14 The Sociology of the Vaginal Examination*

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All of us depend on others for the successful completion of the roles we play. In many ways, this makes cooperation the essence of social life (with due apologies to my conflict theorist friends). Dependence on the cooperation of others is no less true of the specialist, the individual whose role (occupational or otherwise) is highly focused. Without cooperative teamwork, performances fall apart, people become disillusioned, jobs don't get done, and society is threatened. Accordingly, much of our socialization centers on learning to be good team players.

The work setting lends itself well to examine cooperative interaction and the socially acceptable handling of differences—"working arrangements" that defuse threats to fragile social patterns. For example, instructors often accept from students excuses that they know do not "match reality." For their part, students often accept what instructors teach even though they privately disagree with their interpretations. Confrontation is not only unpleasant, and therefore preferable to avoid, but confrontation also threatens the continuity of the interaction. Thus both instructors and students generally allow one another enough leeway to "get on with business" (which some might say is education but others, more cynical, might say is one earning a living and the other a degree).

In any event, underlying our basic interactions in most social settings are such implicit understandings about how to handle differences. One can gain much insight into the nature of society by trying to identify the rules under which we interact with one another—and the definitions that the interaction is designed to maintain. In this selection, Henslin and Biggs draw heavily on Goffman's dramaturgical framework as they focus on the vaginal examination. Note the teamwork that this requires, especially in making the definition stick that nothing sexual is occurring.

What areas of your life are based on teamwork in the interest of trying to "get the show on the road," that is, to make desired definitions stick and allow the action to unfold? (Actually, it might be easier to try to determine what parts of social life do not require teamwork.)

Our thanks to Erving Goffman for commenting on this paper while it was in manuscript ›rm. We have resisted the temptation to use his suggested title, "Behavior in Pubic Places."

GENITAL BEHAVIOR is problematic in American society. Americans in our society are socialized at a very early age into society's dictates concerning the situations, circumstances, and purposes of allowable and unallowable genital exposure.

After an American female has been socialized into rigorous norms concerning society's expectations in the covering and privacy of specified areas of her body, especially her vagina, exposure of her pubic area becomes something that is extremely problematic for her. Even for a woman who has overcome this particular problem when it comes to sexual relations and is no longer bothered by genital exposure in the presence of her sexual partner, the problem frequently recurs when she is expected to expose her vagina in a nonsexual manner to a male. Such is the case with the vaginal examination. The vaginal examination can become so threatening, in fact, that for many women it not only represents a threat to their feelings of modesty but also threatens their person and their feelings of who they are.

Because emotions are associated with the genital area through the learning of taboos, the vaginal examination becomes an interesting process; it represents a structured interaction situation in which the "privates" no longer remain private. From a sociological point of view, what happens during such interaction? Since a (if not *the*) primary concern of the persons involved is that all the interaction be defined as nonsexual, with even the hint of sexuality being avoided, what structural restraints on behavior operate? How does the patient cooperate in maintaining this definition of nonsexuality? In what ways are the roles of doctor, nurse, and patient performed such that they conjointly contribute to the maintenance of this definition?

This analysis is based on a sample of 12,000 to 14,000 vaginal examinations. The female author served as an obstetrical nurse in hospital settings and as an office nurse for general practitioners for fourteen years, giving us access to this area of human behavior which is ordinarily not sociologically accessible. Based on these observations, we have divided the interaction of the vaginal examination into five major scenes. We shall now examine each of these bounded interactions.

The setting for the vaginal examination may be divided into two areas (see Figure 14.1). Although there are no physical boundaries employed to demarcate the two areas, highly differentiated interaction occurs in each. Area 1, where Scenes I and V are played, includes that portion of the "office-examination" room which is furnished with a desk and three chairs. Area 2, where Scenes II, III, and IV take place, is furnished with an examination table, a swivel stool, a gooseneck lamp, a table for instruments, and a sink with a mirror above it.

