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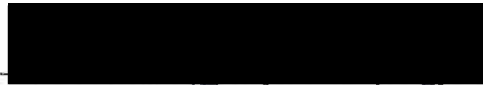
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Intrusions Between Two Cultural Groups

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Man's spatial requirements are seen in terms of territory and personal space. The literature has suggested that cultures and sub-cultures differ in proxemic behavior. Anglo Americans were known to experience unease and discomfort when their territory or personal space was violated or when an appropriate interactional distance was not maintained. It was not documented how Black Americans responded to intrusion.

The purpose of the study was to determine if there was a cultural difference between Anglo Americans and Black Americans in response to territorial and personal space intrusions. Further, it was of interest to the investigator to explore sexual differences within each cultural group in response to intrusions. Of secondary interest to the author was the relationship of length of hospitalization to responses to intrusions; that is, to determine if patients

became sensitized or desensitized to intrusion over time.

Fifteen Black Americans and 15 Anglo Americans were surveyed for their responses to territorial and personal space intrusions which typically occur in health care settings. The subjects consisted of 15 matched pairs who were hospitalized patients and selected from two metropolitan hospitals. A forced choice response questionnaire was utilized to collect data.

The questionnaire consisted of two parts. Part I dealt with territorial intrusions and Part II referred to situations that constituted intrusions of personal space. Data were analyzed by means of t-tests. Though the responses to both territorial and personal space intrusion differed for the two groups, the difference was not statistically significant. With respect to sexual differences within each cultural group, there was no statistical difference.

It was noted that responses to territorial intrusion would differ from the responses to personal space intrusion. More hospitalized patients responded to territorial intrusion with anxiety than responded to personal space intrusion with anxiety. Length of hospitalization did not correlate with responses to intrusion of either territory or personal space. Response to intrusions seemed to be spontaneous and patterned, rather than to be altered by repeated occurrence. Conclusions were drawn and recommendations were made for further study.

COMPARISON OF RESPONSES TO TERRITORIAL AND
PERSONAL SPACE INTRUSIONS BETWEEN
TWO CULTURAL GROUPS

by
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TABLE OF CONTENTS

CHAPTER		Page
I.	INTRODUCTION	1
II.	CONCEPTUAL FRAMEWORK AND REVIEW OF THE LITERATURE	4
	Proxemics	4
	Proxemic Interference	19
	Interpersonal Spacing in American Subcultures	26
	Implications for Hospitalization	30
	Purpose of the Study	34
	Definition of Terms	37
III.	METHODOLOGY	38
	Subjects and Setting	38
	Instrument	39
	Procedure	41
	Approach to Data Analysis	42
IV.	RESULTS	44
	Characteristics of the Subjects	44
	Response to Territorial Intrusion	47
	Response to Personal Space Intrusion	49
	Comparison of Intrusion Responses	49
	Sex Differences Within Each Group	50

TABLE OF CONTENTS (continued)

CHAPTER		Page
	Length of Hospitalization and Responses to Intrusion	54
	Item Analysis	54
V.	DISCUSSION	61
VI.	SUMMARY, CONCLUSIONS, AND RECOMMEN- DATIONS	73
	Summary	73
	Conclusions	74
	Recommendations for Further Study	75
	REFERENCES	76
	APPENDICES	82
A.	Consent Form	82
B.	Questionnaire	84
C.	Descriptive Characteristics per Individual Subject	90
D.	Admission Diagnosis per Individual Subject	93

LIST OF TABLES

TABLE		Page
1.	Descriptive Characteristics of the Two Cultural Groups on Selected Variables	46
2.	Mean Scores for Matched Pairs in the Two Cultural Groups; Parts I and II of the Questionnaire	48
3.	Mean Scores for Sexes Within the Cultural Groups; Parts I and II of the Questionnaire	51
4.	Group Mean Scores of Responses to Individual Items in Parts I and II of the Questionnaire	56
5.	Frequency Distribution of Grouped Scores for Parts I and II of Questionnaire; by Cultural Group	57

CHAPTER I

INTRODUCTION

Man's spatial requirements are seen in terms of territory and personal space. Such spatial requirements are an elaboration of cultures and subcultures. Anglo Americans experience unease and discomfort, and possibly anxiety, when their personal space is violated or an appropriate interactional distance is not maintained. When their territory is intruded upon, they engage in a variety of defensive gestures. Although there are many studies regarding the spatial preferences of Anglo Americans, research about spatial preferences of the American subcultural groups is lacking. Because recognition of minority groups as cultural groups with culturally determined differences is becoming more apparent, this study compared responses of Black Americans to intrusions of personal space and territory with those of Anglo Americans.

Culture is the structure in which communication takes place. It influences, and probably determines, both the verbal and non-verbal aspects of communication. Boas (1938), who first emphasized the relationship between language and culture, found revealing distinctions about the reality conceived by people of different cultures. Whorf (1956) elaborated this relationship by suggesting the language plays a

prominent part in actually molding the perceptual world of the people who use it. Thus, people from different cultures not only speak different languages, but inhabit different sensory worlds and perceive things differently (Hall, 1966). The sensory world a cultural group inhabits serves as a sensory screen so that experience is named, classified and interpreted in a culturally determined way. It is utilized to establish all time and spatial relationships, and is expressed by the architectural and urban environments people create.

In the last two decades, social scientists have begun to explore the significance of space in human relationships. We have become more concerned with space, not only environmentally, but as an entity with the power to convey meaning in relationships (Pluckhan, 1968). It is an active part of any interaction. Hall was one of the first to begin a systematic investigation of spatial arrangements when faced as an anthropologist with the task of helping Americans become more effective in their dealings with people from other countries (1966). He states that as a country we have consistently failed to accept the reality of different cultures within our national boundaries, and consequently have failed to recognize our own cultural differences in spatial patterning. The question has been relatively unexplored: How do the American subcultures differ from the Anglo American culture in proxemic behavior? The answer has definite implications for human interaction and understanding.

Hall (1959) found that in response to spatial organization and behavior, the associations and feelings that are released in a member of one culture are almost invariably different from those released in someone from another culture. This points up the fact that not only does space communicate, but that mis-communication frequently occurs with regard to space cross-culturally. Proxemic interference, or intrusion, occurs when people with two separate patterns of spatial behavior meet in an exchange. Such interference can lead to discomfort and stress, or, more frequently, to alienation from the interaction (Hall, 1963). That spatial patterning is culturally determined and differs cross-culturally suggests the potential for interference and its consequences when persons of a culture other than the dominant Anglo American culture seek health care at our agencies or interact in any way with health care professionals.

Though there is some evidence with regard to proxemic differences among the Black and Mexican-American subcultures, the responses of these subcultures to proxemic interference or intrusion are relatively unexplored. In light of the lack of study pertaining to the intrusion of personal space among American subcultural group members, the thrust of this study will be to explore the responses of Black Americans to intrusion of territory and personal space.

CHAPTER II

CONCEPTUAL FRAMEWORK AND REVIEW OF THE LITERATURE

This chapter includes the theoretical material and supportive research studies necessary to orient the reader to the area of human spatiality. Thus, the chapter is organized into five sections. The first section reviews the major concepts of proxemics as that term is defined by Hall. The second section reviews the basic concepts and studies which pertain to personal space and intrusion. The third section constitutes a review of the state of knowledge in the area of spatial patterning in American subcultures, and the fourth section briefly describes the implications for hospitalization. The last section describes the purpose of the study.

Proxemics

When Edward T. Hall published The Silent Language in 1959, he was involved with the selection and training of Americans for government and business in foreign countries. He became convinced that much of the difficulty Americans had in dealing with people from other countries stemmed from the fact that so little was known about cross-cultural communication. Besides formal training in language, history, government, and customs of another nation, an introduction

to the non-verbal language, which Hall states exists in every country of the world and among the various groups within each country, became essential.

Non-verbal language is an elaborate patterning of behavior which prescribes our handling of our attitudes towards work, play, and learning, our time, and our spatial relationships. Human spatial organization has been a consistently problematic issue, particularly conversational distance. In "The Study of Man's Spatial Relations" (1963), Hall first coined the term "proxemics" for the interrelated observations and theories of man's use of space as a special elaboration of culture.

Any culture characteristically produces a simultaneous array of patterned behavior on several different levels of awareness. Unlike much of the traditional subject matter of anthropological observations, proxemic patterns, once learned, are maintained largely out of conscious awareness. A classical example of this phenomenon and the confusion that can result in a cross-cultural encounter was described by Hall in The Silent Language:

If one person gets too close, the reaction is instantaneous and automatic--the other person backs up . . . I have observed an American backing up the entire length of a long corridor while a foreigner he considered too pushy tries to catch up with him . . . one person trying to increase the distance in order to be at ease, while the other tries to decrease it for the same reason, neither being aware of what was going on. (p. 180)

Though proxemic patterning occurs primarily out of conscious awareness, it is determined to be a form of communication. In agreement with Boas's view that communication constitutes the core of culture, Hall proposed that we communicate through spatial organization as succinctly as we communicate through language.

Hockett (1958) defined communication as any event that triggers another organism. Language is characteristically a human form of communication, and is culturally (not genetically) transmitted. Proxemic behavior is not a language and will never do what language will do. Nevertheless, an analysis by Hall (1963) demonstrated that proxemic communication as a culturally elaborated system lacks none of the features of language listed by Hockett.

In other words, proxemic behavior parallels language. It is, however, much less specialized and more iconic--i.e., a feeling of "closeness" is often accompanied by physical closeness. It tends to be treated as though certain features associated with language were lacking. Language is most commonly treated as an instrument to communicate from one person to another, rather than as a transaction. Proxemic behavior, on the other hand, by its nature is inevitably reduced to a transaction--a transaction between two or more parties, or one or more parties and the environment. It is this very feature that makes it necessary to discuss proxemics at all its significant levels.

Hall (1966) conceived of an organizational model for the system of proxemics. He dealt with human spatial patterning at three broad levels: the infracultural, the precultural, and the microcultural level. The infracultural level generally pertains to human territorial behavior. The precultural level refers to the physiological aspects of man's spatial perception, which include tactility, olfaction, vision and acoustics as well as the thermal aspects of sensation. The microcultural level involves the analysis of architectural designs and the characteristic spatial patterns all persons employ in the regulation of their relationships with others. The microcultural level is further divided into three classifications: fixed feature space, semi-fixed feature space, and informal space. Within the area of informal space, Hall described four general interactional zones for interpersonal spatial arrangements. The four distances were: intimate, personal, social, and public. Much of the study in spatial behavior has focused on the intimate and personal distance which has proven to be so problematic in interpersonal relationships.

The following is a brief overview of Hall's three levels of proxemics, the infracultural, precultural and the microcultural levels. The writings of other authors reflect agreement with Hall's original classification system. Illustrations and studies offered by these investigators are included in the review.

Infracultural Level

Within this level Hall grouped those behaviors considered "territorial," that is, behaviors which deal with man's attempt to control space or defend space as territory. Many situations evoke territorial behavior. International boundary maintenance which is extended to include international territorial waters with its concomitant defense patterns, is one such example. The saying that a man's home is his castle, representative of common law tradition, is a reflection of man's involvement with the codifying of human territorial patterns which would be included in the infracultural level.

