents who have attained some elementary education, have completed elementary education, or have attained some high school education. The Japanese respondents are classified into three categories: fifteen in the first, thirty-two in the second, and three in the third category. However, the Mexican

respondents fit only into the second and third categories with twenty-one in the second and twenty-nine in the third.

TABLE 4.--Educational attainment of respondents

	Japanese	Mexican	Totals
Some elementary	0	4	4
Completed elementary	1 (2)	4 (8)	5
Some high school	2 (4)	21 (42)	23
Completed high school	15 (30)	17 (34)	32
Some college	17 (34)	4 (8)	21
Completed college	9 (18)	0	9
Some graduate or professional	3 (6)	0	3
M.A.	2 (4)	0	2
Ph.D.	0	0	0
M.D. or D.D.S.	1 (2)	0	1
Totals	50 (100)	50 (100)	100

As Table 14 shows, the majority of the respondents of both groups think that having pain is necessary, although the Japanese group has a greater tendency to think so than the Mexican group.

TABLE 14.--Responses of the two groups to question 60: Do you think that having pain is necessary?

	Japanese	Mexican	Totals
Yes	41	30	71
No	9	19	28
Uncertain	0	1	1
Totals	50	50	100

Table 99 shows that 83% of the older Japanese respondents as against 75% of the younger respondents think that having pain is necessary, while Table 100 indicates that 70% of the older Mexicans as against 53% of the younger respondents are so inclined. The conclusion drawn from these two tables is that the older respondents of both groups tend to think that having pain is necessary more than the younger respondents, although, as is indicated by the E figure, this tendency is affected by age more among the Mexicans than the Japanese.

TABLE 99.--Responses of the Japanese group to question 60 by age: Do you think having pain is necessary?

	Over 40	Under 40	Totals	E
Yes	(35) 84%	(6) 75%	(41) 82%	8
No	(7) 17%	(2) 25%	(9) 18%	-8
Totals	(42) 100%	(8) 100%	(50) 100%	16

TABLE 100.--Responses of the Mexican group to question 60 by age: Do you think having pain is necessary?

	Over 40	Under 40	Totals	E
Yes	(15) 70%	(15) 53%	(30) 60%	17
No	(6) 28%	(13) 47%	(19) 38%	-19
Uncertain	(1) 2%	(0)	(1) 2%	
Totals	(22) 100%	(28) 100%	(50) 100%	36

The same item is examined in terms of the educational factor in Tables 101 and 102. As is presented in Table 101, the percentage of positive responses of the college graduates and the high school graduates of the Japanese group are almost equal (80% and 84% respectively), but both percentages are noticeably larger than the proportion of positive responses expressed by these respondents with lower education-levels (66%). However, among the Mexicans, 52% of those having higher education levels and 66% of those having lower education levels think that having pain is necessary. There is a positive correlation in the Japanese group, therefore, between educational attainment and attitudes of accepting the necessity of pain, a negative correlation in the Mexican group.

TABLE 101.--Responses of the Japanese group to question 60 by education: Do you think having pain is necessary?

	College	High School	Less than High School	Totals	E
Yes	(12) 80%	(27) 84%	(2) 66%	(41) 82%	
No	(3) 20%	(5) 16%	(1) 34%	(9) 18%	
Totals	(15) 100%	(32) 100%	(3) 100%	(50) 100%	

Table 16 shows that the majority of the respondents of both groups do not show their sufferings in an emotional manner, though the Mexican group has a greater tendency to express emotion at the time of pain experience than the Japanese group.

TABLE 102.--Responses of the Mexican group to question 60 by education: Do you think having pain is necessary?

	High School		Less than High School		Totals		E
Yes	(11)	52%	(19)	66%	(30)	60%	-14
No	(10)	48%	(9)	30%	(19)	38%	18
Uncertain	(0)		(1)	4%	(1)	2%	
Totals	(21)	100%	(29)	100%	(50)	100%	32

TABLE 16.--Responses of the two groups to question 61: Do you show sufferings by groaning, moaning, or crying?

	Japanese	Mexican	Totals
Yes	10	21	31
No	40	29	69
Totals	50	50	100

The uniqueness of Table 103 is explained by the fact that nine out of the ten Japanese who show sufferings of pain in an emotional manner are the older respondents. Regarding the Mexican group, 47% of the younger respondents, as compared to 37% of the older respondents, give positive responses to the item. It may be consequently generalized that among the Japanese older respondents, there is more emotional response to pain than do the younger respondents, whereas among the Mexican group the reverse tendency is found.

TABLE 103.--Responses of the Japanese group to question 61 by age: Do you show your sufferings by groaning, moaning, or crying?

	Over 40	Under 40	Totals	E
Yes	(9) 21%	(1) 12.5%	(10) 20%	8
No	(33) 79%	(7) 87.5%	(40) 80%	-9
Totals	(42) 100%	(8) 100%	(50) 100%	17

TABLE 104.--Responses of the Mexican group to question 61 by age: Do you show your sufferings by groaning, moaning, or crying?

	Over 40	Under 40	Totals	E
Yes	(8) 37%	(13) 47%	(21) 42%	-10
No	(14) 63%	(15) 53%	(29) 58%	10
Totals	(22) 100%	(28) 100%	(50) 100%	20

Table 105 indicates three interesting characteristics of the Japanese responses to the item. First, none of the respondents with the highest educational levels express positive responses; secondly, the higher the education level of the respondents, the less emotional responses to pain, and thirdly, the original pattern[1] is reversed by those having the lowest

[1] "The original pattern" refers to the pattern of distribution of positive and negative responses which is manifested by the percentages listed under the total column in each table. Example: In Table 105 the original pattern has larger

education levels, signifying that the attitude of the group is more strongly affected by the age factor than by ethnicity. As Table 106 shows, the Mexican respondents having higher education levels also show less emotional response to pain than do those respondents having lower education levels. From these tables it is apparent that there is a negative correlation in both groups between educational attainment and attitudes toward the emotional responses to pain (although the Japanese group is influenced by the education factor significantly).

TABLE 105.--Responses of the Japanese group to question 61 by education: Do you show your sufferings by groaning, moaning, or crying?

	College		High School		Less than High School		Totals		E	
Yes	(0)		(8)	25%	(2)	66%	(10)	20%	-25	-41
No	(15)	100%	(24)	75%	(1)	34%	(40)	80%	25	42
Totals	(15)	100%	(32)	100%	(3)	100%	(50)	100%		

Table 17 shows that the majority of the Japanese and of the Mexicans do not show their sufferings in an emotional manner in the presence of medical personnel, though the latter group is more inclined to show their emotion toward pain than the former.

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proportion of negative answers (80%) than positive answers (20%). The pattern is reversed by those who have the lowest education levels: negative answers, 33%; positive answers, 67%.

TABLE 106.--Responses of the Mexican group to question 61 by education: Do you show your sufferings by groaning, moaning, or crying?

