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A Theoretical Model of Social Consciousness

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The article presents a theoretical model of social consciousness developed from nurses' life histories. A 3-position dialectical framework—acquired, awakened, and expanded social consciousness—makes visible the way people respond to social injustice in their lives and in the lives of others. The positions coexist, are not hierarchical, and are contextually situated. A person's location influences her or his availability for social action. Nurses who could most contribute to challenging social injustices that underpin health disparities are relegated to the margins of mainstream nursing by internal processes of discrimination. More inclusive definitions of "a nurse" would open up possibilities for social change. **Key words:** *cultural safety*, *health disparities*, *horizontal violence*, *marginalization*, *social injustice*

NURSES' social consciousness matters. Although the underpinning causes of the widening gap in health status in populations worldwide are complex and multivariant,[1] the health disparities created are sustained by the institutionalization of discriminatory healthcare policies and practices.[2,3] Nurses' experience is a microcosm for other health professionals and for the larger social structures and systems—all of which constitute a social and political reality of disparity.

The article is the second phase of a cross-cultural life history study of nurses' stories of social injustice in their lives and within nursing.[4] The theoretical model of social consciousness presented developed from evidence that nurses' personal awareness of social injustice in their lives and in the lives of others—their social consciousness—influences whether or not they are able to challenge the status quo of discrimination within nursing and concomitantly within the healthcare system.[4]

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BACKGROUND

The idea for the study came primarily from an analysis of 2 movements that have influenced nursing's approach to cross-cultural issues worldwide for several decades—transcultural nursing and cultural safety. Feminist scholars' critique of oppression and power in relation to nursing, healthcare, and western healthcare systems also contributed to my initial questioning.

Transcultural nursing and cultural safety

Transcultural nursing, which originated in the work of Madeline Leininger[5] in the United States, is largely based on the premise that discriminatory healthcare practices would not exist if health practitioners were knowledgeable concerning their clients' racial/cultural/ethnic differences, as well as caring. Since the 1990s, even though the importance of recognizing individual differences and the fluid and contextual nature of cultural identity has been acknowledged,[6–8] the approach continues to use a narrow definition of culture. Nurses primarily focus on the racial and ethnic differences of others—their clients. Transcultural nursing fails to turn a critical eye inward, toward the dominant

white Anglo American culture or the differences among nurses themselves. The diversity within nursing is for the most part ignored. It is assumed that nurses who are caring and have appropriate cultural knowledge can care for others of diverse cultural backgrounds without prejudice.

In contrast to transcultural nursing's apolitical positioning, cultural safety began as a political act in the 1980s. Initiated by nurses who identified as Maori (indigenous people) in Aotearoa New Zealand, the movement challenged the personal and institutional racism that maintained the many social disparities (especially in health status) between Maori and the dominant British-based society.[9,10] On the basis of a treaty established in 1840, the Treaty of Waitangi, the cultural safety movement influenced nursing policy and the way nurses were educated about cultural difference, not only in Aotearoa New Zealand but in other western countries such as Australia[11,12] and Canada.[13,14] Its process emphasizes the importance of first acknowledging ones own culture, prior to learning about the culture of others. Although since 2002 cultural safety proposes an inclusive definition of culture,[15] its primary focus has been on racism and the historical, economic, and societal interplay of causes that produce social and health disparities.[16]

The focus on racial cultural differences in both approaches has opened up important dialogue on the existence of power imbalances within healthcare, and leads to discussion of issues such as the causes of health disparities and the special healthcare needs of different cultural groups. Inadvertently, however, it creates a powerful hierarchy of "isms." Other cultural differences and related social injustices such as sexism, heterosexism, and classism become relegated to the margins. Social consciousness becomes culturally specific rather than broad-based and challenging of all forms of discriminatory actions related to difference and social injustice.

Although the transcultural nursing and cultural safety movements have led to awareness of the importance of cross-cultural issues for safe and responsible nursing practice, they have not effectively critiqued nursing's contribution to sustaining disparities in healthcare; they have not critiqued the culture of nursing itself.

Feminist critiques of nursing

The oppressed position of nursing within the hierarchy of the patriarchal healthcare system has been documented since the mid-1970s.[17–19] Several scholars have identified internal patterns of oppression including horizontal violence,[20–22] and processes of marginalization.[23] Black feminist scholars in the United States have for decades given evidence of the exclusiveness of the nursing profession and the effects of racism and classism.[24,25] They have also drawn attention to the Anglo-centric nature of nursing and the theory developed from the various research methods.[26–28] What has yet to receive critical attention is the broader issue of nursing's cultural ideological hegemony and the inherent social injustices within its professional, educational, and clinical settings. A 2-phase study was undertaken to explore this issue. The first phase of the study made visible mainstream nursing's attachment to the ideological construction of the "white good nurse" that privileged those who fitted-in and marginalized those who did not.[29] This construction perpetuated discriminatory practices such as stereotyping and mainstream violence. Phase 2 is presented in the article.