The origin of man's territorial nature remains a controversial issue. Hall (1963) takes the position that man's need to claim territory may be as instinctual as the need for food. Ardrey's position is similar to that of Hall in that he maintains that man's territorial nature is "a portion of our evolutionary nature, a behavior pattern of such survival value to emerging human beings that it became fixed in our genetic endowment" (1966, p. 7). While other authors are more hesitant to assert any definite conclusions, they accept the existence of man's territorial nature. For example, Sommer states:

Even if we don't accept the idea of instinctual territoriality in humans, it is still apparent that people actively defend certain places against intruders using the entire repertoire of defensive techniques in the animal kingdom as well as a few new ones. (1966, p. 43)

Lyman and Scott (1967) also distinguish four distinct types of territories: Public territories, home territories, interactional territories, and body territories. Public territories are those officially open to all, but certain expectations of appropriate behavior and the types of individuals who are normally perceived as using these territories modify the freedom. These territories include such places as parks, sidewalks, beaches and shopping areas, and are defended by the police. Home territories are areas where the regular participants have a sense of intimacy and control over the area. Examples of home territories include a streetgang's block, a gay bar, a prostitute's corner, a child's hideaway, or an ethnic enclave. Interactional territories refer to any place where a social gathering may occur with clearly acknowledged invisible boundaries. The clusters of people at a party are an example of interactional territories. They are governed by shared norms for the duration of the interaction, and if interrupted will disintegrate or will alter the norms and shift topics to include the newcomer, only to resume their conversation at a later time. Finally, Lyman and Scott describe body territories, which include the space encompassed by the human body and the anatomical space of the body. This territory is, theoretically, considered the most private and inviolate of territories belonging to an individual. Hall's writings suggest that these territories would be defended by territorial behaviors.

This concept of human territoriality is receiving increasing attention by investigators. Persons labeled schizophrenic, who were in a mental institution, were studied by Esser, Amparo, Chamberlain, Chapple and Kline (1965). The investigators found that patients who occupied positions of higher status were allowed to use all the available space they desired, while those patients who occupied lower status positions were allowed no such territorial claims. In other words, persons tend to establish home territories even in a temporary situation. Allekian (1973) established further that hospitalized patients made territorial claims and responded anxiously to intrusions of their territory by hospital staff.

Sommer and Becker (1969) explored territorial behavior of persons in a university library. They found that personal belongings marked a reserved area, a space which received legitimacy from people in the area as well as from intruders. They found further that if the experimenter engaged a stranger in conversation about directions and other minor matters, the stranger (subject) consistently blocked the confederate from intruding into the experimenter's personally marked territory.

Pauluck and Esser (1971) found that the territorial patterns of institutionalized severely retarded boys are extremely rigid. However, small changes in the allocation and maintenance of territory

are correlated with improvement in the boys' overall psychological functioning.

Precultural Level

Man's space perception has a physiological basis. Vision is the most complex of the five senses and, in combination with touch, feeds back quantitatively the most information. Visual information produces sensations of contrast, color, periphery, movement and depth. Depth is the dominant characteristic of visual experience. Man explores his visual panorama tactually and kinesthetically, activity that is essential for the development of depth perception (Carpenter and McHuhan, 1960). In this way man is able to locate and identify objects in three dimensions.

The most essential characteristic of sound is that it BE, that it fill space; not its location. Auditory space has no point of favored focus, no fixed boundaries, and can be received from any direction. It is dynamic and always in flux. Since auditory space is ambiguous rather than focused, it fulfills a complementary role with visual information in space perception (Carpenter and McHuhan, 1960).

Olfaction is a sense not well-developed in Anglo Americans, though it can function to help us locate ourselves in space. Olfaction serves primarily to alert us to offensive situations, as when interactional territory is contaminated by sudden odors, especially if they

emanate from one of the interactants (Sommer and Becker, 1969). In contrast, Arabs claim they are able to detect friendliness and hostility by body odor. Allowing another person to bathe in one's breath is considered an act of friendship in the Middle East (Hall, 1966).

Hall considered radiated heat as perceived by the skin as instrumental in guiding interpersonal distancing behavior. Even though thermal space, as a distinct aspect of the sensory environment, is not perceived at a conscious level by most sighted persons, many blind people report that they are able to avoid collisions with persons or objects in their environment because they are adept at identifying changes in temperature of their surroundings. They are able to associate these temperature changes with a potential obstruction or hazard (Hall, 1966).

Hall concluded that tactile space is so closely interwoven with the visual experience that the two cannot be separated, much as Carpenter found the tactile experience to be essential in the development of visual depth perception. Montagu (1971) also discussed the enormous importance of touching to the young child. He stressed that the richness and complexity of the skin as a sense organ are illustrated by the fact that the number of sensory fibers entering the spinal cord by the posterior root is well over one-half billion. The infant's perceptions of the spatial environment are first regulated by tactile experiences. Frank (1960) and Montagu both asserted that an infant's

perception of the world is built upon and shaped by tactile experiences. Touching behaviors later in life are then influenced by these early tactile encounters.

Each culture activates or limits tactile communication, not only between its members, but between the individual and the outer world; thus it is culturally defined (Frank, 1960). Hall (1966) described a continuum for humans which ranges from "non-contact" through "contact." North Americans and North Europeans characterize the non-contact behavior, limiting touch to functional interaction and intimate encounters. Symbolic of the contact group, Arabs involve casual friends and strangers in handholding and public crowding, and, like the French and Latin Americans, generally maintain closer conversational distances. Results of proxemic research have supported the existence of the touching continuum cross-culturally (Watson, 1970).

Microcultural Level

The microcultural level deals with those proxemic patterns which are most apparent in man's structuring of his physical world and those which dominate in human interpersonal relationships. These arrangements vary from culture to culture, considerably enough to be partially responsible for the phenomena underlying culture shock. There are three aspects of microcultural spatial patterns:

fixed feature space, semi-fixed feature space, and informal space (Hall, 1966).

Fixed feature space. Fixed feature space is an aspect of spatial patterning which organizes the activities of individuals and groups. This is most obvious in the arrangement of large geographical areas. One of America's distinct patterns is the structuring of the inner city, business district, and suburban zones. Another aspect of fixed feature spatial organization is our predominant architectural patterns. Special rooms within a home, buildings designed for health care or industry or entertainment--all speak to defining the activity for the space they enclose. Hall states that the important point about fixed feature space is that "it is the mold into which a great deal of behavior is cast" (1966, p. 106).

For the most part, Western homes are stationary with stationary walls. In contrast, the walls of Japanese homes are mobile, allowing rooms to be made larger or smaller as the inhabitants desire. Western homes are also organized into stable, functional units; rarely do we cook in the living room or bathe in the kitchen. In light of this pattern, it is interesting that hospitalized patients are required to sleep, eat, bathe, and eliminate all in the same confined space.

Semi fixed feature space. Some spaces tend to keep people apart; these are called sociofugal spaces. Others tend to bring people

together; these are called sociopetal spaces. Sociofugal spaces result when furniture is arranged in horizontal rows. This utilization of space allows people to interact comfortably only with those persons on either side of them. Common examples of places in which sociofugal arrangements are found include churches, theaters, lecture halls, stadiums, and hospital clinic waiting rooms. Conversation and involvement are generally inhibited as a result of the placement of chairs. Since one rarely alters the placement of furniture in public places, furniture placement can be an important environmental variable.

On the other hand, sociopetal spaces encourage interaction and involvement, due largely to the possibility for face to face interaction they provide. This pattern is one in which furniture is placed in some semblance of a circle. Some examples of sociopetal spaces are: seating arrangements at a seminar, restaurant, cocktail lounge, or a dining table.

In homes or offices, while the furniture is generally of a semi fixed nature, the degree varies. Most of the time, however, furniture can be adjusted to make a room either more sociofugal or sociopetal in nature. It is important to remember that what is sociofugal in one culture may be sociopetal in another and that just as sociofugal space is not necessarily bad, neither is sociopetal space universally good.

Informal space. At the microcultural level, informal spaces are identified as those which are maintained in interpersonal relationships. Inherent in Hall's observations about informal spaces is the notion of personal space. Hall stated that man's characteristic spatial requirements extend far beyond the space needed for physical presence alone. Hall described four general interpersonal distances to illustrate interpersonal relationships of the dominant American culture, excluding differences in personality and environmental factors (i. e., low illumination or a high noise level will usually bring people closer together). These four distances include the intimate, personal, social, and public distance, each having a near and far phase.

At intimate distance, the presence of another person is unmistakable; sensory input is greatly stepped up. In the close phase, physical contact or the potential of physical contact is uppermost in the awareness of both persons. In maximum contact, skin and muscles communicate. In the far phase, six to eighteen inches, the extremities can be brought into contact, but the heads, thighs, and pelvis cannot be easily done so. The use of intimate distance in public is not considered proper by most Americans. The far phase is customarily reserved for family interaction.

Personal distance is the term used to designate the distance that consistently separates the members of non-contact species. Hall describes it as a small protective sphere that an organism maintains

between itself and others. Sommer (1969) likens it to an aura or a bubble. The distance involved in the close phase is one and a half to two and a half feet. It is still possible to grasp or hold the other person. The far phase, a distance of two and a half to four feet, extends from a point just out of touching distance by one person to a point where two people can touch fingers if they extend both arms. This distance is exemplified by close friendship patterns (Hall, 1966).

Both the intimate and personal distances are consistently utilized by nurses in providing patient care and in nurse-patient interactions. It is worth noting that while such behavior may violate the norms of Anglo Americans, it may or may not violate the norms of American subcultures. In spite of the fact that many nursing functions probably violate the intimate and personal space of most patients, nurses still behave for the most part with total disregard to the spatial norms.

Business and casual social relationships are carried out in the phases of social distance. At this distance, four to twelve feet, nobody touches or expects to touch the other without some special effort. The major difference between the close and the far phases of this distance is that the far phase, seven to twelve feet, can be used to insulate or screen people from each other. It makes it possible for people to continue working in the presence of others without appearing to be rude. In the hospital, social distance makes it possible for patients to share the room and not feel obligated to interact at great length.

Several sensory shifts occur in transition from the personal and social distances to the public distances. In the close phase, twelve to twenty-five feet, a person can take defensive or evasive action if threatened. This distance is for less formal public speaking. The far phase, twenty-five feet or more, can be used by anyone on public occasions. Gestures and body stance are an active part of non-verbal communication. Most audiences feel comfortable at this distance with a stage performance or a speech by an important public official. This distance is generally for people who are to remain strangers.

To summarize, social scientists are becoming more aware of human spatial behavior and its attendant implications. Hall has coined the term proxemics, which refers to the study of man's use of space as a mode of communication and as a special elaboration of culture. Hall was the first social scientist to develop a theoretical model as a basis for exploring and understanding proxemic behavior. This model included the infracultural level which refers to the territorial aspects of man's management of space, the precultural level which contains the physiological aspects of man's perception of his spatial world, and the microcultural level which encompasses the ways by which man structures his physical environment and man's interpersonal spatial patterns.

