

Complementary and Antagonistic Intergroup Differentiations by New Zealand Nurses

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Antagonistic intergroup differentiation, which occurs when two groups both show ingroup-favouring evaluations on identical attribute(s), has been the main concern of traditional applications of Tajfel and Turner's (1979) social identity theory. Relatively overlooked has been complementary intergroup differentiation, in which the two groups exaggerate ingroup superiority on their respective distinctive attributes but also acknowledge outgroup superiority on the latter's unique attributes. By making available multiple, important attributes for two groups of New Zealand nurses ($N=72$) to evaluate one another on, this survey obtained evaluative biases and exaggerations reflecting both complementary and antagonistic intergroup differentiations.

Individuals belong, or think they belong, to one or more groups. Group membership and its associated emotive meanings contribute to a person's social identity, which forms part of his/her self-concept. Just as individuals will safeguard and enhance their self-concepts, so they will seek increments to their group-based social identities. One way of achieving the latter is by differentiating the ingroup from relevant outgroup(s) in a favourable direction on some valued dimension(s). Concomitant with this search for a positive social identity, which provides the social-motivational basis of intergroup differentiation, there is a perceptual readiness to exaggerate the difference between groups, and to exaggerate the similarity within a group, particularly within the outgroup. These perceptual exaggerations, which are thought to be a natural consequence of categorization, provide the perceptual-cognitive basis of intergroup differentiation.

Social identity theory (Tajfel & Turner, 1979) gives a fairly coherent account of the above social-motivational and perceptual-cognitive bases of intergroup differentiation occurring in

the evaluative, attributional, and behavioural domains. The theory recognises the creative diversity in the realization of intergroup differentiation. In the evaluative domain, for example, differentiation may be achieved by exaggerating the superiority of the ingroup on a traditionally favourable dimension; by creating and legitimizing a new dimension on which the ingroup is advantaged; by changing the value assigned to ingroup attributes (e.g., skin colour, religion, and speech accent) so that they now become positive; or even by choosing a more lowly placed group for comparison so that attributes on which the ingroup was previously disadvantaged when comparing with a superior group may become positive ingroup features in the light of this new comparison. (For integrative reviews, see Brewer and Kramer, 1985; Tajfel, 1982a; and Turner, 1985).

Social identity theory has been applied to various intergroup settings, mainly in the laboratory but also in the field (e.g. Tajfel, 1982b). It has also been applied to the intergroup behaviour of young children (Vaughan, Tajfel & Williams, 1981). Most of the applications are concerned solely with antagonistic intergroup differentiation in which the two groups concerned favour their respective ingroups over the outgroup on the same (usually one) dimensions. Preoccupation with antagonistic intergroup differentiation has led to the relative neglect of the possibility that social identity can be promoted without denigrating the outgroup or preventing the groups from reaching a stable equilibrium in their mutual relations. For example, Stringer

* This research was supported by a Social Sciences Research Fund Committee grant (8235/21/24/8205) to the first author. An earlier version of the paper was read at the 1986 Annual Meeting of Australian Social Psychologists.

We gratefully acknowledge the cooperation of staff nurses and tutors who participated in the surveys, and the assistance of senior nurses and personnel officers. C. Scott and A. Dixon made invaluable comments on the questionnaire, as did two anonymous reviewers on the manuscript.

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and Cairns (1983) have observed that Catholic and Protestant adolescents in Northern Ireland had positive social identities and yet, contrary to popular impressions by outsiders, engaged in little outgroup derogation. Situations like this do not contradict social identity theory. Instead, their understanding can be aided by the theory because of the latter's emphases on the complexity of the human cognitive system and on the flexible, often ingenious, ways whereby group members may fulfill their social identities without directly antagonising members of the opposite group. In this regard, Turner (1980, p. 143) has suggested the concept of "complementary social identities," which refers to a state of positive equilibrium in intergroup relations such that "each group derives positive self-esteem from its distinctive virtues and also positively references the secure superiorities of the outgroup." In a similar vein, van Knippenberg (1984) points out that the distribution of identities among groups is not necessarily conflictual, and groups may "co-exist with consensual appreciation of each other's qualities." (p. 575)

There are now field studies (Bourhis & Hill, 1982; Skevington, 1981; van Knippenberg & van Oer, 1984) and laboratory studies (Dion, 1979; Mummendey & Schreiber, 1983) of intergroup differentiation which indicate some form of complementary social identities. A critical feature of these studies was the availability of different dimensions or attributes on which intergroup differentiation might be based. Whilst this availability can be regarded as a necessary condition for the realization of complementary social identities, it is not a sufficient condition because there are studies which used different attributes but found only antagonistic ethnocentrism (e.g., Brewer & Campbell, 1976).