Underpinning assumptions and arguments

An assumption underpinning this second phase of the study was that feeling different or marginalized is a common human experience. Most people at some time in their lives have felt like an outsider; that they do not belong or fit-in to a group. The argument arising from this assumption was that when the processes of marginalization are sanctioned and reinforced by societal structures, systems, and institutions, they take on discriminatory power. A person's difference then defines his or her status within a group, how he or she is

treated, and the privileges he or she does or does not receive.

A second assumption was that the prejudices enacted within society's social inequities and unjust practices are mirrored within healthcare systems and within the nursing profession. A person who is part of a socially marginalized culture or group, when accessing mainstream healthcare, is therefore likely to experience stereotyping, prejudice, and/or discriminatory actions from his or her nurses and other healthcare providers. Such acts of social injustice are then reinforced by institutional structures, policies, and processes: "That's the way we do it here." The findings of the first phase of the study[4] showed how everyday social injustices that underpin health disparities are difficult to challenge because they have become normalized. Acts of discrimination, so evident to nurses marginalized by their color or identity, can be ignored by mainstream nurses because of the privileges they receive by "fitting-in" to the dominant construction of the "white good nurse." Also, the tenuous nature of a marginalized person's relationship with nursing often inhibits his or her ability to openly challenge such injustices. They often have to work surreptitiously for marginalized clients and colleagues, out of sight of mainstream managers and people in authority.[29]

The argument arising from the second assumption is that if the normalcy of social injustices within the healthcare system and specifically within nursing is not challenged, the gap in the health status (health disparities) between those who are marginalized by their social identities and those who are privileged will be maintained and risks being widened. This risk is higher during times of decreasing public resources, such as limited funding, and increasing privatization of healthcare. Health professionals' social consciousness, therefore, does matter. If a person remains unaware of social inequities and their causes, the status quo of health disparities will be maintained; if aware and active in challenging social injustice, constant, collective, everyday social action can create the space for change and contribute to a narrowing of the gap.

METHODOLOGY AND METHODS

This second phase of the study developed from questions stimulated by the findings of phase 1, a cross-cultural, participatory, life history study of social injustice within nursing.[4] The life history methodology incorporated storytelling in the form of life story. Informed by Freire's notion of conscientization (critical consciousness)[30] and a feminist life story approach,[31] semistructured interviews (2–3 times) were conducted with 26 women nurses of varying racial, cultural, sexual identity, and specialty backgrounds in the United States ($n = 13$) and Aotearoa New Zealand ($n = 13$). Each woman identified as having some understanding of social justice issues, their ages ranged from 24 to 57 years, and years as an RN varied from 1 year to 40. At the first interview, we acknowledged our cultural and identity differences, making visible the unequal relations of power that influenced the way the stories were told and which stories mattered in the context of the interviews.[32] Conversations that developed reflected the narrative process of joint meaning making as stories were reconstructed in the process of their telling.[33] By obtaining the women's narratives, I was able to explore the work they did to position themselves in their social world and the value judgments they made to help them make sense of it all.[34] This methodology enabled the showing of difference as well as exploring the women's experience of being different[4]; it enabled the application of a dialectical reasoning process.[35]

A cyclical immersion analysis style was used for phase 1. Tapes were listened to and relistened to while transcripts were read onscreen. Life story "snippets" were created reflecting the unique aspects of each nurse's story. A thematic analysis process of coding and categorizing led to the overarching theme, *not fitting-in to nursing*, with subthemes related to how the women experienced unfairness and how they survived. The analysis and findings hinted at processes that may underpin a person's awareness of social injustice—her or his social consciousness.[4] This led to this second phase

of the study, the use of a dialectical reasoning approach to develop a theoretical model of social consciousness. The question that guided the theorizing process was, "How do nurses who are different respond to the negation, trivialization, and/or marginalization of their experience?"

THE DIALECTICAL MODEL OF SOCIAL CONSCIOUSNESS

Theoretical framework

The framework for the model of social consciousness was adapted from Gadow's[35] application of Hegel's dialectical reasoning process. Rather than using dialectic as a process of linear progression through thesis-antithesis-synthesis, Gadow proposed that the 3 positions are coexistent and "remain open to exploration."[35(p26)] Within the dialectic, the conceptualization and meaning of social consciousness changes according to the position in which it is framed. The positions coexist and are not exclusive; no one position can encompass the entirety of possible meanings. An understanding of social consciousness incorporates all positions in the dialectic, for according to Gadow,[36] it is the overall process that represents completion. The positions, therefore, are not hierarchical; neither can more value be placed on one position over another.

Overview of the model of social consciousness

The 3 dialectical positions involved in the model of social consciousness, acquired social consciousness, awakened social consciousness, and expanded social consciousness, are summarized in Table 1. Exemplars from the nurses' stories are given in boxes to illustrate various aspects of each dialectical