	High School	Less than High School	Totals	E
Yes	(7) 33%	(14) 48%	(21) 42%	-15
No	(14) 67%	(15) 52%	(29) 58%	15
Totals	(21) 100%	(29) 100%	(50) 100%	30

TABLE 17.--Responses of the two groups to question 62: Is it natural to show pain by groaning, moaning, or crying in front of a doctor or a nurse?

	Japanese	Mexican	Totals
Yes	8	22	30
No	41	28	69
Uncertain	1	0	1
Totals	50	50	100

The statistical analysis of the Japanese group reveals the following evidence. First, seven out of the eight respondents who think that it is natural to show pain in an emotional manner in the presence of medical personnel are in the older group; secondly, the proportion of positive responses of the older respondents (17%) is slightly larger than that of the younger ones (12.5%). The uniqueness of the Mexican group is explained in the following manner: first, the younger

respondents are more inclined to show pain in an emotional manner in the presence of medical personnel than are the older respondents (50% and 37% respectively); secondly, opinions of the younger respondents are equally divided into positive and negative responses, causing the original pattern to be changed significantly, which indicates that the attitude of the group is significantly affected by the age factor. It follows, therefore, that there is a positive correlation in the Japanese group between age and attitudes toward showing pain in an emotional manner in the presence of medical personnel, and a negative correlation in the Mexican group (although the latter group is influenced by age significantly).

TABLE 107.--Responses of the Japanese group to question 62 by age: Is it natural to show pain by groaning, moaning, or crying in front of a doctor or a nurse?

	Over 40		Under 40		Totals		E
Yes	(7)	17%	(1)	12.5%	(8)	16%	4
No	(34)	81%	(7)	87.5%	(41)	82%	-7
Uncertain	(1)	2%	(0)		(1)	2%	
Totals	(42)	100%	(8)	100%	(50)	100%	11

Table 109 indicates that among the Japanese respondents, 13% of the college graduates and 19% of the high school graduates--but none of the respondents who attained less than high school education--think that it is natural to show pain in an

TABLE 108.--Responses of the Mexican group to question 62 by age: Is it natural to show pain by groaning, moaning, or crying in front of a doctor or a nurse?

	Over 40	Under 40	Totals	E
Yes	(8) 37%	(14) 50%	(22) 44%	-13
No	(14) 63%	(14) 50%	(28) 56%	13
Totals	(22) 100%	(28) 100%	(50) 100%	26

emotional manner in the presence of medical personnel. The most interesting feature of the Mexican responses presented in Table 110 is that 52% of the respondents having higher education levels act emotionally in the presence of medical personnel in contrast to only 38% of the respondents having lower education levels. In addition, the fact that the original pattern is reversed by the former illustrates a more significant influence on the attitude of the group from the educational factor than from the cultural factor. Tables 109 and 110 show, therefore, that educational attainment is positively correlated to affirmative responses to this item in both groups (although the Mexican group is influenced by the educational factor significantly).

TABLE 109.--Responses of the Japanese group to question 62 by education: Is it natural to show pain by groaning, moaning, or crying in front of a doctor or a nurse?

	College	High School	Less than High School	Totals	E
Yes	(2) 13%	(6) 19%	(0)	(8) 16%	
No	(13) 87%	(25) 78%	(3) 100%	(41) 82%	
Uncertain	(0)	(1) 3%	(0)	(1) 2%	
Totals	(15) 100%	(32) 100%	(3) 100%	(50) 100%	

TABLE 110.--Responses of the Mexican group to question 62 by education: Is it natural to show pain by groaning, moaning, or crying in front of a doctor or a nurse?

	High School	Less than High School	Totals	E
Yes	(11) 52%	(11) 38%	(22) 44%	14
No	(10) 48%	(18) 62%	(28) 56%	-14
Totals	(21) 100%	(29) 100%	(50) 100%	28

TABLE 27.--Responses of the two groups to question 72: When your children are injured as a result of play, do you show attitudes of worry or concern?

	Japanese	Mexican	Totals
Yes	28	38	66
No	21	12	33
Uncertain	1	0	1
Totals	50	50	100

Although the majority of the Japanese group and of the Mexican group show attitudes of worry or concern to their children who are injured as a result of play, the latter has a higher tendency to do so than the former.

Table 111 reveals that the older Japanese have a higher tendency to show attitudes of worry or concern to their children who are injured than do the younger ones whose diverse responses reverse the original pattern of the group, thus indicating that the attitude of the group is more influenced by age than ethnicity. The younger Mexicans, on the contrary, are more inclined, as is presented in Table 112, to show this attitude than are the older ones. A comparison of the two tables indicates that there is an inverse relationship between the age factor and the attitudes of the two groups; whereas the older Japanese respondents do not cloak their worry or concern from their children as much as the younger respondents, the older Mexicans are less open in this regard than are the younger respondents. The Japanese group is significantly affected by the age factor.

As the percentage figures of 53%, 56%, and 66% of Table 113 show, the proportions of positive responses become larger if education levels go lower among the Japanese respondents. Table 114 also indicates that the proportions of positive responses are larger among the younger Mexicans than among the older ones (83% and 67% respectively). The conclusion that may be drawn here is that the more highly educated respondents of

both groups are less inclined to show worry or concern to their children who are injured than are the less educated respondents.

TABLE 111.--Responses of the Japanese group to question 72 by age: When your children are injured as a result of play, do you show attitudes of worry or concern?

	Over 40		Under 40		Totals		E
Yes	(25)	59%	(3)	37%	(28)	56%	22
No	(16)	39%	(5)	63%	(21)	42%	-24
Uncertain	(1)	2%	(0)		(1)	2%	
Totals	(42)	100%	(8)	100%	(50)	100%	46

TABLE 112.--Responses of the Mexican group to question 72 by age: When your children are injured as a result of play, do you show attitudes of worry or concern?

	Over 40		Under 40		Totals		E
Yes	(15)	66%	(23)	82%	(38)	76%	-16
No	(7)	33%	(5)	18%	(12)	24%	15
Totals	(22)	100%	(28)	100%	(50)	100%	31

TABLE 113.--Responses of the Japanese group to question 72 by education: When your children are injured as a result of play, do you show attitudes of worry or concern?

	College		High School		Less than High School		Totals		E	
Yes	(8)	53%	(18)	56%	(2)	66%	(28)	56%	-3	-10
No	(7)	47%	(13)	41%	(1)	33%	(21)	42%	6	8
Uncertain	(0)		(1)	3%	(0)		(1)	2%		
Totals	(15)	100%	(32)	100%	(3)	100%	(50)	100%		

TABLE 114.--Responses of the Mexican group to question 72 by education: When your children are injured as a result of play, do you show attitudes of worry or concern?

	High School		Less than High School		Totals		E
Yes	(14)	67%	(24)	83%	(38)	76%	-16
No	(7)	33%	(5)	17%	(12)	24%	16
Totals	(21)	100%	(29)	100%	(50)	100%	32

Table 28 shows that the majority of the Mexican group give some verbal expression of emotion to their children, whereas the reverse tendency is found among the Japanese group.