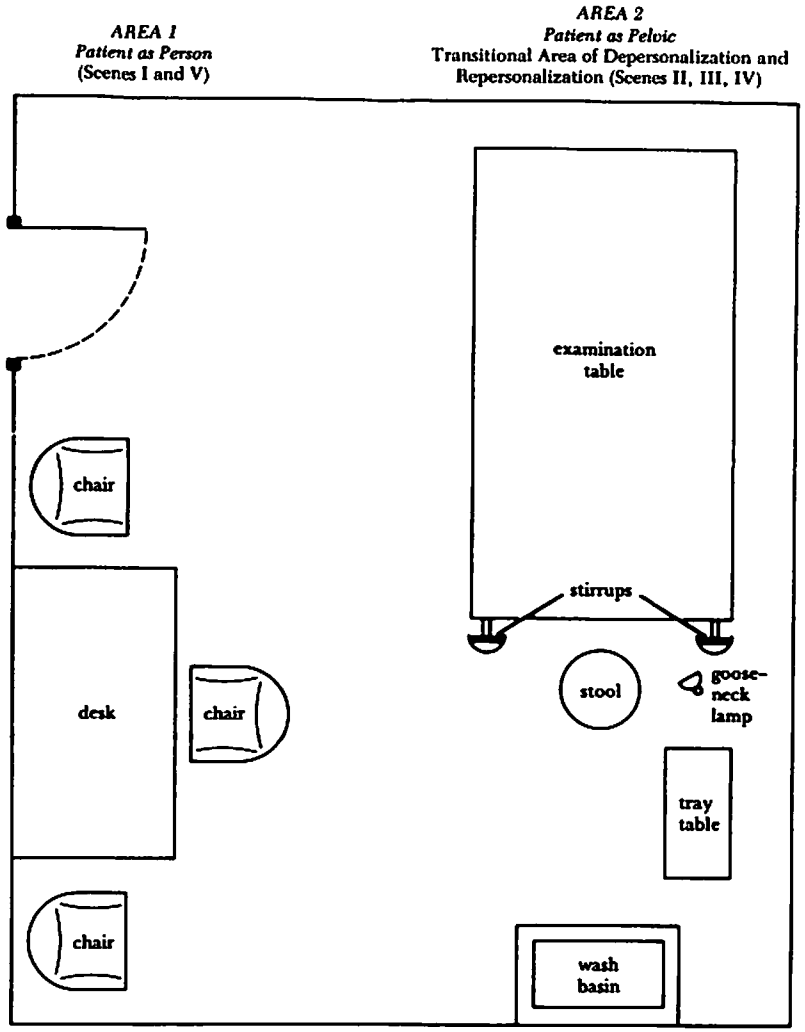

Figure 14.1. The Doctor's Office-Examination Room

Scene I: The Personalized Stage: The Patient as Person

The interaction flow of Scene I is as follows: (a) the doctor enters the "office-examination" room; (b) greets the patient; (c) sits down; (d) asks the patient why she is there; (e) questions her on specifics; (f) decides on a course of action, specifically whether a pelvic examination is needed or not; (g) if he thinks a pelvic is needed, he signals the nurse on the intercom and says, "I want a pelvic in room (X)"; (h) he gets up, and (i) leaves the room.

During this scene the patient is treated as a full person, that is, the courtesies of middle-class verbal exchange are followed, and, in addition to gathering medical information, if the doctor knows the patient well he may intersperse his medical questions with questions about her personal life. The following interaction that occurred during Scene I demonstrates the doctor's treatment of his patient as a full person:

> DOCTOR (upon entering the room): Hello, Joyce, I hear you're going to Southern Illinois University.
>
> PATIENT: Yes, I am. I've been accepted, and I have to have my health record completed.
>
> The doctor then seated himself at his desk and began filling out the health record that the patient gave him. He interspersed his questions concerning the record form with questions about the patient's teaching, about the area of study she was pursuing, about her children, their health and their schooling. He then said, "Well, we have to do this right. We'll do a pelvic on you." He then announced via the intercom, "I want to do a pelvic on Joyce in room 1." At that point he left the room.

This interaction sequence is typical of the interaction that occurs in Scene I between a doctor and a patient he knows well. When the doctor does not know the patient well, he does not include his patient's name, either her first or last name, in his announcement to the nurse that she should come into the room. In such a case, he simply says, "I want to do a pelvic in room 1," or, "Pelvic in room 1." The doctor then leaves the room, marking the end of this scene.