Table 1. Social consciousness within the dialectical framework

Acquired social consciousness	Awakened social consciousness	Expanded social consciousness
Social ascription	Social critique	Social relatedness
Situation a "given"	Awareness of processes of oppression on self and others	Awareness of possibilities and uncertainties in relationships
Action ascribed	Action selected	Action critically chosen
Delineated	Preexisting choices	Considered choice
Hierarchical	Polarized opposites	Socially and culturally constructed
Biologically determined	Active resistance	Difference without opposition
Uncritical acceptance	Self-determination	Situational and contextual
Natural authority and hierarchy	Resistance to others' authority	Considered resistance
Resistance personalized	Externalized difference	Recognition of contradiction
Internalized difference	Blame other	Personal autonomy and knowledge of self
Blames self	Self-definition as "victim"	Social multiplicity
Deserves treatment or punishment	Feels angry	Embodied contradiction
Feels guilty	Oppression is personalized	Critical and reflective
Colludes in own oppression	Colludes in oppression of others	Contingent
Survival in withdrawal	Survival in resistance	Oppression is depersonalized
Physical and/or emotional	Standing in resistance	Active respect of others
"Not my problem"	"A fish going upstream"	Survival in contradiction
		Knowing where one stands on the margins
		"Comfortable in my discomfort"
		"Obnoxious with dignity"

position, indexed with mutually agreed upon pseudonyms and cultural identities, and country (United States or New Zealand). The women now have moved on in their lives; they may tell different stories and have different memories and different interpretations. Each woman's story, however, remains timeless in its telling; it is one of "the ways people make sense of their lives" and "is a necessary starting point for understanding how power relations structure society."[37(p8)]

Acquired social consciousness

When positioned in "acquired social consciousness," a person's social consciousness is ascribed. They are strongly referent to a dominant mainstream cultural worldview, its beliefs and values, and their place within it. Awareness or acknowledgment of how difference may affect the way people are treated within society, that is, being privileged or oppressed by gender, class, ethnic/cultural identity, class, sexual identity, or a differing worldview, is often denied. Personal identification with a marginalized culture or group may be consciously hidden (Box 1). Not fully active in the dominant culture or strongly identified with their marginalized culture, they stay on the margins of both (Fig 1).

Social ascription and uncritical acceptance: When social consciousness is ascribed, the inequalities in power relationships and the disparate situations experienced or observed in the treatment of others are accepted as givens. They are rarely questioned, let alone named. The dominant cultural worldview makes up what is right, normal, and everyday common sense (see Box 1, 1.1). Underpinned by biological determinism, tradition guides behavior and the power relationships between individuals and within groups. The majority of the nurses in the study, especially those who started nursing in their late teens, told how they "just accepted" and "didn't think to question" the subservient position of nursing to medicine and the gendered nature of that relationship, the authority of those above them in the nursing hierarchy, and the feminine attributes assumed of them as nurses, such as always being "nice" and "caring."

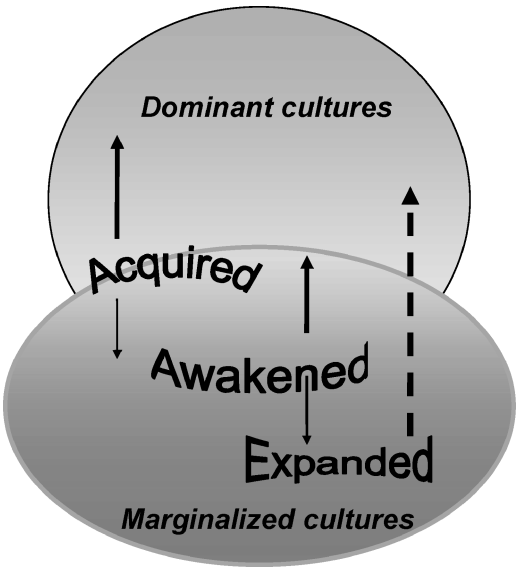

Figure 1. Dialectical model of social consciousness.

Action ascribed: The corollary to an ascribed social consciousness is the ascription of action. There is a right and appropriate way to behave within certain contexts. A great deal of energy and effort is put in to "fitting-in" and "learning the rules" (see Box 1, 1.2). A person in this position, though not necessarily without a sense of discomfort or grievance, acts according to the policy and the traditions of the institution. No matter in what position in the hierarchy, whether high-level, transient, or low-level authority, they are likely to enforce these on others, even the clients (see Box 1, 1.2).

Internalized difference: In this position, people internalize the hierarchical systems of power of a dominant culture in such a way that they do not see if or how they are marginalized or oppressed, let alone privileged (see Box 1, 1.3). The nurses in the study talked of how they were often "silent witnesses" to unjust acts and policies that supported and maintained the oppressive nature of the hospital and nursing structures, systems, and relationships. This silent agreement

Box 1. Acquired social consciousness—exemplars

Sue (NZ—Maori) "*When we were kids Mum made damn sure that we didn't speak Maori and it kind of made you feel being Maori had to be a secret.*" When she started nursing, "*I never told them I was Maori. I never ever took any of my class mates home. Never, no way. It was like I had two lives.*"

1.1 Social ascription and uncritical acceptance

Josie (NZ—Asian) *tried hard to* "*assimilate*" *into nursing by* "*always fitting-in. I always thought their way* [dominant Pakeha culture] *was the right way and the right way to do it was to do it better than they did it.*"

Kate (US—European) *was taught that* "*education was for a certain class of people that could do science and math, and it wasn't us, it wasn't me . . . when you're in the working class you see it's somebody else that goes to university, and you see that as an unattainable goal. That they have something you do not have.*"