TABLE 28.--Responses of the two groups to question 73: Should your children be injured as a result of sports and games, would you console them by giving any verbal expression of emotion such as "poor child"?

	Japanese	Mexican	Totals
Yes	16	27	43
No	34	23	47
Totals	50	50	100

Differences of the proportions of positive responses shown in Table 115 (which are given as 30% of the older Japanese respondents and 47% of the youhger ones) indicate that the latter are slightly more inclined to express emotion verbally to their children than are the former. It is noticeable that the

proportion of positive answers of the older Mexican respondents (45%) is much smaller than that of the younger ones (61%), reversing the original pattern, which explains the significant influence of the age factor on the attitude of the group. Although there exists a negative correlation in both groups between age and attitudes of expressing emotion verbally to children who are injured, the Mexican group is more influenced by the age factor than by the cultural factor.

TABLE 115.--Responses of the Japanese group to question 73 by age: Should your children be injured as a result of sports and games, would you console them by giving any verbal expression of emotion, such as "poor child"?

	Over 40		Under 40		Totals		E
Yes	(13)	30%	(3)	37%	(16)	32%	-7
No	(29)	70%	(5)	63%	(34)	68%	7
Totals	(42)	100%	(8)	100%	(50)	100%	14

TABLE 116.--Responses of the Mexican group to question 73 by age: Should your children be injured as a result of sports and games, would you console them by giving any verbal expression of emotion, such as "poor child"?

	Over 40		Under 40		Totals		E
Yes	(10)	45%	(17)	61%	(27)	54%	-16
No	(12)	55%	(11)	39%	(23)	46%	16
Totals	(22)	100%	(28)	100%	(50)	100%	32

As Table 117 shows, the educational factor does not have an influence on the tendency of the Japanese respondents to refrain from expressing their emotion verbally in comforting their children who are in pain. Among the Mexican group, however, the educational factor affects such attitudes so strongly that the original pattern is reversed in the case of those having higher education levels, 43% of whom console their children in pain with verbal expression of emotion as compared to 62% of those having lower education levels. It may be concluded from Tables 117 and 118 that the educational factor does not influence the Japanese group at all, whereas it does affect significantly the Mexican group, among whom a negative correlation between educational attainment and this attitude is found.

TABLE 117.--Responses of the Japanese group to question 73 by education: Should your children be injured as a result of sports and games, would you console them by giving any verbal expression of emotion such as "poor child"?

	College	High School	Less than High School	Totals	E
Yes	(5) 33%	(10) 31%	(1) 33%	(16) 32%	
No	(10) 67%	(22) 69%	(2) 67%	(34) 68%	
Totals	(15) 100%	(32) 100%	(3) 100%	(50) 100%	

TABLE 118.--Responses of the Mexican group to question 73 by education: Should your children be injured as a result of sports and games, would you console them by giving any verbal expression of emotion such as "poor child"?

	High School		Less than High School		Totals		E
Yes	(9)	43%	(18)	62%	(27)	54%	-19
No	(12)	57%	(11)	38%	(23)	46%	19
Totals	(21)	100%	(29)	100%	(50)	100%	38

The majority of the Japanese group and of the Mexican group do not depend upon herbs and animal parts when they are sick, although the former group is less inclined to use folk medicine than the latter. Since only one Japanese respondent and nine Mexican respondents depend upon folk medicine, this item is not examined by the test variables, which draws the conclusion that the formulation of the attitudes of the two groups are influenced by ethnicity.

TABLE 33.--Responses of the two groups to question 52: Do you depend upon herbs or animal parts when you are sick?

	Japanese	Mexican	Totals
Yes	1	9	10
No	49	41	90
Totals	50	50	100

As Table 53 shows, only a small number of the respondents of both groups say that they failed to see a doctor because they did not wish to spend money, although the Japanese are less likely to use this excuse than are the Mexicans. Since only one Japanese respondent gives an affirmative answer to this item, the test variables are useless in examining the attitudes of the Japanese group in this regard. The formulation of this attitude on the part of the Japanese is considered to be influenced by ethnicity.

TABLE 53.--Responses of the two groups to question 53b: You did not see a doctor because you did not want to spend the money on the doctor unless you had to.

	Japanese	Mexican	Totals
Yes	1	15	16
No	49	35	84
Totals	50	50	100

Table 119 reveals that the older Mexican respondents give a larger proportion of positive responses (36%) than do the younger respondents (25%). The E figure of the table shows that age has a positive effect on the formulation of attitudes in the Mexican group toward not consulting a doctor because of the expense involved.

TABLE 119.--Responses of the Mexican group to question 53b by age: You did not see a doctor because you did not want to spend the money on the doctor unless you had to.

	Over 40	Under 40	Totals	E
Yes	(8) 36%	(7) 25%	(15) 30%	11
No	(14) 64%	(21) 75%	(35) 70%	-11
Totals	(22) 100%	(28) 100%	(50) 100%	22

Table 120 indicates that 34% of the Mexican respondents having lower education levels as against 23% of the respondents having higher education levels did not see a doctor because of money. The E figure of the table illustrates that among the Mexicans the higher the educational attainment, the less they mention a dislike of spending money as their reason for not having seen a doctor.

TABLE 120.--Responses of the Mexican group to question 53b by education: You did not see a doctor because you did not want to spend the money on the doctor unless you had to.

	High School	Less than High School	Totals	E
Yes	(5) 23%	(10) 34%	(15) 30%	-11
No	(16) 77%	(19) 66%	(35) 70%	11
Totals	(21) 100%	(29) 100%	(50) 100%	22

Table 54 shows that none of the Japanese respondents failed to see a doctor because of the fear of the pain they

would experience under treatment. The test variables are, therefore, of no use in investigating the differences of attitudes between the two groups with respect to this item. The formulation of the attitudes of both groups is considered to be influenced by ethnicity.

TABLE 54.--Responses of the two groups to question 53c: You did not see a doctor because it might be painful; the doctor might hurt you.

	Japanese	Mexican	Totals
Yes	0	4	4
No	50	46	96
Totals	50	50	100

Table 50 shows that the majority of the Japanese do not see a doctor immediately if they have a symptom of sore throat or running nose with a fever as high as 100° F for a day or more, while the majority of the Mexicans do so.

TABLE 50.--Responses of the two groups to question 50h: If you have a symptom of sore throat or running nose with a fever as high as 100°F for a day or more, do you see a doctor immediately?

	Japanese	Mexican	Totals
Yes	20	34	54
No	30	16	46
Totals	50	50	100

As the percentage figures of positive responses to Table 121 show, the older the Japanese respondents, the greater the propensity to consult a doctor immediately in the case of the above-mentioned symptom. As is revealed in Table 122, the proportions of responses of both the older and younger Mexicans are identical, indicating that the group is not at all affected by the age factor. These two tables lead to the conclusion that there is a positive correlation in the Japanese group between age and the propensity to see a doctor immediately (if they have a symptom of sore throat or running nose with a fever as high as 100°F for a day or more), while no correlation is present in the Mexican group.