Proxemic Interference

Until about twelve years ago, man's space requirements were thought of in terms of the actual amount of air displaced by his body. Now man's space requirements are seen in terms of personal space, an area with invisible boundaries surrounding a person's body into which intruders may not come. Sommer (1969) further likens it to porcupines: people like to come close enough to obtain warmth and comradeship, but far enough away to avoid pricking each other. This next section will provide an overview of how people protect their personal space, as well as sex- and personality-typed differences in the establishment of space itself.

The concepts of personal space can be distinguished from territory in several ways. The most important difference is that while territory is stationary, personal space is carried with an individual from place to place. The animal or man will usually mark his territorial boundaries with markers so that they are visible to others, but personal space boundaries are invisible. Personal space has the body as its center; territory does not. Often the center of territory is the home of the animal or man. Animals will usually fight to maintain dominion over their territory but will withdraw if others intrude into their personal space. Humans too respond to proxemic interference or deviations of personal distancing.

A deviation in proximity elicits a number of behaviors termed "compensatory behaviors." These behaviors include position shifts, body leans, increased gesturing, and, most noticeably, a decrease in mutual eye contact. Investigators have consistently supported the relationship between compensatory reactions and spatial intrusion (Argyle and Dean, 1965; Patterson, Mullen and Romano, 1973). Porter, Argyle and Salter (1970) found that as distance between two persons decreased, eye contact decreased, position shifts increased, and general arousal was increased as indicated by Galvanic Skin Responses. They found, however, that an increasing distance had the same results and thereby supported Argyle and Dean's contention that an optimum distance is established and that any deviation from that distance is uncomfortable and causes unease.

In their studies, Felipe and Sommer (1969) found that there were wide individual differences in response to intrusion. There was no single reaction to a stranger sitting too close. There were a variety of defensive gestures, shifts in posture, and attempts to move away. If these defensive gestures were ignored by the invader or just plain failed, consistently the victim would leave the situation. It is worth noting that in one study only two of sixty-nine subjects and only one of eighty subjects in another study verbalized a complaint or asked the intruder to move away. These observations support Hall's view that "we treat space somewhat as we treat sex. It is there, but we

don't talk about it" (1959, p. 163).

Allekian (1973) explores intrusions of territory and personal space as an anxiety-inducing factor for hospitalized persons. The results indicated that patients responded with uneasiness whenever personal or physical contact was made between them and personnel. While patients stated that gestures of touch would indicate that the hospital staff were concerned, responses indicated an indifference to touch--that is, an absence of positive or negative emotion. The greatest unease was expressed in response to situations in which the patients' established personal territory in the hospital room was intruded upon.

Albert and Dabbs (1970) found that close proximity was detrimental to persuasion or attitude change, evoking negative response on the part of the receiver, yet not resulting in the unselective derogation of the communicator. Other investigators have found the opposite relationship, however--that spatial closeness is associated with the arousal of positive attitudes and thus facilitates the acceptance of influence (Little, 1965; Mehrabian, 1968; Rosenfield, 1965). Reactions of subjects in yet another study supported the theory that close physical distance arouses negative reactions and that increased sincerity is perceived at intermediate distances (Leipold, 1963). It seems evident that certain spatial zones are appropriate for certain kinds of communication. Placement of a communicator inside or

outside of the appropriate proxemic zone will lower his effectiveness through such processes as distraction from the content of the message itself, the arousal of defensive reactions, the attribution of manipulative intent to the speaker, or the listener's inference that the speaker is treating him in a negative manner ranging from discontent to disdainful avoidance and disinterest.

In a recent study, Mahoney (1974) found that compensatory responses decreased as spatial immediacy increased. He suggested that this may be due to the lack of space in which the subject could make compensatory motor reactions, thus allowing his findings to be complementary to previous studies rather than contradictory. Even so, it is evident that more research in this area is essential so as to yield precise quantification rather than vague concepts.

In general, all of the studies reported indicate that people tend to avoid intrusion of personal space by either moving away or pulling themselves in. When intrusion does occur, the person may experience embarrassment or unease (Garfinckel, 1964). A stress response, a state or condition that manifests itself by measurable changes in the organs of the body, also can be evident (Selye, 1956). These studies support Hall's (1966) finding that proxemic interference can lead to discomfort and alienation from the interaction.

At what point people respond to intrusion of personal space seems to differ between sexes. How the teaching of sexually

differentiated spatial patterns is accomplished may be in accordance with social learning theory as Baldwin and Baldwin (1974) described it. However, studies of adults only indicate that it is accomplished (Birdwhistle, 1970; Sluckin, 1970; Verner, 1970). Meisels' and Guardo's (1969) general findings from a sample which included first through eighth graders supported the idea that sexual spatial patterns are in agreement with our present theories of psychosexual development. Research in other areas of child development supports the proposition that children and adults expect women to be more nurturant and passive, whereas men are expected to be more dangerous and aggressive (Kagan, 1964). The results of studies in personal space seem to reflect these findings.

In both assessed verbal reactions to experimental manipulations and in naturally occurring physical acts, males and females yield sex-specific spatial positioning effects (Fisher and Byrne, 1975). It is a well-established proposition that men are literally allowed more room by both males and females in interpersonal interactions, and women can be approached more closely by members of either sex (Lett, Clark and Altman, 1969). It appears too that males would feel less comfortable than females with face to face seating and more comfortable than females with adjacent seating. Fisher and Byrne (1975) report that males may be threatened by a frontal invasion of their personal space, while females are more threatened by an

invasion at their side. Though sex is an important variable for determining spatial behavior among Anglo Americans, it is not well researched cross-culturally.

Not only are proxemics culturally defined and sex specific among Anglos, it has also been asserted that personality variables are determinant of spatial behavior. With respect to psychopathology itself there is some evidence of increased distancing behavior in certain disturbed groups (Weinstein, 1965; Fisher, 1967; Tolor, 1970; Gerber, 1973). There is also a lack of support for the relationship between psychopathology and increased personal space in some studies. For example, Meisels and Cantor (1970) found conversation distances unrelated to deviancy. In addition, Tolor (1968) obtained no significant differences between emotionally disturbed and normal children nor did he (1970) find greater deviancy for schizophrenic adults when compared with normal adults. Steer, Thronton and Ritting (1974) found few schematic space associations in schizophrenic women in relation to amount of psychopathology. Therefore, serious questions may be raised about Lett, Clark and Altman's (1969) conclusion that abnormal personality is associated with the use of large interpersonal distances.

With respect to more specific personality dimensions, the literature is equally ambiguous. Leipold (1963) and Karabenick and Meisels (1973) reported that greater distancing results in persons with

high anxiety. On the other hand, Dosey and Meisels (1969) found no relationship between distance and indicators of anxiety. Rawls, Trego, and McFaffery (1968) found no relation between interpersonal distance and scores on the Eysenck Personality Inventory when sex differences were controlled. As to the role which internal or external locus of control plays, there is also much uncertainty requiring further clarification (Brannigan and Tolor, 1971; Duke and Nowidki, 1972; Duke and Mullens, 1973).

Finally, inspection of the literature on extroversion as related to psychological distance yields divergent results. Studies supporting the proposition that introverts employ greater distances have been reported by Patterson and Holmes (1966), Patterson and Sechrest (1970), and Williams (1963); those non-supportive of this proposition have been reported by Meisels and Cantor (1970), Williams (1971), and Tolor (1975). In view of the many ambiguities regarding the interaction of personality dimensions and spatial behavior, it cannot be said with any certainty that personality is determinant of spatial patterning. It is only certain that proxemic behavior is culturally defined and learned through the socialization process.

In summary, man's spatial requirements are now seen as his personal space. People experience unease, discomfort, and possibly anxiety when their personal space is violated or an appropriate interpersonal distance is not maintained. When this happens, they engage

in a variety of compensatory behaviors. Not only is proxemic patterning culturally defined, but it is sex-specific in the Anglo American culture and probably not influenced by personality variables.

Interpersonal Spacing in American Subcultures

People from different cultural backgrounds learn to define and utilize geographic space in different ways. Thus, culturally differentiated groups tend to prefer different spatial arrangements of participants involved in social interactions, and usually prefer to interact with each other at different interpersonal distances--some tightly clustered, others more widely spaced (Little, 1968). The following section describes specific cultural variations in spatial behavior among subcultures in the American culture.

The space adopted in an interaction which is affected by the quality and type of interaction also tends to be conducted at different distances in different cultures. An acceptable distance for a personal conversation between adult males of equivalent status under given conditions in an Arab culture may not only be quite unacceptable, but even anxiety-arousing in a North European culture (Hall, 1966).

Hall identified many differences in cultural spatial characteristics which confuse Americans who are living overseas. Some examples are presented briefly to illustrate some basic aspects of human spatiality. In Spanish speaking countries, an American's

sense of spatial orientation is disrupted by the custom of carrying on much of the social life in courtyards behind high walls. Visitors to these countries are often left with a sense of isolation from the audible, but invisible community life around them. Arabs crowd together in public places. They characteristically maintain less distance between one another in the streets, in shops and on buses, where they may comfortably fall asleep leaning on a stranger. By contrast, Americans assiduously avoid touching each other in public and strictly observe spatial privacy of strangers by avoiding crowding or pushing. When crowding or pushing is unavoidable, Americans will rigidly tense their bodies and fix their eyes on "infinity." In Germany, doors are solidly built and are kept closed most of the time, even in office buildings. This pattern is in conflict with Americans' open-door policy in business. It conveys a conspiratorial air and leaves the American with a feeling of being left out, while the German businessman is left with the feeling that Americans are unbusinesslike (Hall, 1955, 1959, 1966).

Conversational distances also vary from culture to culture. Once again, in the Middle East, businessmen may walk down the street holding hands while intently discussing an investment. Their North American counterparts on Wall Street would consider this an unacceptable way to conduct a serious financial discussion or to engage in any conversation in public. In Spain, people may interact

casually with one another at distances North Americans would consider intimate. In Sweden, people consistently engage a greater distance for conversation than Americans normally engage.

A number of investigations from a variety of research traditions have tended to confirm these general observations (Patterson, 1968; Sommer, 1966). Groups which have received the most attention have been Mediterranean, Arabic and East European cultures. Hall has argued that these groups, in general, tend to interact with each other under more proximal conditions and can frequently be seen touching one another during their encounters. A substantial amount of anecdotal data has supported this contention. Systematic data from Watson and Graves (1966) have demonstrated such differences between Arabs and Americans under standardized real life conditions, and Little (1968) has supported the findings with a variety of cultural groups using symbolic tasks. Watson (1970) observed and quantified a large cross-cultural range of behavior, finding that Arabs, Latin Americans and Southern Europeans interact more closely and touch one another more than do Asians, Indians, Pakistanis, and Northern Europeans.

While the dominant cultural heritage in the United States is Northern European, a significant number of minorities from other backgrounds also exist. To the extent that these ethnic groups show corresponding or similar differences in space usage, they may prefer

different interaction conditions and therefore require alterations for optimal interpersonal function (Carr, 1967). To date, little information is available regarding preferred interaction distances of sub-cultural groups in this country, but there are a few.