1.2 Action ascribed

Rebecca (US—African American) "*Nursing for me has just been a daily thing of survival . . . I learnt to do everything by the book. . . I didn't challenge any of the assumptions made about me. . . I kept to myself mostly.*"

Miriam (NZ—Pakeha) stopped to talk with a patient during a "*pan round. We didn't talk for long and I got back to my duties. But the Charge Nurse said, 'we don't have time to sit and talk with patients.' I was watched carefully after that, not just by the Charge Nurse, but all the nurses above me. But what was even worse is that night; she refused to give the patients their desert! Just because I had stopped to talk to this patient!*"

1.3 Internalized difference

Maj (NZ—Maori) described herself as "*Pakehafied.*" When she went nursing, "*I just fitted right in there. I made sure I did what everyone else did, like a glove really. Had blonde blue-eyed friends. . . never Maori. . . It was always a big shock to me when I looked in the mirror and saw that 'he y I am Maori.' I recognize now how racist it all was and still is really, but I never related it to me.*"

1.4 Survival in withdrawal

Anna (NZ—Maori) during her nursing training and when first an RN, "*stayed in the background*" and "*always felt worried that I was going to do something wrong. . . in a new situation always a bit frightened to say anything in case I put my foot in it. So I played it safe and didn't challenge any thing, anything at all really . . . I think I was just looked at like an alien* [laughing]."

Maureen (NZ—Pakeha) prior to openly identifying as lesbian, survived in nursing by being a "*chameleon. I have hidden a lot of my difference. I have only presented that which fits in with the cardboard cut-out nurse . . . I tried to be this reasonable person who made myself acceptable for other people at an enormous cost to myself . . . I would be reasonable and nice when I really wanted to scratch their eyes out. Instead I smiled.*"

to participate in an oppressive system was in exchange for privileges and rewards from the mainstream network of power, including promotion, leave that suited personal needs, and not always being the butt of "put down" jokes.

Survival in withdrawal: A person who is different but not aware or openly acknowledging it survives in this position by withdrawing from openly confronting the system, often holding rigidly to the established rules and policies (see Box 1, 1.4). Any discriminatory treatment is interpreted as "my fault"; any injustices evident within the system are "not my problem." They put effort into fitting-in and not standing out as different. A lesbian nurse, for example, may be closeted from her colleagues and clients, never publicly owning her sexual identity (see Box 1,

1.4). People who are visibly different from the dominant culture may hide certain identifying characteristics and/or emulate those with cultural privilege. Withdrawal can be physical with frequent "sick days" taken, and/or emotional/psychological. The person is not fully present or available to others.

Awakened social consciousness

In the "awakened social consciousness" position, traditionally ascribed assumptions of a dominant culture are critiqued and alternatives are posited. People "stand up to be counted" (Box 2). Although identifying with a marginalized group, a person in this position of the dialectic remains strongly referent to the mainstream culture, expending time and energy on monitoring and scrutinizing it for unjust actions (see Fig 1).

Social critique: In this position, a person is aware of the processes of oppression on self and/or others. The oppressive nature of a traditional role or the effects of a socially imposed identity may be questioned. Social structures and systems come under scrutiny. Through critique a person's attitude changes; social inequities and injustices not only exist but are unfair and need to be challenged: "Surely everyone can see that!" Although the initial awareness can be related to a person's own marginal status, it is most often triggered by awareness of another group's oppressed position (see Box 2, 2.1).

Active resistance: Awareness of social injustice is enacted through active resistance to the power and authority ascribed to others within a hierarchy. This resistance may take the form of naming unjust actions or oppressive relationships, or taking resistant action. As an individual or as part of a group, a person in this position, through direct and indirect means, challenges an authoritative hierarchy (see Box 2, 2.3).

Action selected: A person's action when confronting social injustice is often selected from choices already developed by a resistance group within or outside the institution or system. Developed as an opposing position to the mainstream worldview, the choices can form the basis for agreed upon politically correct or party line actions (see Box 2, 2.3). For people of color, it is often the choice of when to challenge the everyday racist assumptions made about who they are. In this positioning of the dialectic, the focus of discontent and action is often over the right to be visible, to have choice, or to be self-determining.

Externalized difference: The focus in this awakened position is on being a victim of somebody's malice or the workings of an unjust system. When conflict occurs or there is some form of punishment, blame is placed on a person who is determined the aggressor or persons who are representatives of an oppressive system, for example, the managers or the doctors, or an aspect of the system that is deemed oppressive such as the nursing hierarchy (see Box 2, 2.4).

Survival in resistance: In this position, survival happens through continual active resistance and joining "the struggle." A person who constantly challenges taken-for-granted assumptions about his or her identity or assiduously monitors the dominant culture for unjust practices can be likened to "a fish going upstream," swimming against the tide of opinion, which is supported by the mores and norms of the surrounding social structures and systems. If people are open about a socially unacceptable identity, they may receive a subtle but clear message from every level within a dominant culture hierarchy: "Don't be blatant" (see Box 2, 2.5). If they challenge and name the hidden message—"do you mean to say . . ."—then they "haven't got a sense of humor" or "can't take a joke."