We try to examine both antagonistic and complementary social identities in 'real-life' groups by measuring the groups' evaluation of themselves and of each other. To obtain meaningful evaluations, we choose groups which can reasonably be expected to have personal knowledge of one another. As social identity research has usually been carried out on groups which are only minimally marked from each other, we try to preserve this feature by choosing similarly minimal groups. Two categories of nurses — polytechnic-trained

comprehensive nurses and hospital-trained nurses — fulfill these requirements sufficiently well. These two nurse groups work alongside each other, perform interchangeable tasks, and receive identical pay. There are no outward symbols of individual group identity apart from the badge they wear, and even this is often discounted because they are commonly addressed as nurse rather than comprehensive or general nurse.

The polytechnic-based training programme is the newer of the two and represents the most significant nursing reform to follow from Carpenter's (1971) report. She recommended, among other reforms, the gradual transfer of nurse training from the hospitals to colleges of health sciences. Nurse trainees in the polytechnic are granted student status and are freed from the service duties required of their counterparts in the traditional hospital programme. Despite some controversy over the suitability of the polytechnic as the site for conducting the new programme (Ramsay, 1980; Wills, 1973), the training reform itself is generally approved and its implementation represents the New Zealand counterpart of a popular trend towards tertiary nurse education (Aiken, 1982; Burgess, 1984; Jahoda, 1961; Jenkins, King & Gray, 1982; Wills, 1985). An evaluation of polytechnic graduates by Taylor, Small, White, Hall, and Fenwick (1981) found predominantly favourable outcomes.

Since 1973, when the first polytechnic training course was set up, there has been an increasing number of comprehensive nurses in the workforce. These nurses have a broader knowledge base and a more academic approach towards the profession than graduates of the older, now declining, hospital programme. The prospect of gaining a proper formal education in the polytechnic, as opposed to becoming an apprentice in the hospital, has attracted better qualified applicants to the new programme. On the other hand, general nurses have had more practical clinical training, are more familiar with the work setting and more experienced in working with other health professionals.

The two groups of nurses provided a field setting for studying the patterns of evaluative intergroup differentiation, and how the patterns might reflect either one or both of antagonistic and complementary social iden-

tities. For this purpose, as noted above, it was necessary to offer different nurse attributes to the subjects as alternative bases for intergroup differentiation. We attempted to identify important nurse attributes that were characteristic of either the polytechnic training programme, or the hospital training programme, or both. In line with Turner's (1980) argument, some degree of complementarity was expected on the first two types of attributes. That is, comprehensive nurses were expected to evaluate the ingroup favourably on polytechnic-attributes and to evaluate the outgroup favourably on hospital-attributes; whilst general nurses would reciprocate by favouring the comprehensive group on polytechnic-attributes, and only favour the ingroup on hospital-attributes. No definite prediction was made on the third, common type of attributes. To the extent that identity needs could be met through complementary differentiation, the pursuit for a positive social identity might well end just there and there would be no ingroup-favouring differentiation on the common dimension. In a similar vein, Brewer and Kramer (1985, p.225) commented that "distinguishing ingroup from outgroup is not uniformly biased in favour of the ingroup, as long as *some* basis for positive ingroup distinction is available." This hypothesis might be called the 'satisficing' hypothesis, a term borrowed from Simon and Stedry (1969). On the other hand, one could argue that common attributes were particularly salient for social comparison and consequently would excite both groups to engage in ingroup-favouring differentiations. This 'salience' hypothesis appeared plausible in the light of Tajfel's (1978) and Turner's (1985) discussions of social comparison and levels of self categorization.