Willis (1966) utilized either black or white experimenters of both sexes to observe the social greeting distances of either black or white subjects in several types of natural settings. While his results were complex, one clear finding was that black subjects generally tended to greet others, especially other blacks, at greater distances.

While not specifically focusing on these issues, an early study by Efron (1941) also reported differences in body contact and spacing patterns. He studied East European Jewish and Southern Italian subcultures as they conversed on New York City streets. In general, he found greater closeness and more physical contact among his Jewish subjects.

Baxter (1970) also explored the distances at which Anglo, Black, and Mexican-American people interacted with each other in several natural settings. His most impressive finding was attributable to the ethnic group membership of the subject pairs. He reported that Mexican subjects of all ages and sex groupings interacted most proximally. This finding is consistent with reports that Mediterranean cultures, and presumably American subcultures of this origin, interact at closer distances (Hall, 1966; Little, 1968; Watson, 1970).

Mexican-Americans not only stood closer together, but informal observation also suggested that they frequently touched each other and often held each other by the hand, arm, or waist. This behavior was rarely observed in the Anglo and Black groups. The tendency for Blacks to stand at greater distances is a finding consistent with that of Willis (1966). Baxter further reported that Anglos tended to maintain distances intermediately or between the closeness of the Mexican-American and the greater distance of the Black Americans. These results revealed exceedingly consistent subcultural differences between subjects interacting in natural settings in pre-established groupings (Baxter, 1970).

To conclude, just as cultures vary in their spatial patterns, so do subcultures of the American culture. There is evidence that each subculture reflects the proxemic behavior of its culture of origin. In general, Mexican-Americans are most proximal, the Black Americans least proximal, and the Anglo Americans relatively intermediate.

Implications for Hospitalization

Spatial behaviors are so highly patterned and automatic that they function primarily out of awareness. Therefore, these behaviors are not subject to the kind of control and distortion to which the spoken word is subject. When people are hospitalized, their culturally defined proxemic patterns persist. The persistence of these patterns

serves to satisfy certain important needs of the hospitalized patient.

Minckley (1968) states that the identify of the individual is, in large part, the product of territoriality. The hospitalized person marks territory in an attempt to support both his personal and social integrity (Levine, 1968). Upon admission to a hospital or other institution, a new patient will quickly familiarize himself with the new situation by locating his room, his bed, his table--in other words, his territory. Others in the institution also regard that identified space as belonging personally to the particular individual (Sutterly and Donnelly, 1973).

Since individuals carry their personal space with them, the hospitalized patient still has his own culturally determined personal space. The new patient familiarizes himself with his hospital surroundings further by sight and sound (Minckley, 1968). He strives to maintain his personal space by screening himself visually or auditorially. Each culture may have a different method of handling screening or preservation of personal space. A Japanese patient may wish to be screened visually, but sounds will not bother him. A German patient may prefer the doors closed and to be screened as well, thus eliminating both sights and sounds. Americans, Anglo and Black, will most often self-screen by deliberately withdrawing themselves from the social context (Hall, 1966). However, patients encounter many situations which make maintenance of territory and personal space

difficult.

A hospitalized person, who is limited in mobility and/or activities as a result of illness, has his perspective for identity narrowed. Consequently, such a person may experience a more intense territorial drive than usual. Due to the intrusive nature of health care, the patient cannot always control the distance that is maintained between himself and others. But rather, the distance is controlled primarily by health care providers. As a result, the patient may experience persistent threats to his territory and personal space.

Of course, in order to carry out necessary activities on behalf of the patient, hospital personnel must enter a patient's territory and personal space. Unfortunately, these activities within the room and with the patient become so routinized that personnel frequently do not recognize when their behavior constitutes territorial and personal space invasion. In general, spatial needs are ignored in hospitals and cultural differences relating to such needs are rarely acknowledged.

The point at which a person experiences invasion of his/her personal space and the degree of stress associated with such violation, is determined by cultural experiences. In any case, invasion is viewed as a noxious stimuli for Anglo Americans and, as such, it can contribute to a state of tension or anxiety. This is especially true since anxiety has been conceptualized, in part, as a state of physiological arousal or type of tension (Fischer, 1970).

Invasion of personal space, whether the invasion is an actual physical, visual, or audio (i. e., noise) intrusion (Pluckhan, 1968), is also considered a non-verbal message. The message communicated is one of indifference to the patient's comfort and dignity. The patient may then experience depersonalization (Pluckhan, 1968) and a loss of identity and/or status (Allekian, 1973).

Territorial intrusions may also induce unpleasant feelings, stress or anxiety. The person has a psychological need for security and identity, a need fulfilled by territorial claims (Minckley, 1968; Allekian, 1973). Intrusion upon a patient's territory may be perceived as a threat to this security and identity and result in a state of arousal or tension. Beland (1970) suggests that the patient would experience "psychological stress," a mental demand on the patient which frequently leads to unpleasant feelings such as anxiety.

It is evident that man's feelings about space, and about being properly oriented in space, run deeply (Hall, 1970). This fact is acknowledged by many nurses on surgical units who prepare their patients prior to surgery for the transfer to the intensive care unit for post-operative recovery. Without such preparation for a new space and territory, many patients experience disorientation with anxiety and fear (MacKenzie, 1970).

To summarize briefly, when people are hospitalized, their culturally defined proxemic patterns persist. Territorial claims are

established and personal space needs are held in accordance to cultural norms. Intrusions of territory and personal space are proposed to be a source of feelings associated with the loss of identity, or feelings of depersonalization, alienation, insecurity and annoyance. Hospital personnel may even produce anxiety in hospitalized patients through their intrusions and consistent proxemic interference.

Purpose of the Study

The review of the literature has pointed out the importance of the structuring of space in humans. Most studies operate on the assumption that much of man's behavior occurs with a spatial framework and support Hall's contention that proxemic patterns are culturally determined. Thus, when people from cultures employing different patterns of proxemic behavior interact, interference is likely to occur with consequent alienation from the interaction.

Hall has suggested that differences between the subcultures and Anglo culture are basic and grow out of such core values as the use and structuring of time, materials, and space. It is evident that people in the Black culture do employ a different proxemic pattern, specifically that the culture prefers a greater interpersonal distance or personal space. Thus, since Anglos prefer less distance and would violate the Blacks' personal space, there is probably interference when interacting with persons in the dominant Anglo culture. However,

it has not been identified how individuals in the Black culture respond to intrusions of territory or violations of personal space.

This study was not designed to determine the response of Black Americans to intrusion across a variety of situations or content themes. Rather, it was to serve to augment other studies which have determined that Black Americans prefer greater personal distance and which have determined a variety of discomfort responses to intrusion among Anglo Americans. This study was to further supplement the body of knowledge nursing utilizes to more effectively provide care for cross-cultural health care seekers.

The thrust of this study was to determine whether intrusions of territory and personal space are anxiety producing factors for the hospitalized Black person and to compare such responses with those of the Anglo person to determine if there is a cultural difference. Since proxemic patterns are culturally determined, it was assumed that feelings associated with anxiety are experienced at culturally determined points of intrusion. Thus, in this study, intrusion of territory and personal space in two cultural groups were the independent variable and the degree of feelings associated with anxiety was the dependent variable.

Spatial behavior and its implications in terms of psychological comfort or discomfort, as well as cross-cultural health care, are within the realm of nursing. It is further a concern with regard to

nurse-patient interaction. Thus, the author chose a post-test only control group design to ascertain whether culture influences the response to intrusion of territory and personal space. In order to provide a framework in which the comparison could be made, the following hypotheses were formulated:

1. Hospitalized Black American patients will experience greater feelings associated with anxiety when intrusions of their territory occur, than will Anglo patients.
2. Hospitalized Black American patients will experience greater feelings associated with anxiety when intrusions of their personal space occur, than will Anglo American patients.

Since it was of interest to the investigator to further pursue the study of cultural differences, the sexual differences within each culture in response to intrusion of territory and personal space were explored. To provide a framework for such study, two additional hypotheses were formulated:

3. Male Black Americans will experience greater feelings associated with anxiety in relation to territory and personal space intrusions, than will female Black Americans.
4. Male Anglo Americans will experience greater feelings associated with anxiety in relation to territory and personal space intrusions, than will female Anglo Americans.

Of secondary interest to the author was the relationship of length of hospitalization to responses to intrusion of territory and personal space. Do hospitalized patients become sensitized or desensitized to intrusion over time? Data were collected to determine if there is a relationship between length of hospitalization and the presence of anxiety in response to intrusion.

Definition of Terms

The following is a list of terms with their definitions as they were used in this study:

Anxiety. Anxiety refers to an experience which can be described affectively, such as uneasiness, embarrassment, or annoyance (Fischer, 1970).

Intrusion. Intrusion is an unsolicited entrance, activity, or contact.

Personal space. This term refers to an area extending outward from a person's body to a distance of four feet; it is carried with the person from place to place.

Proxemics. This term refers to the "interrelated observations and theories of man's use of space as a specialized elaboration of culture" (Hall, 1959, p. 1).

Territory. Territory refers to "an area of the hospital room which is claimed by the patient" (Allekian, 1973, p. 238).

CHAPTER III

METHODOLOGY

Subjects and Setting

The subjects were drawn from two metropolitan Portland hospitals. One was the University Hospital at the University of Oregon Health Sciences Center, a general acute care facility, and the other was the Portland Veterans Administration Hospital, generally an extended care facility for chronic conditions. A non-probability, purposive sample was used. Thirty participants were selected from the adult (18 to 60 years) Black patient population and 30 participants were selected from the adult Anglo patient population.

The sample population for this study was selected according to the availability of patients who were lucid and responsive, not critically or seriously ill, and not confined to bed or room. The Anglo population did not include first generation Americans or those who were members of an American subculture, i. e. Italian Americans, Indian Americans, Jewish Americans, et cetera. The population included general medical and surgical patients. The selections also depended upon the willingness of the persons to participate in the study. The Black patient group and the Anglo patient group were matched according to age, sex, hospital, service (medical or surgical), specialty service, and severity of illness.

Instrument

To collect data, a two part questionnaire developed by Allekian (1973) was employed. The questionnaire items were based upon an analysis of factors which constitute territorial intrusions and personal space intrusions. Allekian tested for validity by surveying a sample of patients. The questionnaire used in the present study was the result of the pilot study. Allekian's study was replicated twice since her original one, and has demonstrated reliability (Allekian, 1977). Part I of the questionnaire contained 15 questions designed to determine feelings about territorial space. Part II had 12 questions which investigated feelings regarding intrusions of personal space. See Appendix B.

Possible responses were based on a forced-choice selection of five words used to describe degrees of anxiety. These words were chosen by Allekian (1973) on the basis of an analysis of terminology used to describe anxiety by Davitz (1969). Anxiety was thus viewed to have elements of tension and discomfort, and terms which reflected the absence and presence of these elements were selected.

Anger has been described as a means both of releasing tension and handling anxiety (Plutchik, 1962). However, the term "anger" was considered by Allekian (1973) as too forceful and too threatening for use in the questionnaire. The word "annoyance" was substituted

as a descriptive term associated with anxiety arousal when territorial intrusions occur. Further analysis of the terminology by Allekian (1973) led to the selection of the words "uneasy" and "embarrassed" as descriptive terms associated with anxiety arousal when intrusions of personal space occur. The terms "pleased" and "agreeable" were associated with positive feelings and the absence of anxiety arousal. The term "indifferent" indicated a lack of emotional reaction to the intrusions. This author utilized the responses selected by Allekian.