Expanded social consciousness

From the third position of the dialectic, "expanded social consciousnesses," essentialist and structuralist assumptions underpinning a person's identity and associated roles are challenged. Knowing the contingent nature of their acceptance, people move cautiously into the dominant culture, remaining strongly identified with their marginalized culture or group (see Box 3 and Fig 1).

Box 2. Awakened social consciousness—exemplars

Beverly (US—European) "*I choose when* not *to be 'out, not when to be out.' I volunteer to talk about being lesbian with nursing students . . . The straight people were more openly curious. . . . But the gay people were scared shitless. . . . If we knew them and they were friends of ours, they acted like we'd never met. And this was an unexpected backlash that really did surprise me. Our closeted sisters and brothers didn't want to be exposed. Like if we showed up openly gay, that automatically the room would turn to [them] and say, 'Oh so you're one of them!' The self-terrorizing of closeting is very dangerous.*"

2.1 Social critique

Louisa (NZ—originally from Australia—Pakeha) told her story: "*A woman [was] admitted one night having been raped. She was an Aborigine woman and they took photos of her with her legs apart, without the curtains drawn . . . I must have challenged it . . . and the policeman I remember said to me 'She is an Aborigine, what are you going on about?' And that was a first for me . . . I walked off in tears. But I didn't challenge what was happening to that woman . . . it changed me . . . I started seeing things around racism that I hadn't seen before.*"

2.2 Active resistance

Irene (NZ—Pakeha) "*I always resisted being 'nursified,' you know doing things because 'we have always done it that way.' I read this research paper that oil and meths is not helpful for back rubs and I went to the Charge Nurse in the Orthopaedic Ward and I said, 'Guess what, I have got this fantastic information we can change how we do things, we don't have to do these four hourly rubs . . . .' And she was furious at me, and sent me down to the Matron for insubordination! So by then I had an arrogance about how I was and how they were, that maintained my position as a rebel and I was buggered if they were going to get me down.*"

2.3 Action selected

Beverley (US—European) described herself as "*a long-time activist*." Involved in numerous rights movements "*I was always challenging something*." She had set up action and support groups for abused children and battered women "*My friends and I would put stickers on men's cars who were known abusers: 'Rapist! Do not accept a ride'. . . I was always getting into trouble.*"

2.4 Externalized difference

Ginny (NZ—Pakeha) for a time worked as a staff nurse in a cardiology unit, "*and there were tears amongst staff almost every day. Two nurses were actually walking around wearing cardiac monitors because they were so stressed. It was a very, very, unhealthy environment. The Charge Nurse wasn't wearing one! It was the Charge Nurse who generated all of that! I think for them [the staff] it was just survival. Isolation and survival. There was no language, no kind of understanding and that whole hierarchical system reinforces that shame. I decided not to participate in that.*"

2.5 Survival in resistance

Anna (NZ—Maori) when talking about her work in her community, "*my supervisor said, Is this [nursing] or that Maori thing?*" Anna reflected, "*I knew I was walking a fine line between losing my job and staying. I made a conscious decision that if I allow a job to stop me from what I am doing, and then to hell with it, the job is not worth it. So I just carried on stretching the boundaries really.*"

Societal relatedness: A person in this position becomes aware of the constructed nature of oppressive relationships and the contradictions embodied within them. Status and authority and their related privileges are viewed as social and cultural constructs, both contingent and uncertain. Rather than being fixed they are seen as contextual and continually

Box 3. Expanded social consciousness—exemplars

Jo (US—Hispanic) "*Not being part of the privileged group, is what makes me a privileged person. I didn't have the experience of having everything handed to me and I really did have to struggle with so many things. And so, it is having those experiences that make me feel like I am privileged, because I can truly walk into that world of the dominant culture. But all those people in the dominant culture can't just slip over into my culture and function as well in there. I can. And so there's a real positive to having that experience that you can't give to somebody. But I've lived it.*"

3.1 Societal relatedness

Jane (US—European) "*I feel privileged—I am white, middle class, educated, with a profession and a family. I talk about power and abuse, but when I talk it is a reminder to me too. Because I'm privileged, you know, it would be easy for me to be caught up with the dominant paradigm. I guess one of my fears is that if I don't pay attention, I'll slip into being close-minded again and again ….*"

3.2 Considered resistance and actions critically chosen

Rebecca (US—African American) described how a doctor coming on to her unit "*asked me to go and find the nurse on the floor. I just stood there in front of him, not complying with his request. He became more and more agitated. I then said quietly pointing with my hand, 'Look at my name tag,' and he responded with confusion and embarrassment.*" Rebecca noted that it was her skin color he saw.