Scene II: The Depersonalizing Stage: Transition from Person to Pelvic

When at the close of Scene I the doctor says, "Pelvic in room (X)," he is in effect announcing the transition of the person to a pelvic. It is a sort of advance announcement, however, of a coming event, because the transition has not yet been effected. The doctor's signal for the nurse to come in is, in fact, a signal that the nurse should now help with the transition of the patient from a person to a pelvic. Additionally, it also serves as an announcement to the patient that she is about to undergo this metamorphosis.

The interaction flow which accomplishes the transition from person to pelvic is as follows: Upon entering the room, the nurse, without pre-

liminaries, tells the patient, "The doctor wants to do a vaginal examination on you. Will you please remove your panties?" While the patient is undressing, the nurse prepares the props, positioning the stirrups of the examination table, arranging the glove, the lubricant, and the speculum (the instrument which, when inserted into the vagina, allows visual examination of the vaginal tract). She then removes the drape sheet from a drawer and directs the patient onto the table, covers the patient with the drape sheet, assists her in placing her feet into the stirrups, and positions her hips, putting her into the lithotomy position (lying on her back with knees flexed and out).

MEANING OF THE DOCTOR'S ABSENCE

The doctor's exiting from this scene means that the patient will be undressing in his absence. This is not accidental. In many cases, it is true, the doctor leaves because another patient is waiting, but even when there are no waiting patients, the doctor always exits at the end of Scene I. His leaving means that he will not witness the patient undressing, thereby successfully removing any suggestion whatsoever that a striptease is being performed. From the patient's point of view, the problem of undressing is lessened since a strange male is not present. Thus sexuality is removed from the undressing, and when the doctor returns, only a particularized portion of her body will be exposed for the ensuing interaction. As we shall see, the doctor is no longer dealing with a person, but he is, rather, confronted by a "pelvic."

THE PROBLEM OF UNDERCLOTHING

Undressing and nudity are problematic for the patient since she has been socialized into not undressing before strangers.[1] Almost without exception, when the woman undresses in Scene II, she turns away from the nurse and the door, even though the door is closed. She removes only her panties in the typical case, but a small number of the patients also remove their shoes.

After the patient has removed her panties and/or girdle, the problem for her is what to do with them. Panties and girdles do not have the same meaning as other items of clothing, such as a sweater, that can be casually draped around the body or strewn on furniture. Clothing is considered to be an extension of the self (Gross and Stone 1964), and in some cases the clothing comes to represent the particular part of the body that it covers. In this case, this means that panties represent to women their "private area." Comments made by patients that illustrate the problematics of panty exposure include: "The doctor doesn't want to look at these," "I want to get rid of these before he comes in," and, "I don't want the doctor to see these old things."

Some patients seem to be at a loss in solving this problem and turn to the nurse for guidance, asking her directly what they should do with their underclothing. Most patients, however, do not ask for directions, but hide their panties in some way. The favorite hiding or covering seems to be in or under the purse.[2] Other women put their panties in the pocket of their coat or in the folds of a coat or sweater, some cover them with a magazine, and some cover them with their own body on the examination table. It is rare that a woman leaves her panties exposed somewhere in the room.

THE DRAPE SHEET

Another problematic area in the vaginal examination is what being undressed can signify. Disrobing for others frequently indicates preparation for sexual relations. Since sexuality is the very thing that this scene is oriented toward removing, a mechanism is put into effect to eliminate sexuality—the drape sheet. After the patient is seated on the table, the nurse places a drape sheet from just below her breasts (she still has her blouse on) to over her legs. Although the patient is draped by the sheet, when she is positioned on the table with her legs in the stirrups, her pubic region is exposed. Usually it is not necessary for the doctor even to raise a fold in the sheet in order to examine her genitals.

Since the drape sheet does not cover the genital area, but, rather, leaves it exposed, what is its purpose? The drape sheet depersonalizes the patient. It sets the pubic area apart, letting the doctor view the pubic area in isolation, separating the pubic area from the person. The pubic area of female genitalia becomes an object isolated from the rest of the body. With the drape sheet, the doctor, in his position on the low stool, does not even see the patient's head. He no longer sees or need deal with a person, just the exposed genitalia marked off by the drape sheet. Yet, from the patient's point of view in her prone position, her genitals are covered! When she looks down at her body, she does not see exposed genitalia. The drape sheet effectively hides her pubic area *from herself* while exposing it to the doctor.