The possible responses to each item were given a numerical weight of one to five:

<u>Part I</u>	<u>Part II</u>
1. pleased	1. pleased
2. agreeable	2. agreeable
3. indifferent	3. indifferent
4. annoyed	4. uneasy
5. very annoyed	5. embarrassed

Responses numbered one and two were considered favorable. A response of three was neutral or embodying no emotional reaction. Responses of four and five indicated the presence of anxiety. Demographic variables were obtained from the subjects' medical records. Data included the respondent's age, sex, cultural group, length of hospitalization, diagnosis, severity of illness, service and specialty service, and the hospital in which the respondent was a patient.

Procedure

Black American subjects who met the criteria were selected first, according to availability, since the Black population of both hospitals was relatively small. The Anglo American subjects were then chosen according to the matching criteria. This process produced 15 matched pairs.

Each subject was approached by the investigator and asked to volunteer participation in the study. Upon signing the consent form, the patient was given the two-part questionnaire. Verbal instructions were given to reinforce the printed instructions. If any subject was unable to read or write or both, the investigator assisted by reading the items and response choices and then marking the response indicated by the patient.

The subjects were assured that their responses are confidential. This was essential to avoid the patients feeling their responses might be construed as dissatisfaction with their care. The subjects also were informed that the study did not aim at determining their like or dislike of the hospital or the care they received, but was concerned only with the feelings about the situations encountered. Allekian (1973) found such assurance necessary in order to derive more honest responses to the questionnaire.

Approach to Data Analysis

Mean scores for Part I, Territorial Intrusion, and Part II, Personal Space Intrusion, were computed for each subject. The relationships between cultural group (Black and Anglo) and response to intrusion (territorial and personal space) were assessed by the use of t-tests. The t-test was also employed to determine the significance of the difference in the responses of the subjects to the two types of intrusion. Of interest to the investigator were sexual differences, in response to intrusions, within each cultural group. To determine significance, t-tests were again used. A $p = < .05$ level of significance was chosen.

Of secondary interest to the investigator was the relationship between length of hospitalization and responses to territorial and personal space intrusions. Each relationship was assessed by means of a rho correlation.

To explore how the two cultural groups differed in their responses to the content of individual items, a mean score for each item in Parts I and II of the questionnaire was calculated for each group. The individual scores for each situation in both parts were grouped according to the three broad responses (favorable, indifferent, anxiety) and the two cultural groups (Black and Anglo). Items in which the mean scores for the two groups fell into different response categories and

items in which the number of subjects who indicated anxiety responses differed between the two groups by a frequency of four or more, were selected for analysis of a descriptive nature.

CHAPTER IV

RESULTS

Characteristics of the Subjects

The study population consisted of 30 subjects, 15 Black Americans and 15 Anglo Americans, all of whom were hospitalized at the time of data collection. The subjects were matched according to sex, hospital, service (medical or surgical), specialty service, and severity of illness. Eighteen of the subjects were male and 12 were female. Twenty subjects were selected from the University Hospital, of the University of Oregon Health Sciences Center, while 10 subjects were from the Portland Veterans Administration Hospital. Twenty subjects were hospitalized on a medical service and 10 were hospitalized on a surgical service. At the University Hospital, 10 subjects were selected from General Medicine wards, 4 each respectively were from General Surgery wards and a Gynecology ward, and 2 were selected from a Neurology ward. At the Veterans Hospital, 6 subjects were selected from a Renal Medicine ward, 2 each respectively were from a Respiratory-Infectious Disease ward, and a Thoracic Surgery ward. Regarding severity of illness, 26 of the subjects were considered to be in satisfactory condition, while four were considered to be in fair condition. The subjects were matched for age according to decades. This procedure resulted in a comparability in the two groups

with respect to age. Ranging in age from 21 to 60 years, the study population's mean age was 39.2 years. The length of hospitalization ranged from 1 to 22 days, with a mean of 5.7 days. The two groups were comparable with respect to each of the matched variables, as well as length of hospitalization. See Table 1.

Two other variables were of importance, though it was not possible to control for them in assignment to groups. The study population varied in the admission diagnoses assigned to the subjects. However, a measure of control for this variable was achieved by matching subjects according to specialty service. (See Appendix D for admission diagnosis per individual subject.) While it was recognized that room assignment could be an important variable in relation to the dependent variable, it was not possible to control room assignment in the present study. However, inspection of the data showed that assignment to each type of room was evenly distributed between the two groups. Three subjects were hospitalized in private rooms, 19 were in two-bed rooms, and 8 were hospitalized in four-bed rooms.

All subjects met the established criteria which were presented in the preceding chapter. One Black American subject was deleted from the study, as no Anglo American subject could be matched with him during the time period of data collection. Four Black Americans refused participation in the study. No subjects withdrew from participation.

TABLE 1

Descriptive Characteristics of the Two
Cultural Groups on Selected Variables

Variable	Blacks	Anglos
N	15	15
Sex		
M	9	9
F	6	6
Age		
Mean	39.00	39.46
Standard Deviation	4.70	10.40
Hospital		
U. O.	10	10
V. A.	5	5
Service		
Medical	10	10
Surgical	5	5
Specialty Services, University Hospital		
General Medicine	5	5
General Surgery	2	2
Neurology	1	1
Gynecology	2	2
Specialty Services, Veterans Hospital		
Renal Medicine	3	3
Respiratory-Infectious Disease	1	1
Thoracic Surgery	1	1
Severity of Illness		
Good	0	0
Satisfactory	13	13
Fair	2	2
Hospital Days		
Mean	5.7	5.7
Standard Deviation	5.01	5.01

Note. All variables were matched except hospital days.

Response to Territorial Intrusion

To determine support for Hypothesis I, which posited that Black Americans experience greater feelings of anxiety than Anglo Americans in response to territorial intrusion, the mean score on Part I of the questionnaire was first computed for each subject. See Table 2. Scores for the total group ranged from 2.33 to 4.27, with a mean of 3.46 and a standard deviation of 0.47. The scores of the Anglo American group ranged from 2.33 to 4.07; the mean score was 3.32, with a standard deviation of 0.48. The scores of the Black American group ranged from 2.67 to 4.27, with a mean of 3.61 and a standard deviation of 0.42. The mean scores fell in the range of an anxiety response (the predetermined anxiety level is 3.25 - 5.0). These results indicated that both groups did experience feelings associated with anxiety when territorial intrusions by hospital personnel occurred. The mean score of the Black group was slightly higher, indicating greater anxiety than the Anglo group. However, the difference for related measures was not significant at the $p < .05$ level of significance ($t = 1.490$, n.s.), demonstrating a lack of support for the first hypothesis. In that the relationship was significant at the 0.1 level, a trend was indicated in the direction which was originally hypothesized for the relationship between the two groups.

TABLE 2

Mean Scores for Matched Pairs in the Two Cultural Groups;
Parts I and II of the Questionnaire

Matched Pairs	Part I		Matched Pairs	Part II	
	Blacks	Anglos		Blacks	Anglos
1	4.13	3.67	1	3.17	2.75
2	3.80	2.73	2	3.00	2.08
3	4.00	3.60	3	4.42	3.58
4	3.40	3.73	4	3.00	3.25
5	3.27	3.27	5	2.42	3.00
6	3.00	3.60	6	2.50	1.92
7	4.00	2.33	7	3.58	2.00
8	3.53	2.80	8	3.00	2.58
9	3.67	3.53	9	3.58	2.75
10	3.40	3.27	10	2.58	2.92
11	3.47	3.68	11	2.33	2.75
12	3.73	2.53	12	1.92	2.08
13	4.27	3.53	13	4.00	2.00
14	2.67	4.07	14	2.42	3.83
15	3.87	3.47	15	3.75	2.25
Mean	3.61	3.32	Mean	3.04	2.65
SD	0.42	0.48	SD	0.68	0.58
Total Mean	3.46		Total Mean	2.85	
Total SD	0.47		Total SD	0.66	

Response to Personal Space Intrusion

The second hypothesis stated that Black Americans experience greater feelings of anxiety than Anglo Americans in response to personal space intrusion. To determine support for Hypothesis II, again the mean score for Part II of the questionnaire was computed for each subject. See Table 2. The total scores ranged from 1.92 to 4.42, with a mean score of 2.85 and a standard deviation of 0.66. The Black American group had scores which ranged from 1.92 to 4.42; the mean score was 3.04, with a standard deviation of 0.68. The scores for the Anglo American group ranged from 1.92 to 3.83, with a mean of 2.65 and a standard deviation of 0.58. The mean scores indicated that both groups appeared to be indifferent to intrusions of personal space by hospital personnel. Again, the mean score of the Black group, approaching an anxiety response, was slightly higher than that of the Anglo group. There was no significant difference between the response of the two groups at the $p < .05$ level of significance ($t = 1.581$, n. s.), and Hypothesis II was rejected. However, significance between the two groups was present at $p < .10$, indicating a positive trend in support of the hypothesis.

Comparison of Intrusion Responses

Although it had not been anticipated that there would be a difference between the response of the study population to territorial intrusion and personal space intrusion, upon inspection of the data, such

a difference was observed. To Part I, territorial intrusion, no subjects indicated a favorable response, six were indifferent, and 24 indicated an anxiety response. This is in contrast to Part II, personal space intrusion, to which seven subjects responded favorably, 16 responded with indifference, and seven indicated an anxiety response. In other words, 80% of the subjects indicated an anxiety response to territorial intrusion, while only 23% of the subjects indicated such a response to personal space intrusion. It was an unexpected finding that more subjects responded to territorial intrusion with feelings of anxiety than responded to personal space intrusion with anxiety.

Sex Differences Within Each Group

The study population was next analyzed to determine if, in response to intrusion of territory and personal space, sexual differences within each culture existed. Within the Black group, the scores were categorized according to sex. See Table 3. For Part I, response to territorial intrusion, the scores for the males ranged from 2.67 to 4.53. The mean score was 3.65, with a standard deviation of 0.45. The scores for the females ranged from 3.00 to 3.80, with a mean of 3.40 and a standard deviation of 0.36. There was no significant difference between the Black males and females in response to territorial intrusion ($t = 0.409$, n. s.). For Part II, response to personal space intrusion, the scores of the Black males ranged from 1.92

TABLE 3

Mean Scores for Sexes Within the Cultural Groups;
Parts I and II of the Questionnaire

	Part I			
	Blacks		Anglos	
	Males	Females	Males	Females
	4.13	3.80	4.07	3.47
	4.00	3.87	2.53	3.73
	4.53	3.00	3.53	3.60
	3.67	3.40	3.60	3.60
	3.40	4.00	3.27	3.27
	3.47	3.26	2.33	2.73
	3.73		3.53	
	4.27		2.80	
	2.67		3.67	
Mean	3.65	3.40	3.26	3.40
SD	0.45	0.36	0.55	0.33

TABLE 3 (continued)

	Part II			
	Blacks		Anglos	
	Males	Females	Males	Females
	1.92	2.42	2.00	1.92
	2.33	2.50	2.00	2.08
	2.42	3.00	2.08	2.25
	2.58	3.00	2.58	3.00
	3.00	3.75	2.75	3.25
	3.17	4.42	2.75	3.58
	3.58		2.75	
	3.58		2.92	
	4.00		3.83	
Mean	2.95	3.18	2.63	2.68
SD	0.65	0.70	0.55	0.63

to 4.00. The mean was 2.95 with a standard deviation of 0.65. The scores for the females ranged from 2.42 to 4.42, with a mean of 3.18 and a standard deviation of 0.70. While the scores of the Black males were very slightly lower than those of the females, an opposite trend than was predicted by Hypothesis III, there was again no significant difference between the sexes in response to personal space intrusion ($t = 0.596$, n. s.). Since there were no significant differences between Black males and females in response to either territorial or personal space intrusion, the third hypothesis was not supported.