3.3 Social multiplicity

Fiona (US—European) argued that diversity directly challenges white, middle class, academic nursing: "*It [diversity] is threatening, not only to nursing in general, but it's threatening to you and me. Because you and I would not be sitting here having this conversation if we truly valued diversity in nursing. Not only just because of the subject matter, but because you and I wouldn't be in the privileged position that we're in. And I think we continually fail to recognize that.*"

3.4 Survival in contradiction

Molly (US—African American) "*I'll shave down and survive in their world and as soon as five o'clock comes, I unshave and get into my world and be my own self. And so I show two faces which I think, and nobody has really done this research, is why we [African Americans] are so hypertensive. It's because we have to deal in two worlds. And white folks don't. It's their world. And so they operate the same way in their business world as they do in their home and in their environment.*"

Jo (US—Hispanic) learned to keep her two worlds very separate: "*I'm highly skilled at not sharing anything about my personal life unless I really want someone to know. I have to make a real conscious effort that I'm going to tell you something about myself, otherwise, I can talk to you probably for a whole year and you will know maybe five facts about me!*"

Sue (NZ—Maori) "*I was looking after a Maori man who was dying and his family wanted to take him home. The doctors wouldn't let him go. I remember going to the Ward Sister and saying 'He has to go home!' and she said 'Who are you to tell us?' But I knew, because I knew his family. The family accepted that the doctors weren't going to let him go home. So I kept opening his window because his spirit had to go and people kept shutting his window. We had a battle with this window! Every time I would walk past I would go in and open the window. His family would look at me and go 'Oh aye,' because they knew what I was doing. And then somebody else would go in and they would shut his window again. But it was things like that that I tried to do. But you never let on why you were doing them.*"

open to change. Remaining aware of how one responds in these contexts is seen as a lifetime process (see Box 3, 3.1).

Considered resistance and actions critically chosen: Recognition of the interplay of oppression and privilege brings with it acceptance of certain responsibilities. A person in this position is constrained to take action against social injustice. The action taken, however, is critically chosen rather than reactive. Situations are "weighed up" and responses carefully considered. These could include withdrawal, active resistance, consciously using the system, or other possibilities such as humor (see Box 3, 3.2).

Social multiplicity: In this position, the processes of oppression and privilege and of colluding in the oppression of others are recognized and acknowledged. Mainstream nurses, for example, take ownership for their everyday actions that serve to maintain their privilege and the structures and systems that support it. Their collusion, though personally owned, is also recognized as an outcome of the complex interplay of some aspect of their identity and the privilege it gives them in contrast to others. The very existence of certain attributes, such as being white, middle class, heterosexual, educated, or in a position of authority, for example, privileges a person (see Box 3, 3.4). The corollary also holds true, the very existence of attributes such as being a person of color, lower class, lesbian/gay, of limited formal education, or in a position of servitude leads to prejudiced and unjust treatment. Mainstream nurse's privilege is always at the expense of someone else.

Survival in contradiction: Survival in this position of the dialectic is through an acceptance of the contradictory and tenuous nature of a person's relationship with a mainstream culture or group (see Box 3, 3.4). People acknowledge the limitations placed on them by their marginal identity and/or their general commitment to social justice issues, and develop creative ways to challenge the dominant power base while remaining within it (see Box 3, 3.4). Although not fully at ease in mainstream contexts, they are comfortable in their discomfort, in challenging dominant culture assumptions about themselves and others, their goal to be "obnoxious with dignity." They work surreptitiously to meet the cultural needs of those marginalized within the healthcare system (see Box 3, 3.4). Rather than being placed on the margins by the actions of others, a person in this position knowingly stands on the margins, using his or her cultural knowing derived from transiting between 2 (or more) worlds as a "springboard" and a position of strength (see Fig 1).

DISCUSSION

This dialectical model of social consciousness provides a theoretical framework for understanding how people position themselves in relation to social injustice and social action.

A person's location at any one time not only influences his or her availability for social action but also has consequences, both personal and professional. These consequences will be explored through the experiences of the nurses in the study, but their stories could be anyone's story.

Acquired social consciousness positioning

A person who is socially marginalized and functions frequently within a position of acquired social consciousness may accentuate the characteristics that are not in conflict with the dominant cultural ideal, whatever that might be. The stories of the nurses in the study that reflected this positioning revealed that rather than openly acknowledging their own and/or others' differences, initially they strove to become more like the constructed ideal of the "white good nurse." To achieve this, they often accentuated the feminine qualities associated with being female in the white Anglo culture—nurturance and niceness—while following nursing's policies and rules quite rigidly in an attempt to avoid conflict and ambiguity. They tried to do nursing tasks even better than those they imitated, and blamed themselves when things

went awry. Fear of being wrong and/or punished led to personal withdrawal, thus limiting the nurses' availability to their colleagues, the nursing profession, and, more important, their clients. Social actions on behalf of others, whether client or colleagues, were carried out surreptitiously, out of sight of mainstream colleagues and managers. Many of the nurses talked of leading 2 lives, often feeling inauthentic in both. Constant monitoring of self and others, double thinking, second guessing, and sensitivity to the reactions and behavior of those in authority around them, left the nurses little energy to care authentically and creatively for their clients or for themselves. Illnesses such as alcohol problems, depression, and hypertension could be a consequence. The nurses' lack of self-esteem and the feeling of being "just a nurse" translated into their survival in nursing as "just a job" for "just a client." A person positioned in acquired social consciousness is not available to take social action on behalf of himself or herself or others and contributes to maintaining the status quo and continuing health disparities.

