PREVENTATIVE MEASURES AGAINST MISCONCEPTIONS ABOUT ONESELF

ABSTRACT

It is argued that misconceptions about oneself and other people can be reduced through participation in philosophical dialogues. Opportunities for such dialogues should be included in the educational programs of the health profession. Youngsters have proven themselves able participants in similar dialogues. If the reasoning skills of an individual are improved, it is assumed that his or her ideas and judgments will also improve.

INTRODUCTION

I will use the term "self-concept" to refer to the ideas that we have about ourselves, ideas that others may not know of and we ourselves may be unaware of. Our self-concept is an expression of what we think is special about us, both as isolated individuals and as communal beings.

Health authorities have chosen, in general, two main preventive measures to improve or protect our health. First, they have chosen to change the environment by setting rules and regulations against certain behavior, such as smoking in restaurants or against the use of certain ingredients in the food industry. Second, they hand out biological information, for example, how not to get infected by AIDS. The information is sometimes presented in such a way that we are scared to death. The underlying assumption to the second approach is that people will act in accordance with their knowledge or fright.

However, it is up to us to choose appropriate actions. It takes deliberation, (overvejelse/yfirvegun) according to Aristotle (Aristoteles, the Greek philosopher), to make a genuine choice (Nicomacean Ethics Bk. VI). He points out that we can only deliberate about things that are in our own power. For example, we cannot choose, but only wish, to be healthy although we can deliberate on and choose the acts that will make us healthy. The point is: improved quality in deliberation should lead to improved choices. It seems to me that health authorities have overlooked the connection between deliberation and choice in their over-emphasis on preventive propaganda. Deliberation is no easy matter that each one of us should do in privacy. Aristotle said, "We call in others to aid us in deliberation on important questions, distrusting ourselves as not being equal to deciding" (Bk. III, Ch. 3, 11-12). When we deliberate with others we strengthen our reasoning and judgment. Thus, we prepare ourselves to make sounder judgments about other people and ourselves.

Let me now turn to the main theme of my talk: how we come to form ideas about ourselves, more specifically, how health personnel can be prepared to handle issues that touch on the self-concept of their patients and how young patients can be empowered to face illnesses while holding on to or strengthening their self-concept.

HOW DO WE FORM IDEAS ABOUT OURSELVES?

When addressing the question of how individuals form ideas about themselves, it is hard to bypass George H. Mead who saw the human mind essentially as a social phenomenon. It, the human mind, arises and develops through a process of social internalization as individuals take the attitudes of others towards themselves as well as towards the issues that are reflected on (cf. 1972/1934, p. 192). This process is not a question of mechanics as individuals react in unpredictable ways to social stimuli but the quality of their responses rests with their reflective thinking or deliberation.

Mind in a community is a self-conscious self and it has two phases according to Mead: the "I" and the "me." The "I" is a source of spontaneity which allows individuals to react and change the community they belong to. The "I" is neither predictable nor present to us

until we act and without it there would be neither creativity nor inquiries. The "me" is the stable part of the self; it is imported, in a sense, from fellow human beings in the process of viewing things from the perspective of the surrounding social group, the "generalized other." Mead sees an internal dialogue between the "I" and the "me" as a main characteristic of our thinking. This dialogue is both public and hidden, interpersonal and intrapersonal.

In other words, there is a sense in which we invent ourselves in our free choices and actions as we go through life. In another sense we discover ourselves when we find out about rules and limitations of our thinking, what we prefer by instinct or upbringing, or when we find out about our communal duties and responsibilities.

DIFFERENT ORIENTATIONS TOWARDS MORALITY

Let us now turn to an interview study by Mona P. Lyons (1983), a study that supported Carol Gillian's (1977) hypothesis that there are distinct modes of gender dependent moral judgments that relate to modes of self-definition. Lyons selected subjects at nine age levels, from eight years of age to over 60 years of age, two males and two females were at each level so the total number of subjects counted 36. For our purposes it may be noted that 12 of her subjects were 15 years of age or younger. The results that Lyons came to were found across the life span of the subjects involved, i.e. males and females seem to have different orientations towards morality from the very beginning of their moral life. However, it must be noted that these orientations are predominant; they are not mutually exclusive and individual males and females can use both kinds of considerations.

When Lyons asked her subjects to describe (i.e., define) themselves to themselves, she found that the male subjects tended to define themselves in terms of their personal abilities. They also saw their fellow human beings as they would themselves be liked to be seen by them. In this vein, the male subjects separated themselves from other individuals and they used, according to Lyons, a moral framework of "Justice as Fairness" as a guideline in their moral considerations; each person should be respected and treated on equal grounds. Furthermore, Lyons reported that the males saw moral problems as questions of conflicting claims that they wanted to analyze by applying impartial rules, principles or standards. This they wanted to do from the perspective of their commitments, duty or role-related obligations. Their evaluations of moral considerations centered on decision-making, how they were thought about, justified and whether fairness was maintained in the process.

When Lyons asked her female subjects to respond to the same question, how do you describe yourself to yourself, they were found to define themselves in connection to other individuals in their nearest community, i.e. they took interpersonal relationships into account while putting themselves in the place of others who they saw in their own situations and contexts. The females used, according to Lyons, a moral framework or "Care" such that responses to other individuals were made to connect with them on their terms. Thus, the females saw moral problems as questions of how to respond to others and they wanted to come to grips with the problems through maintaining connections among interdependent individuals while working towards their welfare. Their evaluations of moral considerations centered on consequences with a primary concern for maintenance or restoration of personal relationships.