THIGH BEHAVIOR

American girls are given early and continued socialization in "limb discipline," being taught at a very early age to keep their legs close together while they are sitting or while they are retrieving articles from the ground. They receive such cautions from their mothers as, "Keep your dress down,

"Put your legs together," and "Nice girls don't let their panties show." Evidence of socialization into "acceptable" thigh behavior shows up in the vaginal examination while the women are positioned on the examination table and waiting for the doctor to arrive. They do not let their thighs fall outwards in a relaxed position, but they try to hold their upper or mid-thighs together until the doctor arrives. They do this even in cases where it is very difficult for them to do so, such as when the patient is in her late months of pregnancy.

Although the scene has been played such that desexualization is taking place, and although the patient is being depersonalized such that when the doctor returns he primarily has a pelvic to deal with and not a person, at this point in the interaction sequence the patient is still holding onto her sexuality and "personality" as demonstrated by her "proper" thigh behavior. Only later, when the doctor reenters the scene will she fully consent to the desexualized and depersonalized role and let her thighs fall outwards.

After the props are ready and the patient is positioned, the nurse announces to the doctor via intercom that the stage is set for the third scene, saying "We're ready in room (X)."

Scene III: The Depersonalized Stage: The Person as Pelvic

FACE-TO-PUBIC INTERACTION

The interaction to this point, as well as the use of props, has been structured to project a singular definition of the situation—that of legitimate doctor–patient interaction and, specifically, the nonsexual examination of a woman's vaginal region by a male. In support of this definition, a team performance is given in this scene (Goffman 1959: 104). Although the previous interaction has been part of an ongoing team performance, it has been sequential, leading to the peak of the performance, the vaginal examination itself. At this time, the team goes into a tandem cooperative act, utilizing its resources to maintain and continue the legitimation of the examination, and by its combined performance reinforcing the act of each team member. The doctor, while standing, places a plastic glove on his right hand, again symbolizing the depersonalized nature of the action—by using the glove he is saying that he will not himself be actually touching the "private area" since the glove will serve as an insulator. It is at this point that he directs related questions to the patient regarding such things as her bowels or bladder. Then, while he is still in this standing position, the nurse in synchronization actively joins the performance by squeezing a lubricant onto his outstretched gloved fingers, and the doctor inserts the index and middle fingers of his right hand into the patient's vagina while

externally palpating (feeling) the uterus. He then withdraws his fingers from the vagina, seats himself on the stool, inserts a speculum, and while the nurse positions the gooseneck lamp behind him, he visually examines the cervix.

Prior to this third scene, the interaction has been dyadic only, consisting of nurse and patient in Scene II and doctor and patient in Scene I. In this scene, however, the interaction becomes triadic in the sense that the doctor, nurse, and patient are simultaneously involved in the performance. The term triadic, however, does not even come close to accurately describing the role-playing of this scene. Since the patient has essentially undergone a metamorphosis from a person to an object—having been objectified or depersonalized, the focus of the interaction is now on a specific part of her body. The positioning of her legs and the use of the drape sheet have effectively made her pubic region the interaction focus, not only demarcating the pubic region as the focus of interaction but also blocking out the "talklines" between the doctor and patient, physically obstructing their exchange of glances (Goffman 1963: 161). Interaction between the doctor and the patient is no longer "face-to-face," being perhaps now more accurately described as "face-to-pubic" interaction.