Awakened social consciousness positioning

A person who is awoken to the everyday workings of a social injustice related to a particular marginalized issue can undergo a change in attitude that leads to focused social action and commitment to "the cause." These people can become the "rock breakers," essential for spearheading transformative action. The nurses in the study whose story reflected this positioning saw others in this role rather than themselves, but their stories indicated that in their own way they were rock breakers within nursing. They stopped trying to fit the ideal of the "white good nurse" and stopped obeying the rules. The nurses told stories of negative consequences when they stood up for themselves or others and made social injustices visible. Some nurses, not marginalized by their culture or sexual identity but privileged by being white, found they were isolated and labeled "outsider" when, for example, they did not take part in negatively criticizing or labeling colleagues or clients, offered suggestions for solving a problem, or even questioned a policy, or a person who was in authority. All the nurses whose stories reflected this dialectical positioning were directly or indirectly punished in some way including the following: being "watched" or "checked up on"; having "to work with the senior nurse on afternoon shift"; "kept working late"; "reported to the tutor [teacher]"; and "not spoken to by the other nurses." These nurses found they were carrying labels like "trouble-maker," "radical," "lazy," "arrogant," "irresponsible," and "hopeless nurse."

The energy required in this awakened social consciousness position to monitor the mainstream nursing culture and confront any discriminatory and unjust actions resulted in sickness, burn-out, disillusionment, and withdrawal from mainstream nursing. The shame of being associated with nursing often led to their directing their creativity and energy into other areas, outside nursing. Nursing for these nurses became a battleground of winners and losers, oppressors and oppressed, and aggressors and victims. A person positioned in this social consciousness directly challenges the status quo of discrimination that underpins health disparities for a time. But after a while of "hitting my head against a brick wall," they often withdraw from dominant culture activities and work outside the mainstream, so are unavailable for leading mainstream change.

Expanded social consciousness positioning

A person who becomes aware of the contradictions involved in oppressive relationships and structures within professions and organizations expands the possibilities open to him or her for social action. The nurses whose stories reflected such awareness talked of the interrelated and contradictory nature of privilege and oppression. The nurses of color, rather than leading 2 lives, talked of transiting between 2 worlds. Instead of trying hard to fit in to the dominant white

Anglo culture, they "let go" of trying to please and follow rules they often found incomprehensible, and focused their energies on their own needs and those of marginalized groups. They referred to their ability to move between their 2 worlds as a privilege. While working within the dominant white Anglo culture, however, they remained aware of the contradictions, aware of the professional limitations of their position as outsider, and aware of the everyday workings of racism. Lesbian-identified nurses' stories reflected a similar process of acknowledging their outsider status and the necessity of continuing vigilance as they navigated through the heterosexist assumptions so much a part of the dominant nursing culture environment.

In this social consciousness positioning, language is seen as a powerful constructor of social reality, all people being viewed as affected by the social constructions created by the media and institutions that surround them. Nurses who were marginalized by their behavior rather than by their identity saw how social constructions positively created their reality: they were already privileged to be a "white good nurse." This positive positioning was strengthened if they were also middle class, heterosexual, and educated. Their marginalized position came about because they transgressed the more hidden, but equally powerful, assumptions of the mythical Nightingale nurse.[17,38] They talked about coming to understand the anger of a marginalized group toward a dominant culture, toward them. Their position of privilege, they recognized, was "on the backs of others."

The recognition of the processes associated with social privilege alleviated the nurses' sense, not of responsibility, but of personal guilt, that in the past had limited their actions; they became free to act. The action taken, however, was not reactive, but critically chosen, each situation "weighed up" and their responses considered. These could include withdrawal, active resistance, or forms of considered resistance such as humor. Rather than blaming self (ascribed social consciousness) or others (awakened social consciousness), the processes of oppression were critiqued. Their own actions, the actions of others, and the power relations within the nursing hierarchy were deconstructed. Oppression and oppressive processes were named. Their actions reflected social multiplicity, or what Hoagland[39(p13)] calls "moral agency." The nurses were able to knowingly make choices, resist power-over tactics from within the hierarchy, take action with and on behalf of others, and in their own unique ways, challenge social injustice both within nursing and within their practice settings.

In this social consciousness positioning, the considered and selective availability of the nurses' energy, vision, talent, and skill limited their contribution, not to their clients or community, but to nursing as a profession. Negative responses to what was seen as their "lack of commitment" further distanced the nurses from acting within the nursing mainstream. Hall et al[23(p28)] note that, "A great deal of knowledge is situated at the margins" which "can provide a locus of resistance and empowerment." The nurses knowingly stood on the margins, describing their positions in terms such as, "comfortable in my discomfort," "knowing where I stand," "it all happens in the margins," "playing the game," and "obnoxious with dignity." People in this social consciousness positioning are selectively available to their profession, but are committed in their everyday lives to challenging in multiple ways health disparities within their client populations.