The scores of the Anglo Americans were also categorized according to sex; refer to Table 3. In Part I, response to intrusion of territory, the scores for the males ranged from 2.53 to 4.07. The mean was 3.26, with a standard deviation of 0.55. The scores for the females ranged from 2.73 to 3.73, with a mean score of 3.40 and a standard deviation of 0.33. While the mean score for the females was very slightly higher than the score for the males, the opposite of that predicted, no significant difference was found in the Anglo group between males and females in response to territorial intrusion ($t = 0.528$, n. s.). For Part II, response to intrusion of personal space, the scores for Anglo males ranged from 2.00 to 3.83. The mean was 2.63, with a standard deviation of 0.55. For the females, scores ranged from 1.92 to 3.58, with a mean of 2.68 and a standard deviation of 0.63. Again, there was no significant difference between the

sexes in response to personal space intrusion ($t = 0.156$, n. s.). Since there were no significant differences between Anglo males and females in response to either territorial or personal space intrusion, Hypothesis IV was rejected.

Length of Hospitalization and Responses to Intrusion

Length of hospitalization, as an independent variable, was assessed in relation to responses to territorial and personal space intrusion. Length of hospitalization in relation to responses to territorial intrusion was found not to be significantly correlated ($\rho = 0.064$), nor was there a significant correlation between length of hospitalization and responses to personal space intrusion ($\rho = -0.041$). Thus, it was not supported that hospitalized patients become either sensitized or desensitized to intrusion over time.

Item Analysis

It was of interest to the investigator to explore how the two groups may have differed in their responses to the content of individual items and to see if such items grouped into any logical pattern. This portion of the results is admittedly of a descriptive nature, but was pursued to provide additional information that would have implications for cross-cultural health care and that would serve as a basis

for future investigations.

A mean score for each item described in Parts I and II of the questionnaire was calculated for each group. See Table 4. Further, the individual scores for each situation in both parts were grouped according to the three broad responses (favorable, indifferent, and anxiety) and the two cultural groups (Black and Anglo). See Table 5. Items in which the mean scores for the two groups fell into different response categories and items in which the number of subjects who indicated anxiety responses differed between the two groups by a frequency of four or more, were selected for analysis of a descriptive nature.

In Part I, the two groups responded differently to three items. That is, the Black group had a mean score which indicated an anxiety response and the Anglo group had a mean score which indicated an indifferent response. See Table 4. Two of these items dealt with the entrance to the territory. Item 3 referred to the nurse's ignoring the patient's preference for having the door closed, by leaving the door open; item 12 referred to the orderly's entering the room without knocking. The third item, item 13, referred to the situation in which the cleaning woman rearranged the patient's personal belongings on the bedside table without asking the patient's preference. Not only did the scores fall into different categories of response, but, as can be seen in Table 5, the distribution of responses differed as well.

TABLE 4
Group Mean Scores of Responses to Individual Items in
Parts I and II of Questionnaire

Item	Part I		Item	Part II	
	Blacks Response	Anglos Response		Blacks Response	Anglos Response
1	3.10	2.67	1	3.87	3.33
2	2.93	2.53	2	3.20	2.53
* 3	3.60	3.13	3	2.60	2.27
4	3.73	3.53	4	2.73	2.33
5	4.10	4.20	5	2.80	2.67
6	3.47	3.27	6	2.33	2.20
7	3.33	3.33	7	2.93	2.93
8	3.73	3.53	8	3.00	2.60
9	4.73	4.73	* 9	3.27	2.67
10	3.93	3.27	*10	3.33	2.80
11	2.67	2.33	*11	3.27	2.80
*12	3.73	3.13	12	3.20	2.67
*13	3.53	3.20			
14	3.83	3.47			
15	3.93	3.40			
Mean	3.61	3.32	Mean	3.04	2.65
SD	0.48	0.42	SD	0.68	0.58

Note. Favorable response = 1.0 to 2.25; indifferent response = 2.26 - 3.25; anxiety response = 3.26 - 5.00.

*These items differed in the response categories of the two groups.

TABLE 5

Frequency Distribution of Grouped Scores
for Parts I and II of Questionnaire;
by Cultural Group

Item	Part I						Part II						
	Blacks			Anglos			Blacks			Anglos			
	F	I	A	F	I	A	F	I	A	F	I	A	
1	4	6	5	6	7	2	* 1	1	0	14	2	6	7
2	6	5	4	6	8	1	* 2	2	8	5	7	7	1
* 3	2	3	10	4	5	6	* 3	8	3	4	10	5	0
4	1	3	11	3	1	11	* 4	7	4	4	10	5	0
5	0	1	14	0	1	14	5	7	2	6	7	5	3
6	1	7	7	2	8	5	6	11	3	1	12	2	1
7	1	9	5	1	9	5	7	9	1	5	5	8	2
8	1	3	11	2	4	9	8	5	4	6	8	4	3
9	0	0	15	0	0	15	* 9	4	4	7	6	7	2
*10	0	3	12	3	6	6	10	2	7	6	6	6	3
11	6	7	2	9	5	1	11	2	8	5	7	4	4
*12	2	3	10	4	6	5	*12	5	3	7	7	5	3
*13	2	4	9	4	6	5							
14	1	5	9	3	4	8							
15	0	2	13	3	3	9							

Note. F = Favorable; I = Indifferent; A = Anxiety.

*These items differed in the frequency of anxiety responses by ≥ 4 between the two groups.

Item 10 also dealt with a situation in which the patient's preference was ignored. This item referred to the window shades being raised or lowered without asking the patient's preference. While the mean scores did not fall into different response categories, the mean for the Anglo group was 3.27, at the lowest end of the scale indicating an anxiety response. The mean for the Black group was 3.93. Half of the Anglo group responded favorably or indifferently to the item and half responded with an anxiety response. In contrast, no Blacks responded favorably to the item and 12 responded with an anxiety response.

In Part II, response to personal space intrusion, one item elicited responses which differed between the two groups. This situation referred to the nursing assistant leaning over the patient, who was lying in bed, in the process of making the bed (item 9). The Black group had a mean score which indicated an anxiety response and the Anglo group had a mean which indicated an indifference to the situation. A similar item elicited anxiety responses from both groups, but to a greater degree in the Black group. The situation dealt with the nurse leaning over the patient so that the nurse's breath was felt against the patient's face (item 1). Fourteen of the Blacks responded with anxiety, while only seven of the Anglos did. See Table 5.

Two of the items in Part II referred to situations in which health care personnel stood or sat too close to the patient. Item 2 dealt with

the nursing assistant standing close to the head of the bed, talking with the patient, when he/she was lying down. In the second situation, item 4, the physician sat close to the patient on his/her bed while talking with the patient. Although both groups responded to these items with mean scores that indicated indifference, it was noted that the groups differed in the distribution of individual responses among the predetermined categories. Specifically, five Blacks responded to item 2 with an anxiety response and only one Anglo responded indicating anxiety; to item 4, no Anglos indicated an anxiety response, while four Blacks did.

The two groups had different distributions in response to items which dealt with touch behavior on the part of health care personnel. Item 3 referred to the nurse coming close to the patient and putting her hand on his/her shoulder; item 10 described the situation in which an orderly places his hands on the patient's arms while talking with him/her; item 11 referred to the physician taking the patient's hand in his while the patient was telling him about a problem; and item 12 dealt with a situation in which the nursing aide puts her arm around the patient while talking with him/her. In terms of mean scores, the Black group indicated an anxiety response to items 10 and 11, but the Anglo group indicated indifference. The mean score responses to the other items indicated indifference for both groups, yet, based upon inspection of both the means and the frequency distribution in the

response categories, it appeared that the items aroused more feeling in the Black group. See Tables 4 and 5.

CHAPTER V

DISCUSSION

It will be recalled that the first hypothesis was concerned with the cultural difference in response to territorial intrusion. However, the two cultural groups did not differ significantly in response to such intrusion, at least not at a statistically significant level. This finding is in contrast to a number of investigations that have tended to confirm that cultural groups differ in their proxemic behavior (Hall, 1966; Little, 1968; Patterson, 1968; Sommer, 1966; Watson and Graves, 1966; Watson, 1970). It has further been suggested that subcultural groups in this country also differ in proxemic behavior (Hall, 1966; Carr, 1967), and that, more specifically, Black Americans do prefer a greater interpersonal distance than Anglo Americans. Since the Black group and Anglo group responded to territorial intrusion with essentially the same degree of anxiety, it must be considered that in this aspect of proxemic behavior (response to territorial intrusion), the two cultural groups do not differ. The point at which Blacks responded to territorial intrusion did differ to some extent from the Anglos, in that the Blacks responded with greater anxiety to territorial intrusions that were more distant. Situations that involved health care personnel entering the territory or hospital room aroused more feeling of anxiety in the Black group than in the Anglo

group. No previous studies were identified which explored whether or not cultural groups establish territory of differing size or if cultures differ regarding the point at which intrusion of territory occurs. Whether or not Black Americans differ from Anglo Americans in the actual amount of territory they prefer is not clear.

Authors have contended that man does possess a territorial nature (Hall, 1963; Ardrey, 1966; Sommer, 1966) and that man tends to establish territories even in a temporary situation (Esser et al. 1965; Somer and Becker, 1969; Pauluck and Esser, 1971; Allekian, 1973). In this study, both Black Americans and Anglo Americans responded to territorial intrusion with feelings of anxiety, a finding which suggests that man's need to protect territory is one of great value. That the subjects responded in a concerned way, supports the contentions that man does possess a territorial nature and tends to establish territory in a temporary situation.

The literature suggests that many situations, including hospitalization, evoke territorial behavior (Hall, 1963; Lyman and Scott, 1967; Minkley, 1968). Minckley (1968) stated that the identity of the individual is, in large part, a product of territoriality. Therefore, the hospitalized person marks territory in an attempt to support both his personal and social integrity. At least one previous study found that persons defended territory with a variety of defensive gestures (Sommer and Becker, 1969). Allekian (1973) established that

hospitalized Anglo patients made territorial claims and responded anxiously to intrusions of territory by hospital staff. Results of the present study suggest that, when hospitalized, Black Americans, as well as Anglo Americans, respond to territorial intrusions with anxiety.