BREASTS AS NONSEXUAL OBJECTS

Projecting and maintaining the definition of nonsexuality in the vaginal examination applies also to other parts of the body that are attributed to have sexual meaning in our culture, specifically the breasts. When the breasts are to be examined in conjunction with a vaginal examination, a rather interesting ritual is regularly employed in order to maintain the projected definition of nonsexuality. This ritual tries to objectify the breasts by isolating them from the rest of the body, permitting the doctor to see the breasts apart from the person. In this ritual, after the patient has removed her upper clothing, a towel is placed across her breasts, and the drape sheet is then placed on top of the towel. Since the towel in and of itself more than sufficiently covers the breasts, we can only conclude that the purpose of the drape sheet is to further the definition of nonsexual interaction. Additionally, the doctor first removes the sheet from the breasts and exposes the towel. He then lifts the towel from *one* breast, makes his examination, and *replaces* the towel over that breast. He then examines the other breast in exactly the same way, again replacing the towel after the examination.

THE NURSE AS CHAPERONE

That interaction in Scene III is triadic is not accidental, nor is it instrumentally necessary. It is, rather, purposely designed, being another means

of desexualizing the vaginal examination. Instrumentally, the nurse functions merely to lubricate the doctor's fingers and to hand him the speculum. These acts obviously could be handled without the nurse's presence. It becomes apparent, then, that the nurse plays an entirely different role in this scene, that of chaperone, the person assigned to be present in a male–female role relationship to give assurance to interested persons that no untoward sexual acts take place. Although the patient has been depersonalized, or at least this is the definition that has been offered throughout the performance and is the definition that the team has been attempting to maintain, the possibility exists that the vaginal examination can erupt into a sexual scene. Because of this possibility (or the possible imputation or accusation of sexual behavior having taken place), the nurse is always present.[3] Thus even the possibility of sexual content in the vaginal examination is ordinarily denied by all the role-players. It would appear that such denial serves as a mechanism to avoid apprehension and suspicion concerning the motivations and behaviors of the role-players, allowing the performance to be initiated and to continue smoothly to its logical conclusion.[4]

THE PATIENT AS A NONPERSON TEAM MEMBER

With this definition of objectification and desexualization, the patient represents a vagina disassociated from a person. She has been dramaturgically transformed for the duration of this scene into a nonperson (Goffman 1959: 152). This means that while he is seated and performing the vaginal examination, the doctor need not interact with the patient as a person, being, for example, constrained neither to carry on a conversation nor to maintain eye contact with her. Furthermore, this means that he is now permitted to carry on a "side conversation" with the person with whom he does maintain eye contact, his nurse. For example, during one examination the doctor looked up at the nurse and said: "Hank and I really caught some good-sized fish while we were on vacation. He really enjoyed himself." He then looked at his "work" and announced, "Cervix looks good; no inflammation—everything appears fine down here." Such ignoring of the presence of a third person would ordinarily constitute a breach of etiquette for middle-class interactions, but *in this case there really isn't a third person present*. The patient has been "depersonalized," and, correspondingly, the rules of conversation change, and no breach of etiquette has taken place.[5]

The patient, although defined as an object, is actually the third member of the team in the vaginal examination. Her role is to "play the role of being an object"; that is, she contributes her part to the flow of the interaction by acting as an object and not as a person. She contributes to the definition of herself as an object through studied alienation from the

interaction, demonstrating what is known as dramaturgical discipline (Goffman 1959: 216–218). She studiously gazes at the ceiling or wall, only occasionally allowing herself the luxury (or is it the danger?) of fleeting eye contact with the nurse. Eye contact with the doctor is, of course, prevented by the position of her legs and the drape sheet.

After the doctor tells the patient to get dressed, he leaves the room, and the fourth scene is ready to unfold.

Scene IV: The Repersonalizing Stage: The Transition from Pelvic to Person

During this stage of the interaction the patient undergoes a demetamorphosis, dramaturgically changing from vaginal object to person. Immediately after the doctor leaves, the nurse assists the patient into a sitting position, and she gets off the table. The nurse then asks the patient if she would like to use a towel to cleanse her genital area, and about 80 percent of the patients accept the offer. In this scene, it is not uncommon for patients to make some statement concerning their relief that the examination is over. Statements such as "I'm glad that's over with" seem to indicate the patient's overt recognition of the changing scene, to acknowledge that she is now entering a different scene in the vaginal drama.

During this repersonalizing stage the patient is concerned with regrooming and recostuming. Patients frequently ask if they look all right, and the common question, "My dress isn't too wrinkled, is it?" appears to indicate the patient's awareness of and desire to be ready for the resumption of roles other than vaginal object. Her dress isn't too wrinkled for what? It must be that she is asking whether it is too wrinkled (1) for her resumption of the role of (patient as) person and (2) her resumption of nonpatient roles.