Pilot Studies

Important Nurse Attributes

Taylor et al. (1981) asked polytechnic nurse graduates and their supervisors to select from a list of 25 attributes 10 which they considered to be the most important for nurses to possess. Eleven attributes were selected by more than half of the graduates and/or supervisors. We adopted these 11 attributes, modified their wording slightly, and asked 74 practising staff nurses to rate the importance of each attribute. All the attributes received mean ratings less

than 5.3 on an 11-point scale where 1 represented Most Important and 11 represented Not Important. To guard against omitting other important attributes, the staff nurses were also asked to nominate other attributes which they would rate most importantly. The nominated attributes were examined with the help of a senior nurse tutor. This exercise resulted in one of the original attributes being replaced by a more specific attribute, and three other original attributes being rephrased to form four attributes. This modified list of 12 attributes was used in the main study (see Table 2 for the full wording of the attributes.)

Preliminary Classification of Nurse Attributes

Seven nurse tutors with experience in both the polytechnic and hospital training programmes were asked to judge whether each of the 12 attributes was more strongly emphasized by one programme than by the other, or was equally emphasized by both. They rated the degrees of polytechnic programme emphasis and hospital programme emphasis on a 9-point scale which varied from Strongly Emphasized (1) to Not Emphasized (9). Table 1 shows the mean ratings and t-test results.

Referring to Table 1, it can be observed that attributes A, B, C, and, to a less extent, D, were more strongly emphasized by the polytechnic programme than by the hospital programme. The hospital programme emphasized attributes E, F and G more strongly. The remaining five attributes were equally emphasized by both programmes; amongst them, attributes H and I were particularly strongly emphasized. The above tutor-based classification was later related to a nurse-based classification (see below) in order to produce a more general classification of the attributes for the study of intergroup differentiation.

Nurse Survey

Subjects and Procedure

In early September, 1985, a cover letter, a free post return envelope, and a questionnaire containing the 12 attributes as well as some other demographic, job satisfaction, and nursing role items, were distributed via the hospital personnel office to a random sample of 100 staff nurses in two city public hospitals. The sample was equally divided between general and comprehensive nurses. Within

Table 1: *Tutors' (N=7) Ratings of the Emphases Given by the Polytechnic- and Hospital-training Programmes to each Nurse Attribute*

Nurse attribute	Polytechnic emphasis		Hospital emphasis		t(6)
	M	SD	M	SD	
A. Care plan	1.6	0.8	5.4	1.5	-5.8**
B. Holistic approach	1.6	0.5	4.1	1.6	-4.9**
C. Communication and counselling	1.7	0.8	3.7	1.8	-2.9*
D. Theoretical knowledge	2.1	2.2	4.1	0.7	(-2.0)
E. Clinical experience	4.4	2.0	1.3	0.5	3.7**
F. Work	6.0	1.3	2.3	0.5	7.1**
G. Get along with health professionals	4.7	1.8	2.7	1.4	(1.8)
H. Patients' welfare and comfort	1.3	0.5	1.9	1.1	ns
I. Patients' feelings	1.9	0.9	2.7	1.9	ns
J. Problem solving	3.0	2.3	3.6	1.9	ns
K. Decision-making	3.7	2.2	3.3	1.4	ns
L. Intelligence	4.3	2.7	4.1	2.2	ns

Note. Ratings were made on a 9-point scale varying from Strongly Emphasized (1) to Not Emphasized (9). * $p < .05$, ** $p < .01$.

three weeks, 61 subjects returned the questionnaire to us in the free post envelope. A letter was sent to all subjects thanking them for completing the questionnaire and, if they had not yet completed it, reminding them to do so. A further 20 subjects completed the survey by mid-October, resulting in a total response rate of 81%. After excluding five male nurses and four females who were hospital-trained comprehensive nurses, the final all-female sample consisted of 36 comprehensive and 36 general nurses. The two groups were comparable on age, year of registration, and number of years spent in nursing since qualifying. The mean age was 28.1 years old ($sd=7.9$ years), and the average number of years spent in nursing since qualifying was 3.9 years ($sd=2.8$). (Job satisfaction and nursing role responses were in the main similar across the groups, and these descriptive results will be reported in Ng, Cram & Dixon, 1986).

Subjects rated the importance of each attribute on a 10-point scale varying from Supremely Important (1) to Not Important (10). They then evaluated an average general nurse and an average comprehensive nurse on each attribute by means of a 7-point scale with 1 representing Excellent and 7 representing Poor. They could assign identical or different

evaluations to the two target categories. To minimize the cueing of artificial differentiation, subjects were asked to give different evaluations only if they felt it was necessary.