While the second hypothesis predicted that Black Americans would respond differently to personal space intrusion than Anglo Americans, the difference between Black and Anglo Americans in response to such intrusion was not significant in the present study. It is worth noting that previous studies have consistently supported the observation that cultures and subcultures differ in proxemic behavior. Specifically, it has been found that Black Americans prefer greater personal distance than Anglo Americans (Willis, 1966; Baxter, 1970). Not only did cultures and subcultures differ in the amount of personal space preferred, but they differed in the ways that they protected that personal space (Hall, 1966). Yet, in the present study, the findings suggest that while the preferred interpersonal or personal space may differ, response to intrusion in these two cultural groups does not. In a sense, this finding is supportive of the observation that both Black and Anglo Americans protect their personal space by self-screening, tensing rigidly and fixing their eyes on infinity or by withdrawing deliberately from the social context (Hall, 1966). Such behavior can be indicative of apathy

or indifference, and may in fact correspond to the responses to the questionnaire in the present study.

Although many of the studies reviewed indicate that intrusions of personal space evoke a negative response in people (Leipold, 1963; Albert and Dabbs, 1970; Garfinkle, 1964) or result in people experiencing embarrassment or unease (Garfinkle, 1964), such findings were generally not supported by the present study. For Part II (Personal Space) of the questionnaire, the means of both groups indicated an indifferent response to intrusions of personal space. This finding, while inconsistent with those of studies concerning a non-hospitalized population, is consistent with the results Allekian (1973) found with a hospitalized population. Anxiety responses to personal space intrusion may have been minimal because the persons who enter the hospital expect a certain amount of physical contact; it is an inherent part of the provision of health care. Therefore, the persons may be psychologically prepared for these intrusions.

That persons were tolerant of personal space intrusions within the hospital setting, suggests that the setting dictated to some extent the type of behavior that was acceptable. The hospital is an architectural pattern designed for health care; as such, it is an aspect of fixed feature spatial organization. Hall states that the important point about fixed feature space is that "it is the mold into which a great deal of behavior is cast" (1966, p. 106). The findings of this

study, as well as that of Allekian (1973), suggest that indeed the behavior and response to intrusion with regard to personal space is defined by the hospital setting.

A difference between the study population's responses to territorial intrusions and personal space intrusions was noted. Allekian (1973) also found that reactions to territorial and personal space intrusions differed; as in this study, the subjects indicated greater anxiety in response to territorial intrusion than to personal space intrusion. The findings of this study would tend to support Allekian's.

It may be that since a psychological need for security and identity is fulfilled by territorial claims (Minckley, 1968), subjects were unprepared for, and unwilling to submit readily to, territorial intrusions. Further, if man's territorial behavior is instinctual (Hall, 1963; Ardrey, 1966), then it is less likely to be altered by the social context or setting. On the other hand, since subjects responded less to personal space intrusions, including those that involved contact with a personal part of the body, it is apparent that personal space can be altered by the setting. Thus, the fact that patients are prepared for personal space intrusion prior to entering the hospital can be attributed to the fixed-feature characteristics of the hospital. The hospital, by providing health care, dictates that personal space intrusion will occur, particularly in the hospital room. Since personal space intrusion may be a foregone conclusion when a patient enters

the hospital, it is possible that the temporarily established territory takes on greater value. Due to the loss of control with regard to personal space, territorial intrusions may easily be seen by the patient as a reduction of his/her personal control, individuality, and identity.

Studies have supported the contention that proxemic behavior is sex-specific among Anglo Americans (Birdwhistle, 1970; Sluckin, 1970; Verner, 1970; Fisher and Byrne, 1975) and that women can be approached more closely by either sex, while men are literally allowed more room by both males and females in interpersonal encounters (Lett et al. 1969). However, this study found that no significant difference existed between the sexes of the Anglo population in their responses to intrusions. Allekian (1973) corroborated these findings; her study found no significant difference between males and females in their response to intrusions of territory or personal space. It is possible that while Anglos are sex-specific in their use of personal space, they are not sex-specific in their response to intrusion. That is, no matter how much space is preferred, once intrusion occurs, the response is the same.

Sex as an important variable for determining spatial behavior has not been well researched cross-culturally. It is known that Black Americans of both sexes tend to allow greater personal distance than Anglo Americans (Baxter, 1970). Black Americans in

this study population showed no significant difference in response to territorial intrusion. Although Black males, in response to personal space intrusion, had a mean score slightly lower than the females (indicating less feeling about the intrusion), again, no significant difference existed. Since personal space and territory would begin at the point intrusion occurred, the results of this study would suggest that perhaps in the Black culture, spatial behavior is not sex-specific. Yet, it is also possible the tolerance for intrusion is similar or the response to intrusion the same for the sexes, rather than the amount of territory or personal space.

It was of secondary interest to the investigator to determine if there was a relationship between the length of hospitalization and the response to intrusion. In this study's population, the number of days hospitalized ranged from one to 22 days. There was no correlation between the length of hospitalization and responses to territorial intrusion or personal space intrusion. Allekian (1973) had found that there was no significant difference between the responses of subjects who had been hospitalized more than a year and those who had been hospitalized less than a year. No other studies were identified which investigated whether persons became sensitized or desensitized to intrusion over time. Apparently, the assumption is that people respond spontaneously to intrusion each time it occurs. The findings of this study would certainly support that assumption.

In the analysis of certain items on the questionnaire, cultural differences were noted in the responses. Even though trends may be indicated, caution must be exercised in any attempt to generalize the findings. Individual differences still existed within each group; note Table 5 and the variability of responses. The intent is not to advocate relating to the groups in a stereotypical way, but rather to point up possible differences which have implications for the provision of health care.

With respect to territorial intrusion, anxiety appeared to be greater as the intrusions became more strongly identified with the subjects' territory. For example, the subjects reacted more strongly to a situation in which their bedside table was moved (item 5) than to one in which a chair was removed from their room (item 6). There seemed to be less territorial claim on objects that were not as related to the subjects' identity.

The Black group responded with anxiety to items which referred to entrance into the territory or hospital room, while the Anglo group responded with indifference (items 3 and 12). Having the window shades adjusted without asking the patient's preference (item 10) was a situation which also aroused more feeling of anxiety in the Black subjects than in the Anglo subjects. It is not certain whether these findings suggest that the Black group responds more anxiously to such intrusions or if they suggest that intrusion for the Black

group occurs at a more distant point.

Both groups responded with anxiety to having the nurse look through their personal belongings (item 9) and to having the cleaning lady rearrange their belongings on the bedside table without asking their preference (item 13). Such behavior may indicate to the patient a lack of concern or consideration for not only his/her preferences, but for personal property as well. Since the Blacks responded to having the cleaning lady rearrange their personal belongings with much greater anxiety than did the Anglos, it is possible that the Blacks more highly value consideration for their personal property.

Regarding personal space intrusion, situations in which health care personnel leaned closely to the patient elicited anxiety responses from the Black group. While both groups responded anxiously to having the nurse lean over the patient so that her breath was felt against his/her face, the Blacks responded to a greater degree. In response to a nursing assistant leaning over the patient, who was lying down, while she was in the process of making the bed, the Blacks indicated anxiety and the Anglos indicated indifference to the situation. Such behavior on the part of the nurse and nursing assistant would be considered by Anglo Americans a violation of space reserved for intimacy (Hall, 1966). The responses to these items also suggest that perhaps Blacks respond more anxiously to intimate intrusion or consider the intimate space more inviolate.

Situations that pertained to health care personnel sitting and standing close to the patient (items 2 and 4) were met with indifference by both groups. However, the Black subjects indicated greater feeling in response to such behavior. Further, the situations that involved touching behavior on the part of personnel (items 3, 8, 10, 11, and 12) also elicited indifference from the groups. These items involve touch within a social context and are in contrast to the favorable response indicated on the item which referred to the physician examining the patient. Again, the Black subjects had a stronger reaction to each of these situations than did Anglos, particularly with respect to the item that described the orderly touching the patient's arm while talking to the patient about a problem. The Black group also responded to such behavior on the part of the physician with anxiety.

These responses to touch thus raise questions regarding the therapeutic value of touch in the nurse-patient relationship, particularly with respect to the Black culture. While the results do not suggest that closeness or touching behavior be eliminated in a health care setting, they do suggest that individual preferences should be explored before engaging in such behavior.

The present study is believed to be the first attempt to compare two cultural groups, Anglo Americans and Black Americans, in their responses to territorial and personal space intrusions in the hospital.

Although use of a nonprobability, purposive sample negates the generalization of the findings, the scores reflected by the subjects of this study could be the basis for further investigation into more specific responses to territorial and personal space intrusion, as well as comparisons with other cultural groups. Each subcultural group needs to be represented in order to expand the body of knowledge pertinent to cross-cultural health care. Further research is needed in which the cultural variation of the intruder is controlled, as well as that of the respondent, so as to measure the responses to intruders from a variety of cultural groups. Thus, it would be possible to account for the possible confounding variable of interracial attitudes.

There is admittedly a degree of limitation with respect to the data collection instrument, in that the subjects responded to hypothetical situations. The responses may or may not have corresponded to their actual behavior. Experimental study is needed in which subjects are given a variety of treatments and exposed to a number of behaviors which constitute territorial and personal space intrusion. Responses need to be objectively recorded, preferably by a physiological monitoring system, so as to explore finer responses.

There is a degree of limitation with respect to the self-selection procedure for participation in the study. Four of the 19 Black Americans whose participation was requested, refused; no

Anglo Americans refused to participate. Since all subjects approached by the investigator had fulfilled the selection and matching criteria, the only known difference between the number of refusals in the two groups was culture. There is no known data to substantiate any speculation about the difference. It is mere conjecture that the request itself, for participation in research, was viewed as an intrusion by those Blacks that refused. If so, the Blacks that did participate possibly represent those less anxious in response to intrusion. Such a possibility must be viewed as a limitation.

CHAPTER VI

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

Man's spatial requirements are seen in terms of territory and personal space. The literature has suggested that cultures and sub-cultures differ in proxemic behavior. Anglo Americans were known to experience unease and discomfort when their territory or personal space was violated or when an appropriate interactional distance was not maintained. It was not documented how Black Americans responded to intrusion. Therefore, 15 Black Americans and 15 Anglo Americans were surveyed for their responses to territorial and personal space intrusions which typically occur in health care settings. The subjects consisted of 15 matched pairs who were hospitalized patients and selected from two metropolitan hospitals. A forced choice response questionnaire was utilized to collect data.

The purpose of the study was to determine if there was a cultural difference between Anglo Americans and Black Americans in response to territorial and personal space intrusions. Further, it was of interest to the investigator to explore sexual differences within each cultural group in response to intrusions. Of secondary interest to the author was the relationship of length of hospitalization

to responses to intrusions; that is, to determine if patients became sensitized or desensitized to intrusion over time.

The questionnaire consisted of two parts. Part I dealt with territorial intrusions and Part II referred to situations that constituted intrusions of personal space. Data were analyzed by means of t-tests. Though the responses to both territorial and personal space intrusion differed for the two groups, the difference was not statistically significant. With respect to sexual differences within each cultural group, there was no statistical difference.