TABLE 121.--Responses of the Japanese group to question 50h by age: If you have a symptom of sore throat or running nose with a fever as high as 100°F for a day or more, do you see a doctor immediately?

	Over 40	Under 40	Totals	E
Yes	(18) 40%	(2) 25%	(20) 40%	15
No	(24) 60%	(6) 75%	(30) 60%	-15
Totals	(42) 100%	(8) 100%	(50) 100%	30

The percentage figures of positive responses (given as 20%, 47%, and 66% in Table 123) indicate that the higher the education levels of the Japanese respondents, the less the inclination to see a doctor immediately in the case of the

TABLE 122.--Responses of the Mexican group to question 50h by age: If you have a symptom of sore throat or running nose with a fever as high as 100°F for a day or more, do you see a doctor immediately?

	Over 40	Under 40	Totals	E
Yes	(15) 68%	(19) 68%	(34) 68%	0
No	(7) 32%	(9) 32%	(16) 32%	0
Totals	(22) 100%	(28) 100%	(50) 100%	0

above-mentioned symptom. Table 124 shows that the proportions of positive responses of both Mexican respondents having higher education levels and lower education levels are almost identical (66% and 69% respectively), indicating that educational attainment does not influence the attitude of the Mexican group. A comparison of Tables 123 and 124 signifies, therefore, that there exists a negative correlation in the Japanese group between educational attainment and the propensity to see a doctor immediately (if there is a symptom of sore throat or running nose with a fever as high as 100°F for a day or more), while there is no correlation in the Mexican group.

TABLE 123.--Responses of the Japanese group to question 50h by education: If you have a symptom of sore throat or running nose with a fever as high as 100°F for a day or more, do you see a doctor immediately?

	College	High School	Less than High School	Totals	E	
Yes	(3) 20%	(15) 47%	(2) 66%	(20) 40%	-27	-19
No	(12) 80%	(17) 53%	(1) 33%	(30) 60%	27	20
Totals	(15) 100%	(32) 100%	(3) 100%	(50) 100%		

TABLE 124.--Responses of the Mexican group to question 50h by education: If you have a symptom of sore throat or running nose with a fever as high as 100°F for a day or more, do you see a doctor immediately?

	High School	Less than High School	Totals	E
Yes	(14) 66%	(20) 69%	(34) 68%	-3
No	(7) 33%	(9) 31%	(16) 32%	2
Totals	(21) 100%	(29) 100%	(50) 100%	5

Summary

In this chapter, the different attitudes of both groups with regard to the items which bear upon the two hypotheses are tested by two social factors--age and educational attainment, which results in certain correlations between social variables and attitudinal differences that are manifested in various

patterns. (Since two of these items are not tested on either group and one item of the Japanese group, only six out of the nine items are examined on both groups).

Patterns of correlations between age and attitudes are as follows:

1. Positive correlations of age and attitudes in both groups.
   a) There is a positive correlation between age and attitudes toward the necessity of pain in both groups.

   This may be due to differences in experience between the older and younger respondents; the elder respondents, having had a greater variety of experiences than the younger respondents, are more inclined to think that pain is an important symptom of a certain disease.

2. Negative correlations of age and attitudes in both groups.
   a) There is a negative correlation in both groups between age and attitudes toward verbal expression of emotion to injured children.

   This may be explained by the fact that the younger respondents have young children who, generally, are consoled with verbal expression of emotion.

3. Positive correlations of age and attitudes in one group and negative correlations in another.

   a) There is a positive correlation in the Japanese group between age and attitudes toward emotional response to pain experience; a negative correlation in the Mexican group.

   b) There is a positive correlation in the Japanese group between age and emotional response to pain in the presence of medical personnel; a negative correlation in the Mexican group.

   c) There is a positive correlation in the Japanese group between age and attitudes regarding the exhibition of worry or concern to injured children; a negative correlation in the Mexican group.

   This may be due to differences of acculturation patterns in the two groups. It seems that the older the Japanese respondents, the less stoic they become; the Mexican respondents, on the other hand, become more stoic as they grow older.

4. Positive correlations of age and attitudes in one group and no correlations in another.

   a) There is a positive correlation in the Japanese group between age and the propensity to consult a doctor immediately in the case of sore throat

or running nose with a fever as high as 100°F for a day or more but no correlation is found in the Mexican group.

The Japanese attitude may be due to differences in experience between the older and younger respondents; the older, more experienced respondents are more inclined than the younger respondents to think that this symptom can cause serious illness. The Mexican attitude is not influenced by age; it seems that both the older and younger respondents feel that this symptom should not be neglected (see p. 146, 4a)

5. Positive correlations of age and attitudes in one group.

a) There is a positive correlation in the Mexican group between age and failure to see a doctor because of the expense involved. (The Japanese group is not examined by the test variable).

Since this correlation comes from a method of data analysis that divides the respondents into two groups--under forty and over forty--the younger group's experience may reflect in a large measure the affluency of the post-war era.

Patterns of correlations between educational attainment and attitudes are as follows:

1. Positive correlations of educational attainment and attitudes in both groups.

   a) There is a positive correlation in both groups between educational attainment and attitudes toward emotional responses to pain experience in the presence of medical personnel.

   The explanation of this surprising fact appears to be that those respondents of either group with higher educational levels regard medical personnel as professionals to whom they entrust themselves and in whose presence they think it natural to be emotional.

2. Negative correlations of educational attainment and attitudes in both groups.

   a) There is a negative correlation in both groups between educational attainment and attitudes toward emotional response to pain experience.

   b) There is a negative correlation in both groups between educational attainment and attitudes regarding the exhibition of worry or concern to injured children.

   This may be due to differences in degree of sophistication of attitudes in accordance with levels of education; the more highly educated respondents, being more refined through educational learning than

the less educated respondents, are more inclined to cloak their emotions than are the latter.

3. Positive correlations of educational attainment and attitudes in one group and negative correlations in another group.

   a) There is a positive correlation in the Japanese group between educational attainment and attitudes toward the necessity of pain; a negative correlation in the Mexican group.

   This surprising fact on the part of the Mexican group may be closely related to their social environment; the less educated respondents, being more exposed than those with higher educational levels to a type of socio-economic position where illness results in income and/or job security losses, will manifest a high awareness of pain.

4. Negative correlations of educational attainment and attitudes in one group and no correlations in another group.

   a) There is a negative correlation in the Japanese group between educational attainment and the propensity to consult a doctor immediately in the case of sore throat or running nose with a fever as high as 100°F for a day or more, no correlation in the Mexican group.

The attitude of the Japanese may be due to their selection of doctors; the more highly educated respondents are more inclined than are the less educated respondents to consult with a specialist whom people with this symptom in general do not see. The Mexican attitude is not influenced by educational attainment. Since it is neither affected by age (see p. 144, 4a) nor by educational attainment, it is strongly affected by their cultural background; they try to live each day as if it were their whole life.

b) There is a negative correlation between educational attainment and attitudes toward giving verbal expression of emotion to their children of the Mexican group who have been injured, no correlation in the Japanese group.