Results

Importance and Final Classification of Nurse Attributes

All mean ratings were less than 5, indicating that the 12 attributes were important qualities for nurses to possess. There was no significant difference at the 5% level between the comprehensive and general subjects on any of the attributes. Rankings of the attributes, based on group means, were highly correlated between the two groups of nurses (Spearman $R=.89$, $N=12$, $p < .01$).

On the basis of the importance ratings, principal components with above unitary eigenvalues were extracted. The resulting three components, which accounted for 61% of the variance, were varimax rotated. The component loadings (Table 3) indicated a satisfactory degree of correspondence between this 3-component solution and the tutor-based classification reported above. The two schemes produced identical grouping for 9 of the 12 attributes. (a) Care plan, Holistic approach,

INTERGROUP DIFFERENTIATION

Table 2: *Importance Ratings of Nurse Attributes Arranged in Descending Order of Importance (N=72)*

Nurse Attribute	Mean	SD
H. Concern with patients' welfare and comfort	1.31	0.69
I. Ability to appreciate patients' feelings	1.99	0.97
K. Ability to make decisions	1.99	1.04
C. Ability to communicate with and counsel patients	2.58	1.33
J. Ability to solve problems	2.81	1.50
B. Willingness to adopt a holistic approach to patient care and treatment	2.91	1.89
G. Ability to get along with other health professionals	2.99	1.49
D. Theoretical knowledge of subjects related to nursing	3.04	1.37
E. Clinical nursing experience	3.25	1.77
F. Willingness to work under occasionally trying conditions	3.29	1.61
L. Level of intelligence	4.11	1.53
A. Ability to write care plans intelligibly	4.39	2.45

Note. Subjects rated each attribute on a 10-point scale varying from Supremely Important (1) to Not Important (10).

Table 3: *Attribute Loadings after Varimax Rotation of the First 3 Principal Components*

Attribute	PC ₁	PC ₂	PC ₃
A. Care plan	.67	-	-
B. Holistic approach	.67	-	-
C. Communication and counselling	.56	-	.45
D. Theoretical knowledge	.63	-	-
E. Clinical experience	-	.76	-
F. Work	.67	-	-
G. Get along with health professionals	-	.46	-
H. Patients' welfare and comfort	-	-	.86
I. Patients' feelings	-	-	.75
J. Problem solving	-	.75	-
K. Decision-making	-	.52	.61
L. Intelligence	.47	.67	-
Eigenvalue	4.83	1.44	1.04

Note. Loadings <.4 had been omitted.

Table 4: *Intergroup evaluation on each Dimension: Summary of ANOVA results*

Dimension	R		T		R x T	
	F(1, 68)	MS _e	F(1, 68)	F(1, 68)	MS _e	MS _e
Comprehensive	4.6*	1.1	38.6***	5.3*	0.4	0.4
General	0.3	1.4	33.4***	17.6***	0.4	0.4
Common	3.1	0.9	7.8**	16.4***	0.2	0.2

Note. R = rater variable (Comprehensive vs General subjects). T = target variable (Average Comprehensive Nurse vs Average General Nurse). MS_e = mean sums of squares of the error term. Two of the 72 subjects with incomplete answers were omitted from the analysis.

* p < .05, ** p < .01, *** p < .0005.

Communication/counselling, and Theoretical knowledge formed one group. This group represented those qualities considered by the tutors to be relatively more characteristic of the polytechnic programme, and for this reason, might be named the 'Comprehensive dimension'. (b) Clinical experience, and Get along with other health professionals would, by the same token, form the 'Generals dimension'. (c) Patients' welfare/comfort, Patients' feelings, and Decision-making loaded on the same component and were considered by the tutors to be equally emphasized by the two programmes. They were also the most important of all the attributes (see Table 2). This group of attributes represented the core values common to both programmes, and was named the 'Common dimension'. The remaining attributes (Work, Problem-solving, and Intelligence) were unassigned because of grouping disagreement between the tutor-based and the principal component analysis schemes.