Modesty continues to operate during this scene, and it is interesting that patients who have just had their genital area thoroughly examined both visually and tactually by the doctor are concerned that this same man will see their underclothing. ("He won't be in before I get my underwear on, will he?") They are now desiring and preparing for the return to the feminine role. They apparently fear that the doctor will reenter the room as they literally have one foot in and one foot out of their panties. They want to have their personal front reestablished to their own satisfaction before the return of this male and the onset of the next scene. For this, they strive for the poise and composure that they deem fitting the person role for which they are now preparing, frequently using either their own pocket-mirror or the mirror above the sink to check their personal front.

During this transitional role patients indicate by their comments to the nurse that they are to again be treated as persons. While they are

dressing, they frequently speak about their medical problems, their aches and pains, their fight against gaining weight, or feelings about their pregnancy. In such ways they are reasserting the self and are indicating that they are again entering "personhood."

The patient who best illustrates awareness that she had undergone a process of repersonalization is the woman who, after putting on her panties, said, "There! Just like new again." She had indeed moved out of her necessary but uncomfortable role as object, and her appearance or personal front once again matched her self-concept.

After the patient has recostumed and regroomed, the nurse directs the patient to the chair alongside the doctor's desk, and she then announces via intercom to the doctor, "The patient is dressed," or, "The patient is waiting." It is significant that at this point the woman is referred to as "patient" in the announcement to the doctor and not as "pelvic" as she was at the end of second scene. Sometimes the patient is also referred to by name in this announcement. The patient has completed her demetamorphosis at this point, and the nurse, by the way she refers to her, is officially acknowledging the transition.

The nurse then leaves the room, and her interaction with the patient ceases.

Scene V: The Repersonalized Stage: The Patient as Person Once More

When the doctor makes his third entrance, the patient has again resumed the role of person and is interacted with on this basis. She is both spoken to and receives replies from the doctor, with her whole personal front being visible in the interaction. During this fifth scene the doctor informs the patient of the results of her examination, he prescribes necessary medications, and, wherever indicated, he suggests further care. He also tells the patient whether or not she need see him again.

The significance of the interaction of Scene V for us is that the patient is again allowed to interact *as a person within the role of patient.* The doctor allows room for questions that the patient might have about the results of the examination, and he also gives her the opportunity to ask about other medical problems that she might be experiencing.

Interaction between the doctor and patient terminates as the doctor gets up from his chair and moves toward the door.

Conclusion: Desexualization of the Sacred

In concluding this analysis, we shall briefly indicate that conceptualizing the vagina as a sacred object yields a perspective that appears to be of value in analyzing the vaginal examination. Sacred objects are surrounded by rules protecting the object from being profaned, rules governing who may approach the "sacred," under what circumstances it may be approached, and what may and may not be done during such an approach (Durkheim 1965: 51-59). If these rules are followed, the "sacred" will lose none of its "sacredness," but if they are violated, there is danger of the sacred being profaned.

In conceptualizing the vagina in this way, we find, for example, that who may and who may not approach the vagina is highly circumscribed, with the primary person so allowed being one who is ritually related to the possessor of the vagina, the husband. Apart from the husband (with contemporary changes duly noted),[6] except in a medical setting and by the actors about whom we are speaking, no one else may approach the vagina other than the self and still have it retain its sacred character.[7]

Because of this, the medical profession has taken great pains to establish a routine and ritual that will ensure the continued sacredness of the vaginas of its female patients, one that will avoid even the imputation of taboo violation. Accordingly, as we have herein analyzed, this ritual of the vaginal examination allows the doctor to approach the sacred without profaning it or violating taboos by dramaturgically defining the vagina as just another organ of the body, disassociating the vagina from the person while desexualizing the person into a cooperative object.