The Mexican attitude seems to be due to differences in degrees of sophistication of attitudes in accordance with levels of education. Differences of educational attainment do not affect the formulation of the Japanese attitude at all; since age affects their attitude (see p. 145, 2a), ethnicity is not the only influential factor.

5. Negative correlations between educational attainment and attitudes in one group.

a) There is a negative correlation in the Mexican group between educational attainment and failure to see a doctor because of the expense involved. (The Japanese group is not examined by the test variable).

This may be due to differences in knowledge on medical care, and also differences in income, in accordance with levels of education; the more educated respondents, learning more about the importance of medical treatment through education and receiving more income than the less educated respondents, are consequently less inclined to have failed to see a doctor than are the latter.

Out of the nine items supporting the hypotheses, seven items concerning the Mexican group and six items concerning the Japanese group are examined by the test variables. The remaining items are not examined because it is obvious that these attitudes with regard to these items are influenced by ethnicity.

1. The Japanese are not examined by the test variables with regard to failure to see a doctor because of expense involved because only one Japanese has failed to do so. Their attitudes are considered to be influenced by ethnicity.

2. Neither the Japanese nor the Mexicans are examined by the test variables with regard to dependence on folk

medicine, because only one Japanese and nine Mexicans depend upon folk medicine. Their attitudes are considered to be influenced by ethnicity.

3. Neither the Japanese nor the Mexicans are examined by the test variables with regard to failure to see a doctor immediately because of fear of pain because none of the Japanese and only four Mexicans have failed to do so. Their attitudes are considered to be influenced by ethnicity.

As a result of the examinations of attitudinal differences of the two groups by the test variables it is found that attitudes are also influenced by differences of social backgrounds. It is further found, however, that some of the attitudes are not influenced by the social factor(s) at all and that some of them are much more strongly affected by the social factor(s) than by the cultural factor.

1. The following attitudes are <u>not</u> influenced by age and/or educational attainment <u>at all</u>.

a) With regard to attitudes toward giving verbal expression of emotion to their children who are injured <u>the Japanese</u> are not at all influenced by <u>the educational factor</u>.

b) With regard to the propensity to consult a doctor immediately in the case of sore throat or running nose with a fever as high as 100°F for a day or more <u>the Mexicans</u> are not influenced at all by either <u>the age factor</u> or <u>the educational factor</u>.

2. The following attitudes are influenced significantly by age and/or educational attainment.

a) With regard to attitudes toward emotional response to pain experience the Japanese are influenced significantly by the educational factor.

b) With regard toward emotional response to pain experience in the presence of medical personnel the Mexicans are influenced significantly by both the age factor and the educational factor.

c) With regard to attitudes toward exhibiting worry or concern to children who are injured the Japanese are significantly influenced by the age factor.

d) With regard to attitudes toward giving verbal expression of emotion to their children who are injured the Mexicans are influenced significantly by both the age factor and the educational factor.

Basic Problems of the Research

In addition to the above findings, the researcher ought to emphasize the basic problems of the present research created by the unmatched social backgrounds of the sample. Such great dissimilarities of the social backgrounds of the two groups cause the difficulties of statistical analysis of the present chapter and also the difficulties in the investigation of causal factors of attitudinal differences.

Secondly, the attitudinal differences are found to be due to dissimilarities of social backgrounds (such as age and educational attainment) with a few exceptions, but may be due to other social factors which are not examined in this chapter.

CHAPTER VIII

SUMMARY, CONCLUSIONS, AND SUGGESTIONS FOR FURTHER STUDY

Summary

In Chapter I the purpose of the thesis was introduced. In this thesis one area of medical sociology, the attitudes toward medicine, was studied. The subjects of the study were the second generation Americans of Japanese and Mexican ancestry in the Chicago area. The main concern in this thesis was to explore and compare the two ethnically different groups with reference to their attitudes towards pain experience, towards advances in modern medicine, and towards medicine in general.

The related literature, both substantive and methodological, in the field of medical sociology was reviewed. An attempt was made to define the term "culture," the variation of which, as was hypothesized, affects the formulation of different attitudes of the Americans of Japanese and Mexican ancestry.

In this thesis two hypotheses were established:

1. Because of differences in cultural background, dissimilarities are expected to exist between Japanese-Americans and Mexican-Americans regarding emotional responses toward pain caused by disease or injury.

2. Because of differences in cultural background, dissimilarities are expected to exist between Japanese-Americans and Mexican-Americans regarding their reactions to modern medicine.

In Chapter II methods and techniques were discussed. The subjects of the study were fifty Japanese-Americans and fifty Mexican-Americans; each group is composed of an equal proportion of both sexes. The subjects were selected on the basis of having been married, having been a patient in a hospital, and being a second generation American. Random sampline was employed as a sampling technique. The sample was chosen from the list of selected community and national organizations and of a religious organization. After the random sampling was performed, a telephone call requesting an interview was made to every selected subject.

The interview technique was chosen as a method of gathering data. The structured interview schedule, consisting of seventy-six questions, was divided into two parts; the first part dealing with social background, and the second part pertaining to attitudes toward medicine.

An interview which took approximately forty minutes was conducted, usually at the interviewee's residence. Entry and rapport were easily established between the interviewer and the interviewees, who were cooperative throughout the interview.

In Chapter III social characteristics of the Japanese and Mexican respondents were looked into. The main findings of the chapter are as follows:

1. There exist age differences between the two groups. The Japanese respondents are older than the Mexican respondents.

2. There exist differences in the educational attainment between the two groups. The Japanese respondents have a higher educational attainment than the Mexican respondents.

3. There exist differences in the type of occupation between the two groups. The Japanese respondents are inclined to be non-manual workers, whereas the Mexican respondents are inclined to be manual workers.

4. There exist differences in annual income between the two groups. The Japanese respondents are inclined to earn higher income than the Mexican respondents.

In Chapters IV, V, and VI the attitudes of the Japanese and the Mexican respondents toward medicine were studied by analysis of data gathered from interview. The subject matter is respectively: attitudes toward pain experience with regard to Hypothesis I, attitudes toward advances in modern medicine with reference to Hypothesis II, and attitudes toward medicine in general without regard to the two hypotheses. The examination found in these three chapters shows that there exist <u>more similarities</u> than dissimilarities in the attitudes of the two

groups; thirteen out of the total of sixty-four items examined show significant differences of attitudes between the two groups.

Although nine items support the hypotheses, it is not valid to conclude that attitudinal differences are due to the dissimilarities of cultural backgrounds in these two groups unless social variables proved to influence attitudes, especially since in Chapter III marked differences in social backgrounds are found between the two groups. Therefore, Chapters IV and V may be regarded as preliminary to Chapter VII in which these significant differences with reference to the two hypotheses are examined by two test variables--age and educational attainment--differences of which are remarkable. The purposes of this chapter is to single out the major factors of attitudinal differences and to lead to the conclusion of the thesis. The following evidence is found in Chapter VII.

1. With regard to attitudes toward the necessity of pain, the findings are as follows:

a) There is a positive correlation in both groups between age and this attitude;

b) There is a positive correlation in both groups between educational attainment and this attitude.