Intergroup Evaluation

The evaluations were grouped into the predetermined comprehensive, general, and common dimensions. Each dimension was analysed according to a 2 x 2 mixed ANOVA design comprising rater (general vs comprehensive subjects) as a between-subjects variable, and the rated target (an average general nurse vs an average comprehensive nurse) as a within-subject variable. All dimensions showed a significant main effect of the target variable, and a significant target x rater interaction effect. In addition, there was a main effect of rater on the comprehensive dimension (see Table 4).

The interaction effects were examined by graphing the cell means. The comprehensive dimension graph (see Figure 1) revealed two features. Firstly, both groups of raters evaluated the comprehensive target as superior to the general target. Secondly, the relative superiority of the comprehensive target was accentuated by comprehensive raters and attenuated by general raters. The results of the general dimension (see Figure 2) were a reversal of the comprehensive dimension results. Here, there was consensus concerning the superiority of the general target over the comprehensive target, and the general raters exaggerated their ingroup's relative superiority. Finally, on the common dimension, both groups of raters

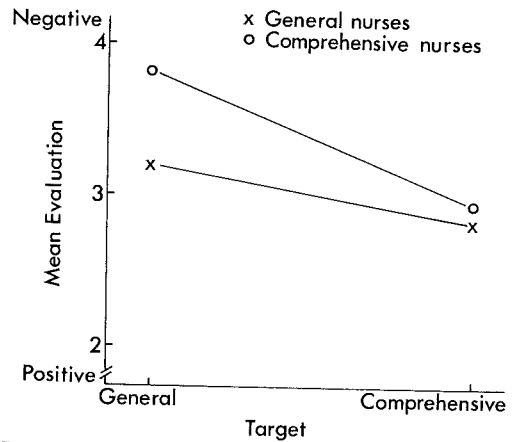


Figure 1. Evaluation of an average general nurse and an average comprehensive nurse on the *Comprehensive Dimension*.

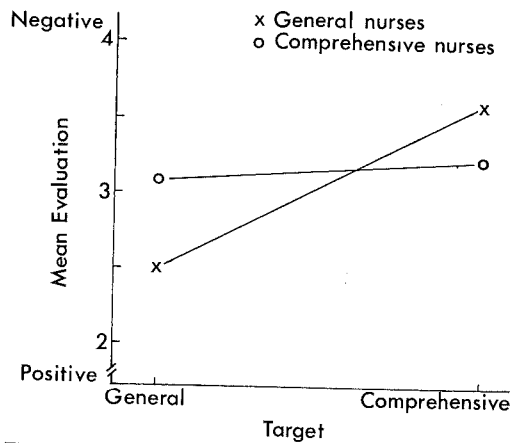


Figure 2. Evaluation of an average general nurse and an average comprehensive nurse on the *General Dimension*.

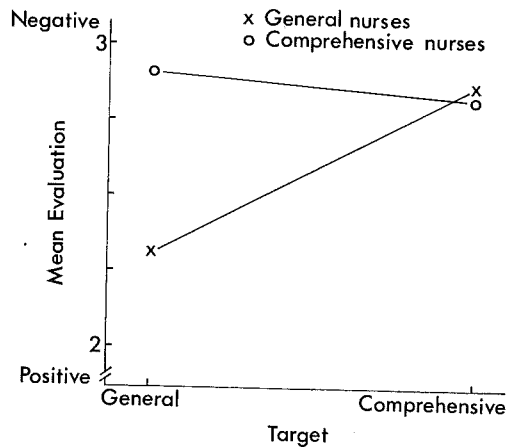


Figure 3. Evaluation of an average general nurse and an average comprehensive nurse on the *Common Dimension*.

evaluated their respective ingroups more favourably than the outgroup (see Figure 3).