Lyons' study does not address the question of how health personnel can be prepared to handle moral issues that touch on the self-concept of their patients. It was cited here to point out to you the possibility that moral orientations may be very different within the same profession, or, for that matter, within the same family or within the same place of work. It may very well be by the case that some health personnel proceed from principles and standard procedures to persons while others are more pragmatic in their moral

approach, preferring to proceed from persons to procedures and principles. But dialogue is needed both to find out about such differences as well as to resolve them.

MORAL REASONING

You may have the question of which of the two kinds of moral orientation is the correct one. Which one should be applied in health service to children and which should be put out of practice. I suspect that some of you have already chosen the "Morality of Care," although those of you who believe in developmental theories of morality (a la Kohlberg, 1981) may already "know" that "Morality of Justice" is more mature than the one of Care! However, for a moral agent the question is not which moral orientation to choose but what he or she ought to do in a particular situation. Where people work together, they sometimes need to reason together in order to find out what options they have. Provided that the parties can reason together, different orientations towards morality within the health profession should contribute to its strength but not to its weakness. Without counterbalance from the other gender, there is even a danger that females could head for too much relativism in their moral considerations and the males could head for dogmatism. In extreme situations the females could be too dependent on the self's "I," to borrow from Mead's vocabulary, and the males could be too dependent on the self's "me." Moral reasoning that bridges the gap between the "me" and the "I," that takes both male and female orientation into account, has a more secure foundation than one-sided reasoning.

If health professionals are to engage in moral reasoning at their staff meetings, some training and experience in that area would most likely be of help to them. Courses about moral theories or ethics in nursing will not serve this aim if the participants are not offered opportunities to exercise their own reasoning. I am tempted to briefly describe to you a study on a course where the students were given opportunities to exercise their reasoning.

Martin Benjamin is a philosopher at Michigan State University who has, for many years, given courses in moral reasoning to students of nursing. Kenneth Howe (1985?) did a study on one of his courses. At the beginning of the course, the student nurses were pre-tested, they were given typical scenarios from hospital settings and they were asked to resolve the situation in writing. At the end of the course, they were post-tested by using the same or similar task. A numerical code was put on all the solutions from both tests and they were given to graduate assistants who were used to grade undergraduate philosophy papers. The results yielded the utmost statistical requirements of significance and they showed, in short, a stark difference in improved quality of reasoning and moral considerations between the pre- and post-tests. What happened in between the tests was that Benjamin succeeded in involving his students in a philosophical dialogue about moral questions that were taken from the context of nursing. It seems to me, that such a course is not only ideal to strengthen the students' reasoning but also their judgment and ideas about themselves.

Although young patients may already have definite orientations towards morality, they lack experience and security in moral matters. They may never have experienced being a patient at a hospital; they may never have experienced being seriously ill. They are more likely than grownups to have magical fantasies about causes and effects of their illnesses, about life and death. They may have a feeling of complete lack of control of what will happen to them. We know that ignorance breads insecurity in such situations. Young patients need, as most other patients do, adequate information at their own level about the facts, causes and reasons that relate to their illnesses and treatment; otherwise, they feel even more powerless and their self-esteem is most likely affected for the worse.

In normal settings it takes some kind of a dialogue to learn about another person's self-concept and it takes time and trust. Hospital settings are unnatural places to most of

the youngsters who have to stay there. I am sure it must be very difficult and time-consuming for the staff to approach the self-concept of the young patients. The grownup can, of course, use monologue and explain all that he or she can to the young one; explanations are certainly needed although they do not always make much sense to the patients. But sense is certainly not made by simply telling or describing to children how things are; the problem is <u>not</u> that children do not believe what they are told but that often what they are told has no meaning to them.

Matthew Lipman (1980) is a philosopher who has written philosophical curriculum from kindergarten to high school. Instead of writing the usual textbooks he writes novels that are especially intended for audiences of different ages. Each novel avoids traditional philosophical terminology. Perplexities within students' own experiences are emphasized instead. Readers of the novels are provided with alternative examples of how different participants reflect on their experiences and how they make sense out of it. The characters have many different styles of thinking with no one style portrayed as the correct one.

Lipman's teaching method, like Benjamin's, can best be described as involving the students in a philosophical dialogue. The novels are about children at similar age as the students are and thus the students can take sides with characters in the story. Sometimes they do not like to talk about themselves, they do not, for example, like to talk about their
own secrets although they like talking about secrets that characters in the story have. In turn they may assign their own ideas and feelings to the characters discussed and thus they get to know how others respond to their own ideas, the main purpose being to help children learn to think creatively and critically for themselves.

The dialogue also brings other advantages, according to Lipman and his associates:

> in particular, it promotes children's awareness of one another's personalities, interests, values, beliefs, and biases. This increased sensitivity is one of the most valuable by-products of classroom communication. Unless children have some insight into the nature of the individuals with who they share their lives, they are not likely to make sound judgments regarding them (Lipman, et al. 1980, p. 65).

Lipman's Philosophy for Children program has been used with promising results in school settings with children who are behind, normal or gifted when compared in terms of mental maturity to their peers. It has also been tried on a small scale in hospital settings with schizophrenic and neurotic children.

I hardly know anything about exactly what perceptions youngsters have about themselves when ill and under treatment at hospitals, but my original working title was headed in that direction. I am convinced, however, that philosophical education in the elementary school has the potential of helping youngsters hold on to and strengthen the ideas that they have about themselves.

This talk was meant to give you something to think about. It is up to you to do the thinking, but I have two last questions for you: Do you think it would matter if more youngsters entering hospitals had already participated in discussions on the following questions or questions of similar nature, questions that are often inappropriate at hospitals although appropriate under normal school settings? Do you think it would matter if health personnel would discuss questions of similar nature in their educational preparation?

Hreinn Palsson

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