2. With regard to attitudes toward emotional response to pain experience, the findings are as follows:

a) There is a positive correlation in the Japanese group between age and this attitude, a negative correlation in the Mexican group;

b) There is a negative correlation in both groups between educational attainment and this attitude; the Japanese group is influenced significantly by the educational factor.

3. With regard to attitudes toward emotional response to pain experience in the presence of medical personnel, the findings are as follows:

a) There is a positive correlation in the Japanese group between age and this attitude, a negative correlation in the Mexican group; the latter is influenced by the age factor significantly;

b) There is a positive correlation in both groups between educational attainment and this attitude; the Mexican group is influenced significantly by the educational factor.

4. With regard to attitudes toward exhibiting worry or concern to children who are injured, the findings are as follows:

a) There is a positive correlation in the Japanese group between age and this attitude, a negative correlation in the Mexican group; the former is influenced significantly by the age factor;

b) There is a negative correlation in both groups between educational attainment and this attitude.

5. With regard to attitudes toward giving verbal expression of emotion to their children who are injured, the findings are as follows:

a) There is a negative correlation in both groups between age and this attitude; the Mexican group is influenced significantly by the age factor;

b) There is a negative correlation in the Mexican group between educational attainment and the attitude, no correlation in the Japanese group; the former is influenced significantly by the educational factor, but the latter is not at all influenced by it.

6. With regard to the propensity to consult a doctor immediately in the case of sore throat or running nose with a fever as high as 100°F for a day or more, the findings are as follows:

a) There is a positive correlation in the Japanese group between age and this propensity, no correlation in the Mexican group; the latter is not at all influenced by the age factor;

b) There is a negative correlation in the Japanese group between educational attainment and this propensity, no correlation in the Mexican group; the latter is not at all influenced by the educational factor.

7. With regard to failure to see a doctor because of expense involved, the findings are as follows:

a) The Japanese are not examined by the test variables, because only one Japanese has failed to do so. Their attitudes are considered to be influenced by ethnicity;

b) There is a positive correlation in the Mexican group between age and this failure;

c) There is a negative correlation in the Mexican group between educational attainment and this failure.

8. With regard to dependence on folk medicine the findings are as follows:

a) Neither the Japanese nor the Mexicans are examined by the test variables because only one Japanese and nine Mexicans depend upon folk medicine. Their attitudes are considered to be influenced by ethnicity.

9. With regard to failure to see a doctor immediately because of fear of pain, the findings are as follows:

a) Neither the Japanese nor the Mexicans are examined by the test variables because none of the Japanese and only four Mexicans have failed to do so. Their attitudes are considered to be influenced by ethnicity.

Conclusions

In this thesis, two hypotheses were established and investigated.

Hypothesis I: Because of differences in cultural background, dissimilarities are expected to exist between Japanese-Americans and Mexican-Americans regarding emotional responses toward pain caused by disease or injury.

Hypothesis II: Because of differences in cultural background, dissimilarities are expected to exist between Japanese-Americans and Mexican-Americans regarding their reactions to advances in modern medicine.

As a result of the examinations of the two hypotheses, the conclusion is drawn as follows:

1. There are more similarities than dissimilarities in attitudes toward medicine between the two groups.

2. Hypotheses I and II are supported by five and four items respectively.

3. Social variables--age and educational attainment--influence the attitudinal differences with regard to those items which support the hypotheses.

a) Out of the nine items, two items concerning the Mexican group and three items concerning the Japanese group are not examined by the test variables because it is obvious that these attitudes with regard to these items are influenced by ethnicity.

b) The remaining items, seven items concerning the Mexican group and six items concerning the Japanese, are examined by the test variables.

(1) One item shows that the Japanese attitude is not at all influenced by the educational variable.

(2) One item shows that the Mexican attitude is not at all influenced by either the age factor or the

educational factor.

(3) One item shows that the Japanese attitude is significantly affected by the age factor.

(4) One item shows that the Japanese attitude is significantly affected by the educational factor.

(5) Two items show that the Mexican attitude is significantly affected by both the age factor and the educational factor.

4. The previous conclusion indicates a probability that not only age and educational attainment but also other social variables influence the formulation of attitudes.

5. Differences of attitudes between the two groups with different cultural backgrounds are due not only to ethnicity but also to social factors.

6. Therefore, the hypotheses are partly supported.

Suggestions for Further Study

1. With reference to the cultural study in the area of attitudes toward medicine, a suggestion is made to examine the differences of attitudes between other ethnic groups.

2. With reference to the study of acculturation in the area of attitudes toward medicine, a suggestion is made to examine the differences of attitudes between the first and second generation within the same ethnic groups.

3. With reference to the cultural study in the area of attitudes toward medicine, a suggestion is made to examine the differences of attitudes between the socio-economic classes within the same ethnic groups.

4. With reference to the methodological study in the area of attitudes toward medicine, outside the hospital setting, a suggestion is made to examine the differences of attitudes inside the hospital setting.

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APPENDIX I

EXPLANATION OF STRUCTURED INTERVIEW SCHEDULE

The twelve-page long structured interview schedule with seventy-six questions is mainly divided into two parts:

1. Items regarding social background of the selected subjects;

2. Items regarding attitudes of the selected subjects toward medicine.

The first part of the structured interview schedule is divided into two sections:

1. Items dealing with the subjects' own social variables;

2. Items dealing with social background of the subjects' parents.

1. Items dealing with social background of the subjects are as follows:

Marital Status, Age, Sex, and Number of Children--Questions 3, 4, 5, and 6.

Occupation, Educational Attainment, Curriculum Courses Followed in High School, Major Subject in Collge, Religious

Affiliation, Family Income, and Birth Place--Questions 7, 8, 9, 10, 11, 12, and 13.

2. Items dealing with the social background of the subjects' parents are as follows:

Nationality, Place of Birth, Length of a Stay in America, Citizenship, Last Occupation and Educational Attainment--Questions 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, and 24.

The second part of the structured interview schedule is divided into three sections:

1. Items relating to the subjects' attitudes toward pain experience which bear upon Hypothesis I;

2. Items relating to the subjects' attitudes toward acceptability of advances in modern medicine which bear upon Hypothesis II;

3. Items relating to the subjects' attitudes toward medicine in general which do not directly deal with either Hypothesis I or Hypothesis II.

1. Items relating to the subjects' attitude toward pain experience are as follows:

Response to Pain Experience--Questions 59, 61, 62, 63, 64, 65, 66, 67, 68, 69, and 70.

Transmission of Cultural Attitudes toward Pain to Subjects' Children--Questions 71, 72, 73, 74, 75, and 76.

2. Items relating to the subjects' attitudes toward acceptability of advances in modern medicine are as follows:

Acceptability of Modern Medical Instruments and Use of Folk Medicine--Questions 29 and 52.

Preference of the Type of the Doctor--Question 43.

Patients' Participation with the Doctor in Medical Treatment by Directing the Doctor's Attention to Something and by Getting Information about Condition from the Doctor--Questions 37 and 44.