Though not required for purpose of hypothesis-testing, it would be interesting to compare the four cells that showed ingroup favouritism. Two of these cells were in the common dimension (see Figure 3), and two others were in the respective dimensions that were relatively unique to the groups concerned, i.e. comprehensive dimension for comprehensive raters (Figure 1) and general dimension for general raters (Figure 2). The latter two might be thought of as unique dimension ingroup favouritisms, in contrast to the former, common dimension ingroup favouritisms. The unique and common dimension favouritisms were treated as a within-subject variable, which was combined with the rater variable to form a two-way mixed ANOVA design. Ingroup favouritism, the dependent measure, was formed by subtracting outgroup evaluation from ingroup evaluation. The results showed no significant interaction effect but main effects for dimensions, $F(1, 68)=33.3$, $p<.001$, and for raters, $F(1, 68)=4.9$, $p<.05$. In absolute terms, the common dimension elicited *less* ingroup favouritism than did the unique dimension (means = -0.32 vs -0.99), and general raters showed *more* ingroup favouritism than did comprehensive raters (means = -0.83 vs -0.48). Finally, correlational analyses were carried out to examine if ingroup favouritism on a particular dimension was correlated with the importance rating assigned to that dimension. Pearson's product moment correlation coefficients for the common and the unique dimensions were both nonsignificant, r 's = $.074$ and $.067$ respectively.

Discussion and Conclusion

Two types of data (importance ratings and degrees of training emphasis), given by two different samples, converged on a tripartite grouping of nine important nurse attributes. The resultant dimensions represented attributes that were either common to both training programmes or relatively more unique to one programme. This enabled an examination of complementary and antagonistic intergroup differentiations on theoretically meaningful dimensions. The three nurse attributes that were dropped in the process of deriving the dimensions were loaded on different compo-

nents and had middling or low importance ratings relative to those that were retained. The omission would not have distorted or seriously lowered the overall importance of the dimensions.

As one might expect from the minimal intergroup situation of the two nurse groups, the *magnitude* of the differentiations was limited. The results which were of theoretical interest was the systematic *pattern* of the differentiations. Comprehensive subjects, like their general counterparts, differentiated the ingroup positively from the outgroup on the dimension which was relatively more characteristic of their training. Both groups of subjects also sought positive differentiation for their ingroups on the common dimension, but did not do so on the dimension which was more characteristic of the outgroup. Their pursuit for positive differentiation from the outgroup was selective rather than global. In sum, the results indicated complementary intergroup differentiation on the respective unique dimensions, and antagonistic intergroup differentiation on the common dimension. More clearly than other studies of British registered and enrolled nurses (Skevington, 1981) and Dutch hospital-trained and college-trained nurses (van Knippenberg & van Oers, 1984), the present study showed how the direction of intergroup differentiation by nurses varied systematically with the nature of the dimension on which the differentiation was based.

The systematic variation cannot be attributed to the rated importance of the dimensions (attributes). Across dimensions, ingroup favouritism was smaller on the common dimension, even though the common dimension was the most importantly rated dimension. Within a dimension, it may be also recalled that the nurse groups rated the importance of each attribute in essentially the same way. Should dimensional importance affect differentiation, then the two groups should differentiate on any one dimension to essentially the same extent. Only the differentiations on the common dimension, but not on the other two, can be said to match this expectation.

The occurrence of antagonistic differentiation favours the 'salience' hypothesis over the 'satisficing' hypothesis. Salience was originally considered to be based on dimensional commonality. It can now be observed that in

addition to the commonality quality, the common dimension also comprised the most importantly rated attributes. Consequently, commonality was confounded by rated importance, and it is not possible at the present to determine whether antagonistic differentiation was due to one or both of these elements.

Finally it was noted that general subjects showed more ingroup favouritism than did comprehensive subjects. One explanation suggested by social identity theory would be in terms of the threat posed to general nurses by the rapidly increasing number of polytechnic nurse graduates and by the latter's greater career prospects. But more information is needed to ascertain this.

Individuals do not live by social identity alone. Peaceful co-existence with others is also essential to life. The ability to promote a positive social identity, without unnecessarily antagonizing others, lies partly in the complexity of the individual cognitive system and in the survival value which such a system may provide. Social psychology should adapt its theories of intergroup relations to fully account for both the successful and the seemingly unsuccessful realization of this ability. Social identity theory can be so adapted by developing the concepts of complementary and antagonistic social identities. The present study, which demonstrated elements of complementary and antagonistic social identities in evaluative intergroup differentiation, represents a development in this direction.

A related development will be to look at the task performance of groups. Deschamps and Brown (1983) found that groups working jointly on a task differentiated from one another less when they were assigned distinctive, non-comparable roles than when their roles were comparable. In the natural setting where the groups could design their own tasks and roles, one may expect from the viewpoint of complementary social identities to find a preference for distinctive over comparable roles.

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