It was noted that responses to territorial intrusion differed from the responses to personal space intrusion. More hospitalized patients responded to territorial intrusion with anxiety than responded to personal space intrusion with anxiety. Length of hospitalization did not correlate with responses to intrusion of either territory or personal space. Response to intrusions seemed to be spontaneous and patterned, rather than to be altered by repeated occurrence.

Conclusions

This study has suggested that (1) while trends may exist with respect to cultural differences in response to intrusions, there are individual differences within the cultural groups, (2) territory may be of great value to hospitalized patients, and hospital personnel must find ways of assessing health care in relation to this need, and

(3) touch behavior may not be welcomed by patients and individual preferences must be considered by health care personnel. The second and third conclusions concur with at least one previous study. All conclusions have implications for clinical practice.

Recommendations for Further Study

On the basis of the present study, it is suggested that the following recommendations be considered:

(1) An experimental study be designed to introduce specific behaviors and treatments which may be intrusive; responses be recorded objectively, by a physiological monitoring system, to determine physiological indicators of anxiety.

(2) Replicate the present study with comparison of other sub-cultural groups.

(3) Compare responses to intruders of different cultural backgrounds.

(4) Compare responses of hospitalized patients to those of non-hospitalized patients.

(5) Compare responses of patients before, after, and during hospitalization.

(6) Match subjects according to socio-economic level to determine if it is a variable.

(7) Submit the data collection instrument to further validity testing.

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APPENDICES

APPENDIX A

Consent Form

UNIVERSITY OF OREGON HEALTH SCIENCES CENTER
SCHOOL OF NURSING

INFORMED CONSENT

I, _____, herewith agree to
(first name) (middle initial) (last name)
serve as a subject in an investigation which explores how patients
with different cultural backgrounds respond to commonly occurring
situations in the hospital. The study will be conducted by Gail M.
Houck under the supervision of May Rawlinson, R.N., Ph.D., Uni-
versity of Oregon School of Nursing. The procedure I will be sub-
jected to is the completion of a written questionnaire which requires
that I indicate my responses to typical situations which patients ex-
perience in the hospital. The procedure will take approximately 20
minutes.

I may benefit from participation in the study by aiding in the
advancement of scientific knowledge for improvement in interpersonal
relationships and patient care. The information will be kept confi-
dential. My name will not appear on the records and anonymity will
be insured by the use of code numbers.

Gail Houck has offered to answer any questions that I might
have about my participation in this study. I understand that I am free
to refuse to participate or to withdraw from participation in the pro-
ject at any time and it will in no way affect my relationship with, or
treatment at, the University of Oregon Health Sciences Center.

I have read the foregoing.

(Date)

(Subject's Signature)

(Witness' Signature)

APPENDIX B

Questionnaire

QUESTIONNAIRE

DIRECTIONS: In response to each statement, please circle the number of the feeling which best describes that which you experience. Answer all statements.

PART I

1. Your door is closed, and a nursing assistant enters without knocking.
 1. pleased
 2. agreeable
 3. indifferent
 4. annoyed
 5. very annoyed
2. While you are sitting in your chair, the aide sits on your bed while conversing with you.
 1. pleased
 2. agreeable
 3. indifferent
 4. annoyed
 5. very annoyed
3. You prefer to have your door closed, but the nurse always leaves it open when she leaves your room.
 1. pleased
 2. agreeable
 3. indifferent
 4. annoyed
 5. very annoyed
4. The nursing assistant talks in an unusually loud voice while working in your room.
 1. pleased
 2. agreeable
 3. indifferent
 4. annoyed
 5. very annoyed
5. Your bedside stand is moved to a position where it cannot be easily reached by you.
 1. pleased
 2. agreeable
 3. indifferent
 4. annoyed
 5. very annoyed

6. The nurse removes a chair from your room without asking whether you will be using it.
 1. pleased
 2. agreeable
 3. indifferent
 4. annoyed
 5. very annoyed
7. While you are lying in bed, the nurse bumps the bed as she walks by it.
 1. pleased
 2. agreeable
 3. indifferent
 4. annoyed
 5. very annoyed
8. The window in your room is opened or closed without asking your preference.
 1. pleased
 2. agreeable
 3. indifferent
 4. annoyed
 5. very annoyed
9. Without asking your permission, the nurse looks through your personal belongings in your drawer.
 1. pleased
 2. agreeable
 3. indifferent
 4. annoyed
 5. very annoyed
10. The window shades in your room are raised or lowered without asking your preference.
 1. pleased
 2. agreeable
 3. indifferent
 4. annoyed
 5. very annoyed
11. The nurse sits on your bed while talking to you.
 1. pleased
 2. agreeable
 3. indifferent
 4. annoyed
 5. very annoyed

12. An orderly opens the door to your room and enters without knocking.
 1. pleased
 2. agreeable
 3. indifferent
 4. annoyed
 5. very annoyed
13. The cleaning woman rearranges your personal belongings on the bedside stand without asking you how you would like them rearranged.
 1. pleased
 2. agreeable
 3. indifferent
 4. annoyed
 5. very annoyed
14. The nursing assistant enters your room and begins to move your bed while you are in it.
 1. pleased
 2. agreeable
 3. indifferent
 4. annoyed
 5. very annoyed
15. The nurse speaks in an unusually loud voice while talking with you.
 1. pleased
 2. agreeable
 3. indifferent
 4. annoyed
 5. very annoyed

PART II

1. While you are lying in bed, the nurse leans over you and you feel her breath against your face as she talks.
 1. pleased
 2. agreeable
 3. indifferent
 4. uneasy
 5. embarrassed

2. The nursing assistant stands close to the head of your bed when talking with you while you are lying down.
 1. pleased
 2. agreeable
 3. indifferent
 4. uneasy
 5. embarrassed
3. While you are sitting in a chair, the nurse comes close to you and puts her hand on your shoulder while she talks with you.
 1. pleased
 2. agreeable
 3. indifferent
 4. uneasy
 5. embarrassed
4. The doctor sits close to you on your bed while talking to you.
 1. pleased
 2. agreeable
 3. indifferent
 4. uneasy
 5. embarrassed
5. The nursing assistant holds your hand for a few minutes after putting a thermometer in your mouth.
 1. pleased
 2. agreeable
 3. indifferent
 4. uneasy
 5. embarrassed
6. After asking you some questions, the doctor begins to examine you by feeling and listening to different parts of your body.
 1. pleased
 2. agreeable
 3. indifferent
 4. uneasy
 5. embarrassed
7. The nurse administers a treatment to a more personal area of your body.
 1. pleased
 2. agreeable
 3. indifferent
 4. uneasy
 5. embarrassed

8. The nurse holds your hand while talking with you about your activities for the day.
 1. pleased
 2. agreeable
 3. indifferent
 4. uneasy
 5. embarrassed
9. While you are lying in bed, the nursing assistant leans over you in the process of making your bed.
 1. pleased
 2. agreeable
 3. indifferent
 4. uneasy
 5. embarrassed
10. The orderly places his hand on your arms while talking to you.
 1. pleased
 2. agreeable
 3. indifferent
 4. uneasy
 5. embarrassed
11. The doctor takes your hand in his while you are telling him about a problem.
 1. pleased
 2. agreeable
 3. indifferent
 4. uneasy
 5. embarrassed
12. The aide approaches you in your room and puts her arm around you while talking with you.
 1. pleased
 2. agreeable
 3. indifferent
 4. uneasy
 5. embarrassed

APPENDIX C

Descriptive Characteristics of Individual Subjects

DESCRIPTIVE CHARACTERISTICS OF INDIVIDUAL SUBJECTS

Number	Culture		Sex		Age	Hospital		Service		Severity of Illness		
	B	A	M	F		UO	VA	Med.	Surg.	Good	Satis,	Fair
01	x		x		33	x		x			x	
02	x			x	40	x		x			x	
03		x	x		38	x		x			x	
04	x			x	30	x			x		x	
05		x		x	42	x		x			x	
06	x			x	37	x			x		x	
07	x			x	58	x		x			x	
08	x			x	34	x			x		x	
09	x		x		40	x		x			x	
10		x		x	59	x		x			x	
11		x		x	26	x			x		x	
12		x		x	34	x			x		x	
13	x		x		47		x	x				x
14		x	x		41		x	x				x
15	x		x		50		x	x			x	
16		x	x		49		x	x			x	
17		x	x		44	x		x			x	
18		x		x	34	x			x		x	
19	x		x		21	x		x			x	
20		x	x		34	x		x			x	
21	x		x		58		x		x		x	
22		x	x		60		x		x		x	
23	x		x		34		x	x			x	
24		x	x		44		x	x			x	
25	x		x		44		x	x			x	
26		x	x		21		x	x			x	
27	x		x		35	x			x		x	
28		x	x		35	x			x		x	
29	x			x	24	x		x				x
30		x		x	31	x		x				x

CHARACTERISTICS (continued)

Number	Specialty Service							Hospitalization (in days)	Room Size (No. beds)
	Gen Med	Gen Surg	Gyn Surg	Renal	Neuro	Resp	Thoracic		
01	x							22	1
02	x							01	2
03	x							18	4
04			x					02	2
05	x							01	2
06		x						03	2
07	x							07	2
08			x					02	2
09	x							08	4
10	x							04	4
11			x					02	2
12			x					03	1
13				x				09	2
14				x				09	2
15						x		07	2
16						x		05	2
17	x							05	4
18		x						16	2
19					x			02	2
20					x			03	4
21							x	11	4
22							x	02	4
23				x				05	2
24				x				06	2
25				x				01	2
26				x				07	2
27		x						02	2
28		x						05	2
29	x							02	1
30	x							02	4
Totals:	10	4	4	6	2	2	2		

APPENDIX D

Admission Diagnosis per Individual Subject

ADMISSION DIAGNOSIS PER INDIVIDUAL SUBJECT

Number	Culture	Admitting Diagnosis
01	B	Cellulitis, Right Arm
02	B	Work-up, Rheumatoid Arthritis
03	A	Pancreatitis; Cellulitis, Left Arm
04	B	Abortion
05	A	Work-up, Right Bundle Branch Block
06	B	Mass, Right Breast
07	B	Work-up, Rheumatoid Arthritis
08	B	D and C
09	B	Pancreatitis
10	A	Work-up, Rheumatoid Arthritis
11	A	Abortion
12	A	Removal of Ovarian Tumor
13	B	Chronic Renal Failure
14	A	Chronic Renal Failure
15	B	Pulmonary Infiltrate
16	A	Pulmonary Infiltrate
17	A	Seizures
18	A	Mass, Right Upper Quadrant (abdominal)
19	B	Multiple Sclerosis
20	A	Cervical Disc Herniation
21	B	Pulmonary Infiltrate
22	A	Pulmonary Infiltrate
23	B	Diabetes Mellitus
24	A	Renal Stones
25	B	Diabetes Mellitus
26	A	Urticaria
27	B	Skin Graft, Thigh
28	A	Lysis of Lesions, Abdominal
29	B	Pulmonary Infiltrate
30	A	Lymphatic Ca

Note. B = Black American; A = Anglo American