Cross-Checking of the Diagnostic concern with other Specialists--Question 47.

Evaluation of Specialists--Questions 48 and 49.

Attitudes toward Symptoms of Disease--Questions 50a, 50b, 50c, 50d, 50e, 50f, 50g, and 50h.

Reasons for not Consulting the Doctor at the Time of Illness--Questions 53a, 53b, 53c, 53d, 53e, and 53f.

Opinions on Regular Medical Check-Ups--Questions 56 and 57.

Knowledge of Health and Medicine through Reading Materials--Questions 54 and 55.

3. Items relating to the subjects' attitudes toward medicine in general are as follows:

Last Hospitalization Experiences, Date and Duration of the Hospitalization, and Type of Illness and Name of Hospital--Questions 31a, 31b, 31c, and 31d.

Last Hospitalization Experiences--Satisfaction with the Doctor--Questions 32, 33, 34a, 34b, 34c, 35, and 36.

Last Hospitalization Experiences, Selection of the Doctor--Questions 38, 38A, and 38B.

Last Hospitalization Experiences, Treatment for Teaching Purposes--Questions 39, 39A, and 39B.

Last Hospitalization Experiences, Expectation to Return to the Hospital and the Doctor--Questions 40a and 40b.

General Ideas on Doctors--Questions 45 and 46.

Health Insurance and Medical Care--Questions 25, 25A, 26, 27, and 28.

Dependence on Home Therapy--Questions 51 and 58.

The second part of the structured interview schedule, composed of questions with reference to main problems of the present study, that is, attitudes toward pain experience, attitudes toward advances in modern medicine and attitudes toward medicine in general, is not subdivided into three sections according to different types of problems, but is composed of all mixed questions which are arranged so that the respondents may easily answer the questions.

APPENDIX II

STRUCTURED INTERVIEW SCHEDULE

1. Name_____

2. Address_____

3. Marital Status

    1. Married _____
    2. Widowed _____
    3. Separated _____
    4. Divorced _____

4. Sex

    1. Male _____
    2. Female _____

5. Age

    1. 20-24 _____
    2. 25-29 _____
    3. 30-34 _____
    4. 35-39 _____
    5. 40-44 _____
    6. 45-49 _____
    7. Over 50 _____

6. Number of children

    1. None _____
    2. One _____
    3. Two _____
    4. Three _____
    5. Four or more _____

7. What is your occupation?

1. Professional _____
2. Manager, official or proprietor _____
3. Semi-professional or technical _____
4. Clerical _____
5. Other (please specify) _____

8. What is your educational attainment?

1. Some elementary _____
2. Completed elementary _____
3. Some high school _____
4. Completed high school _____
5. Some college _____
6. Completed college _____
7. Some graduate or professional _____
8. M.A. _____
9. Ph.D. _____
10. M.D. or D.D.S. _____
11. Other (please specify) _____

9. If you attended high school, what course did you follow?

1. Academic course _____
2. Technical course _____
3. Business course _____
4. Other (please specify) _____

10. If you attended college, what was your major?

1. _____
2. _____

11. What is your religion?

1. Buddhist _____
2. Shintoist _____
3. Protestant _____
4. Catholic _____
5. Other _____

12. What is your family's annual income?

1. Less than $1999 _____
2. $2000 - $4999 _____
3. $5000 - $7999 _____
4. $8000 - $9999 _____
5. $10000 - $14999 _____
6. More than $15000 _____

13. What is your place of birth?

Country _____

_____

14. What is your father's nationality?

1. Japanese-Japanese _____
2. Mexican-Mexican _____
3. Japanese-Non-Japanese _____
4. Mexican-Non-Mexican _____

Please specify the nationality other than Japanese and/or Mexican

1. _____
2. _____

15. What is your mother's nationality?

1. Japanese-Japanese _____
2. Mexican-Mexican _____
3. Japanese-Non-Japanese _____
4. Mexican-Non-Mexican _____

Please specify the nationality other than Japanese and/or Mexican

1. _____
2. _____

16. What is your father's place of birth?

Country _____

_____

17. How long has your father lived in this country?

1. 0 - 0 _____
2. 10 - 19 _____
3. 20 - 29 _____
4. 30 - 39 _____
5. 40 or more _____

18. Has your father become an American citizen?

1. Yes_____ 2. No_____

19. If your father works (worked), what is (was) his occupation?

1. _____
2. _____
3. _____
4. _____

20. How far did your father go to school?

1. Some elementary _____
2. Completed elementary _____
3. Some high school _____
4. Completed high school _____
5. Some college _____
6. Completed college _____
7. Some graduate or professional _____
8. M.A. _____
9. Ph.D. _____
10. M.D. or D.D.S. _____
11. Other (please specify) _____

21. What is your mother's place of birth?

Country _____
_____

22. How long has your mother lived in this country?

1. 0 - 9 _____
2. 10-19 _____
3. 20-29 _____
4. 30-39 _____
5. 40 or more _____

23. Has your mother become an American citizen?

1. Yes_____ 2. No_____

24. How far did your mother go to school?

1. Some elementary _____
2. Completed elementary _____
3. Some high school _____
4. Completed high school _____
5. Some college _____
6. Completed college _____
7. Some graduate or professional _____
8. M.A. _____
9. Ph.D. _____
10. M.D. or D.D.S. _____
11. Other (please specify) _____

25. Do you have health insurance?

1. Yes_____ 2. No_____

25A. If yes, please specify.

1. Hospital insurance _____
2. Surgical insurance _____
3. Medical insurance _____
4. Hospital and surgical insurance _____
5. Other (please specify) _____

26. Has any health insurance you own been purchased through your company?

1. Yes_____ 2. No_____

27. Should you become ill, how would you meet the medical costs involved?

Please explain_____
_____
_____
_____

28. Are you in favor of socialized medicine?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____
_____
_____
_____

29. Do the instruments in the doctor's office or in the hospital cause fear in you?

1. Yes_____ 2. No_____
3. Uncertain_____

30. Do you mind or dislike any of these in a hospital?

a. Impersonal atmosphere

1. Yes_____ 2. No_____
3. Uncertain_____

b. Separation from family

1. Yes_____ 2. No_____
3. Uncertain_____

Please explain_____
_____
_____
_____

31. When were you last treated in the hospital?

a. Please specify date _____
b. Please specify your illness _____
c. How long were you in the hospital?_____
d. Please specify the name of the hospital_____

32. Were the number of visits by your doctor, in your opinion, enough to take care of the kind of pain or discomfort you were experiencing?