Reflections on the consequences for nursing and social action

At every social consciousness position there were negative consequences for the nursing profession and for its role in challenging the discriminatory and unjust practices that sustain health disparities. Bottom line, the clients suffer. Nursing's inability to deal effectively with its own internal processes of oppression and privilege deprives it of the nurses who could most contribute to social action: the nurses who are different for whatever reason, are measured

against the traditional characteristics of the "white good nurse," found wanting, and disciplined accordingly. This ideological construction of "a nurse" legitimizes mainstream violence within nursing; it condones and supports both formal and informal acts of discrimination. Although addressing health disparities is a priority in nursing in the United States and Aotearoa New Zealand and comprehensive strategies have been developed,[40–42] it is instituting the changes that will disrupt the constructed ideal that is the challenge. Openly naming and making visible the interconnectedness between the assumptions of the "white good nurse" and the marginalizing policies and discriminatory practices would make space for new definitions, definitions that would reflect the multiple differences within client communities and nursing specialties. Active recognition of the interplay of oppression and privilege would in time and with persistence, challenge the discriminatory economic policies that underpin the institutionalized injustices sexism, racism, heterosexism, and classism. A tall order for a profession itself marginalized? Is there a choice?

The consequences of the 3 social consciousness positions and the model itself were explored through the stories of nurses who reported being aware of social injustice, but can be generalized to the experiences of all nurses, other health professionals, and people in other social contexts. It appears to be useful in understanding social consciousness development generally, not just in health-related contexts. Extending the study to include mainstream nurses and men could also uncover further complexities of the model. These would be fruitful areas for future research.

Reflections on social consciousness

It does not follow that an awareness of social injustice within one context (especially one's own) extends to awareness of other forms of discrimination. For example, the nurses whose stories reflected an expanded social consciousness told of how they were "jolted," "challenged," and "pulled screaming" into an awareness of how often they colluded in the oppression of others. Even harder, some said, was recognition of the privilege inherent in their being white, educated, or heterosexual and that such privilege was always at someone else's expense. A person who is privileged, is also privileged not to see.[43] This selective blindness was reflected in the stories the nurses told of being challenged by other socially marginalized groups for not being inclusive or ignoring the reality of their experiences.

At any one time, a person can be located in all 3 social consciousness positions. Knowledge of cultural difference and the effects of oppression do not necessarily equate with more understanding or empathy, nor do they result in being viewed by a marginalized person as culturally safe. It is hard to make space for others by giving up a privilege, especially when recently gained. It is possible, however, that once a person has experienced the increased awareness and changing attitudes arising from expanded social consciousness, there is more chance his or her sensitivity to social injustice will remain open. Rather than immediately defending a mainstream position that supports the status quo and therefore his or her privilege, a person may be more sensitive to the possibility that something is amiss.

Theoretical contributions

The assumption of coexistence proposed by Gadow[35] is supported by the daily reality of the lives of the nurses in the study. Their stories resisted rigid location and reflected movement across, between, and within the dialectical positions: acquired social consciousness, awakened social consciousness, and expanded social consciousness. A few of the nurses entered nursing with experiences that reflected all 3 positions, but the majority developed a broad social consciousness while a student or when working as an RN.

The nurses' stories also captured how the positions within the dialectic remain open

as new experiences triggered various shifts within, between, and across positions. Some stories did show, however, that a person can become fixed within one position on a particular social issue for a period of time. The nurses' experiences of marginalization also differed depending on their cultural and personal contexts (eg, primarily identified as dominant/privileged culture or marginalized culture such as African American, Maori, or Lesbian), but their movement across the dialectical positions was similar.

Although it became apparent that time and maturity did contribute to the nurses' consciousness shifts, the process reflected more the contradictory nature of social consciousness, dependent on the nurses' shifting personal, social, cultural, and political contexts. As noted in the above discussion, awareness of privilege or oppression within one context of their lives was not automatically transferred to another.

CONCLUSION

The focus of the article on social consciousness in relation to health disparities is a reminder of the subtle nature of the marginalizing assumptions that pervade mainstream thinking. First, by focusing the analysis on the notion of disparities rather than on the privileging and marginalizing processes within the larger societal structures and systems, there is a risk of inadvertently reinforcing stereotypical attitudes and prejudices about marginalized groups. A disparity model as a basis for social action constructs and situates "these people" at the deficit end of a continuum. Their social issues and needs become the "target" of mainstream interest and action reinforcing the discriminatory processes of othering. Second, dividing the social realities of disparity into subcategories such as health, education, and justice draws attention away from their interconnectedness; underpinning them all are economic and political systems that institutionalize the processes of privilege and oppression.

This model of social consciousness is only that—a model constructed from my application of Gadow's[35] dialectical reasoning process to the stories of difference and fairness told by nurses in the United States and Aotearoa New Zealand. It is offered, at the risk of being accused of universalism, as a way of thinking about social consciousness and notions of difference, oppression, and privilege. It makes visible the tyranny of the traditional construction of the "white good nurse" and contributes to the debate concerning the causes of mainstream violence and possible interventions. It problematizes the concept of "horizontal violence." The nurses' everyday experience of bullying and abuse was not confined within nursing's professional boundaries as the descriptor indicates, but affects all within the healthcare system, especially those with least power, their clients. A more workable description might be "mainstream violence."

The model also troubles the notion of cultural competence by moving the focus of analysis from the recipient of care to the professional caregiver. It usefully complements the political notion of cultural safety as it challenges all health professionals, no matter what their culture or identity, to consider the complex and contradictory interplay of oppression and privilege. Our social consciousness does matter; it determines how we see ourselves in relation to others and whether or not we become part of the solution to the social injustices within nursing and those that underpin current health disparities.

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