Notes

1. With a society that is as clothing conscious and bodily conscious as is ours, undressing and nudity are probably problematic for almost everyone in our society from a very eary age. It is, however, probably more problematic for females than for males since males ordinarily experience structured situations in which they undress and are nude before others, such as showering after high school physical education classes, while females in the same situation are afforded a greater degree of privacy with, for example, private shower stalls in place of the mass showers of the males. Jim Hayes has given us a corroborating example. In the high school of 4,000 students that he attended in Brooklyn, swimming classes were segregated by sex. Male students swam nude in their physical education classes, but female students wore one-piece black bathing suits provided by the school. One can also think of the frequently traumatic, but required, en masse nudity experiences of males in military induction centers; such experiences are not forced upon our female population.

2. From a psychiatric orientation this association of the panties with the purse is fascinating, given the Freudian interpretation that the purse signifies the female genitalia.

In some examination rooms, the problem of where to put the undergarment is solved by the provision of a special drawer for them located beneath the examination table.

3. It is interesting to note that even the corpse of a female is defined as being

in need of such chaperonage. Erving Goffman, on reading this paper in manuscript form, commented that hospital etiquette dictates that "when a male attendant moves a female stiff from the room to the morgue he be accompanied by a female nurse."

4. Compare what Goffman (1959: 104) has to say about secrets shared by team members. Remember that the patient in this interaction is not simply a member of the audience. She is a team member, being also vitally interested in projecting and maintaining the definition of nonsexuality. Another reader of this paper, who wishes to remain anonymous, reports that during one of her pregnancies she had a handsome, young, and unmarried Hungarian doctor and that during vaginal examinations with him she would "concentrate on the instruments being used and the uncomfortableness of the situation" so as not to become sexually aroused.

5. In this situation a patient is "playing the role" of an object, but she is still able to hear verbal exchange, and she could enter the interaction if she so desired. As such, side comments between doctor and nurse must be limited. In certain other doctor–patient situations, however, the patient completely leaves the "person role," such as when the patient is anesthesized, which allows much freer banter. In delivery rooms of hospitals, for example, it is not uncommon for the obstetrician to comment while stitching the episiotomy, "She's like a new bride now," or, when putting in the final stitches, to say, "This is for the old man." Additionally, while medical students are stitching their first episiotomy, instructing doctors have been known to say, "It's not tight enough. Put one more in for the husband."

6. Consensual approaches by boyfriends certainly run less risk of violating the sacred than at earlier periods in our history, but this depends a good deal on religion, education, age, and social class membership.

7. It is perhaps for this reason that prostitutes ordinarily lack respect: They have profaned the sacred. And in doing so, not only have they failed to limit vaginal access to culturally prescribed individuals, but they have added further violation by allowing vaginal access on a pecuniary basis. They have, in effect, sold the sacred.

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15 Street Corner Society: The Social Structure of an Italian Slum

WILLIAM FOOTE WHYTE

To many Americans ethnicity is relatively unimportant. ("My great grandparents came from Germany. So what?") To others, ethnicity is a central feature of their lives. This is especially the case for many poor Americans who are now clustered together in relatively homogeneous areas variously known as ghettos, barrios, and slums. Here they share with other residents many customs not readily understood by people living elsewhere in that they are based on different experiences and sometimes contrasting values. They have developed institutions and expectations of one another that have helped them adapt to their impoverished life circumstances. With their common culture, they often form an in-group, looking outward at a larger society that they do not understand, while those in the larger society look at them, equally uncomprehending.

It is the inside story of such a group, with close boundaries drawn around themselves to separate them from others, that William Foote Whyte set out to get. He lived for three and a half years in what he calls Cornerville, observing and analyzing how people interact with one another. We can conclude from this selection, as well as from the previous ones, that one cannot understand the behavior of others until one can see things from their perspective.

You might wish to grapple with the question of how you can overcome your own perspectives (biases, socialization into particular views) in order to grasp the perspective of others.

THIS IS A REPORT UPON a three-and-a-half-year study of "Cornerville." My aim was to gain an intimate view of Cornerville life. My first problem, therefore, was to establish myself as a participant in the society so that I would have a position from which to observe. I began by going to live in Cornerville, finding a room with an Italian family. Since the mother and father of the family spoke no English, I began studying Italian. Conversations with them and practice with the Linguaphone enabled me to learn enough to talk fairly fluently with the older generation.