1. Yes_____ 2._____
3. Uncertain_____
Please explain_____
_____
_____

Please specify the number of visits of your doctor._____

33. Did you have confidence in the doctor who treated you or did you harbor any doubts?

1. Confidence_____ 2. Doubts_____
3. Uncertain_____
Please explain_____
_____
_____
_____

34. When the doctor visited you, did he give you the kind of satisfaction you wanted in terms of the nature of symptoms, prognosis, and relief?

a. Symptoms
1. Yes_____ 2. No_____
b. Prognosis
1. Yes_____ 2. No_____
c. Relief
1. Yes_____ 2. No_____
Please explain_____
_____
_____
_____

35. Did you feel that the doctor took a personal interest in you?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____
_____
_____
_____

36. When you were in the hospital, did you direct the physician's attention to some aspect of your illness?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____
_____
_____
_____

37. Do you think that as a patient you should always quietly do whatever the physician says or directs you to do while you are under his care?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____

38. Prior to hospitalization how did you choose your doctor?

1. Family doctor _____
2. Specialist other than family doctor _____
3. Specialist recommended by family doctor _____
4. Doctor recommended by hospital _____
5. No particular doctor _____

Please explain_____

38A. If you chose the doctor, is he the doctor who treated you?

1. Yes_____ 2. No_____

38B. If you chose the doctor, what was the reason of your choice?

39. Have you ever felt that a particular doctor who was treating you was using your body for teaching purposes?

1. Yes_____ 2. No_____
3. Uncertain_____

39A. If yes, were you entirely satisfied with your treatment?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____

39B. If yes, did you resent the secondary purpose?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____

40. Should you become ill, would you like to return to the hospital to which you were previously confined and to the same doctor?

a. Hospital
1. Yes_____ 2. No_____
b. Doctor
1. Yes_____ 2. No_____
Please explain_____

41. Are there any suggestions that you would care to make for a possible improvement of the patient's comfort in a hospital?

42. Who is a good hospital patient?

43. Which do you expect a doctor to be?

1. Professional man _____
2. Dispenser of protection and love _____
3. Both _____
Please explain_____

44. Do you think a good physician should give the patient full information about his condition and explain it carefully?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____
_____
_____
_____

45. Do you feel that doctors are generally dedicated to their profession and have a sincere interest and desire to help people?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____
_____
_____
_____

46. Do you believe that any doctors are careless in attitude and treatment towards the sick?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____
_____
_____
_____

47. Generally, even when your pain is relieved, do you tend to check the diagnosis and treatment of one doctor against the opinions of other specialists in the field?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____
_____
_____
_____

48. In your opinion, is there any advantage in consulting a a specialist rather than a general practitioner?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____
_____

49. Would you prefer to have your family doctor (if you have one) examine you before contacting a specialist?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____
_____
_____
_____

50. If you have symptoms as follows, do you see a doctor immediately?

a. Cough any time during the day or night which lasts for three weeks.
1. Yes_____ 2. No_____
b. Getting tired for weeks at a time for no special reason.
1. Yes_____ 2. No_____
c. Skin rash or breaking out on any part of the body.
1. Yes_____ 2. No_____
d. Diarrhea (loose bowel movements) for four or five days.
1. Yes_____ 2. No_____
e. Shortness of breath even after light work.
1. Yes_____ 2. No_____
f. Unexplained loss of over ten pounds in weight.
1. Yes_____ 2. No_____
g. Repeated pains in or near the heart.
1. Yes_____ 2. No_____
h. Sore throat or running nose with a fever as high as 100°F for a day or more.
1. Yes_____ 2. No_____

51. If you think that you can cure sickness or injury by home therapy, is it necessary to go to the doctor?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____
_____
_____
_____

52. Do you depend upon herbs or animal parts when you are sick?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____
_____

53. People sometimes do not see a doctor with some reasons when perhaps they should. Thinking back over your own experience, which of these reasons have ever kept you from seeing a doctor when perhaps you should have?

a. You did not know any really good doctor.
1. Yes_____ 2. No_____
b. You did not want to spend the money on a doctor unless you had to.
1. Yes_____ 2. No_____
c. It might be painful; the doctor might hurt you.
1. Yes_____ 2. No_____
d. You were too busy to see a doctor.
1. Yes_____ 2. No_____
e. The doctor might find something really wrong with you.
1. Yes_____ 2. No_____
f. You did not think the doctor could help you any.
1. Yes_____ 2. No_____

54. Do you read the health columns in newspapers, and newspaper articles about health?

1. Frequently _____
2. Only occasionally _____
3. Hardly ever _____
Please explain_____
_____
_____
_____

55. Have you read any magazine columns or articles about health and medicine in the last month?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____
_____
_____
_____

56. What is your opinion on medical check-ups?

_____
_____
_____
_____

57. Do you have a regular medical check-up?

1. Yes_____ 2. No_____
Please explain_____

58. When you have pain, do you call for relief?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____

59. Which do you think concerns you most, when you have pain?

1. The physical pain experience itself. _____
2. Significance of pain in relation to your health welfare and the welfare of the family. _____
3. Uncertain _____

60. Do you think that having pain is necessary?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____

61. Do you show your sufferings by groaning, moaning, or crying?

1. Yes_____ 2. No_____
3. Uncertain_____

62. Is it natural to show pain by groaning, moaning, or crying in front of a doctor or a nurse?

1. Yes_____ 2. No_____
3. Uncertain_____

63. Do you feel free to complain of your pain to a doctor or a nurse?

1. Yes_____ 2. No_____
3. Uncertain_____

64. Do you think it natural to complain of your pain a great deal to your family?

1. Yes_____ 2. No_____
3. Uncertain_____

65. Do you think it natural to call for help from your members of family when you are in pain?

1. Yes_____ 2. No_____
3. Uncertain_____

66. Do you think it natural to expect sympathy from your members of the family when you are in pain?

1. Yes_____ 2. No_____
3. Uncertain_____

67. When you are in pain, do you prefer to be left alone or to be cared for by others?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____
_____
_____
_____

68. Do you think that emotional expressions are helpful for the relief of pain experience?

1. Yes_____ 2. No_____
3. Uncertain_____
Please explain_____
_____
_____
_____

69. Does the relief from pain give you security?

1. Yes_____ 2. No_____
3. Uncertain_____

70. When in pain, which causes you more discomfort?

1. Physical effects of pain experience. _____
2. Worry or anxiety. _____
3. Uncertain. _____

71. Do you expect your children to be hurt in sports and games?

1. Yes_____ 2. No_____
3. Uncertain_____

72. When your children are injured as a result of play, do you show attitudes of worry or concern?

1. Yes_____ 2. No_____
3. Uncertain_____

73. Should this occur, would you consele them by giving any verbal expression of emotion such as "poor child"?

1. Yes_____ 2. No_____
3. Uncertain_____

74. In the same case, do you stimulate their ability to resist pain, telling them to act grown up?

1. Yes_____ 2. No_____
3. Uncertain_____

75. Do you expect your children to come to you crying and complaining of pain?

1. Yes_____ 2. No_____
3. Uncertain_____

76. What type of behavior do you expect from your children if they are in pain?

_____
_____
_____
_____

APPROVAL SHEET

The thesis submitted by Miss Michiko Sakamoto has been read and approved by the director of the thesis. Furthermore, the final copies have been examined by the director and the signature which appears below verifies the fact that any necessary changes have been incorporated, and that the thesis is now given final approval with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

_____ _____

Date Signature of Adviser