FEELINGS AND ATTITUDES OF PULMONARY TUBERCULOUS PATIENTS SUBSEQUENT TO DIAGNOSIS AND DURING HOSPITALIZATION

by

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To my son, Dean Roger, and to my family, I extend my deepest plaudits for their interest and patient understanding during the completion of this project.

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CHAPTER I

Introduction

Interest in understanding the "total" person who comes for tuberculosis treatment has been encouraged for many decades. The student entering the social work profession, whose field placement is in a tuberculosis hospital, is immediately confronted with the need for this understanding. Student-supervisory conferences inevitably center around efforts to develop this understanding in order to adequately prepare the student to fulfill the enabling role. Knowledge of the patient's physical condition as related to his feelings and attitudes regarding the illness, and the resulting limitations, is considered to be the basis for this understanding. The reactions of the patient are the observable clues by which to better understand him. It was in realizing the need on the part of the social worker to learn about the total person that interest in this type of study originated.

That tuberculosis is a disease affecting the entire social organism is recognized by even the most somatically oriented practitioner. The patient has innumerable problems, not the least of which is that he faces an illness which can be, at best, only arrested, never cured.[1] Treatment requires months and often years, during which the patient must be away from home and family for inestimable periods of time.

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[1] Edward Weiss, M.D., and O. Spurgion English, M.D., Psychosomatic Medicine. (2nd ed: Philadelphia: W. B. Saunders Company, 1949) p. 615

Even though the patient returns to a modicum of health the process may be most difficult. With present chemotherapy the patient generally feels better much earlier in the treatment process, which fact often creates further emotional problems. The social worker considers the factors contributing to these problems and attempts to help the patient in the process of adjustment .

The problem is a study of patient attitudes and needs subsequent to diagnosis and during hospitalization. The basic reason for such a project is involved with the assumption that the tuberculous patient has attitudes and needs peculiar to, and resulting from, the illness and that there are services by which to meet these needs. If we accept the premise that the attitudes of an individual are usually defined by his previous experiences, individual reactions would be of assistance in the rehabilitation of the patient.

The patients' attitudes and feelings are often indications of his understanding of tuberculosis as conditioned by his economic, social and intellectual perspective. To discover something about the patients' reactions to hospital services a questionnaire for a controlled interview was developed.[1] Within this structure the patient was given opportunity for self-expression which would hopefully yield to evaluation and analysis. It was believed that the social work philosophy could

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[1] Boring, Langfeld, Weld, Foundations of Psychology, (New York: John Wiley and Sons, Inc., 1948) pp. 560 - 567

be applied in three ways: (1) in the development of the structured interview, (2) in the actual interviewing process, and (3) in the evaluation of the reactions.

The focus of the study was to determine the surface reactions as related to the following specific areas:

1. How does the patient feel concerning his illness and subsequent hospitalization?

2. What are the typical (general) reactions found among the patients?

To understand the patient, one must grant him the opportunity to express how he feels about the illness and how his family feels. His reactions may indicate something as to whether or not services are adequate to meet his needs. It is, in a sense, the study of inter-relationships. Present day medical practice is predicated on attention to the combination social, emotional, and pathological forces in treatment. If this be so, then the reactions of patients regarding available services and facilities would be useful indices of needs, either met or unmet. Knowledge of this type could conceivably provide an avenue to the integration between the understanding of, and the needs of the patient.

Further motivation to conduct this study was the realization that relatively few social work students have the opportunity to work in a tuberculosis hospital setting in Michigan.[1] Worker's requirements are basically the same as one reviews social work skills and knowledge,

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[1]Interview with Margery Ross, Assistant Professor of Social Work, Michigan State University. February, 1956.

but the added necessity to avail oneself of pertinent medical information is imperative. One must, at all times, be cognizant that the individual and his "total" life situation is inevitably involved with tuberculosis. The worker's focus is on the personal - social problems incident to the illness. The patient, family, worker - team approach is necessary to help in solving these problems.[1]

Thus, the study is devoted to an examination of attitudes and needs subsequent to diagnosis and during hospitalization. The writer will present a description of the hospital, a review of general literature on social work with tuberculous patients, and the findings from the questionnaire. Any implications which may be drawn from the evaluation of the findings will be stated in the concluding chapter.

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[1] Weiss and English, op. cit., p. 617

CHAPTER II

History of Ingham Chest Hospital

Since the hospital was opened in 1913 tremendous progress has been realized in the physical structure, scientific treatment and services of qualified personnel.[1] Evolution stems from an original ten bed facility, manned by one nurse, a maid and a janitor, all under the medical supervision of six Lansing physicians. By 1919 the bed capacity grew to thirty-six and in that year the first medical director was appointed. The entire forty-three year history of operation records the services of only three medical directors. The first was replaced after four years and the second appointee resigned after thirteen years of service. The third and present director is completing his eighteenth year of service in May of this year.

Administration of services and facilities for patient care is delegated by the Medical Director, C. J. Stringer, M.D., to the following key personnel: A. L. Stanley, M. D., Assistant Director, who is completing twelve years of service in this hospital; Valere Trapp, R. N., Directress of Nurses since 1944; Olive Henderson, Directress of Food Service for sixteen years, and Kenneth Crouse, Business Manager for twelve years. One can readily see that the administration has been conducted by the same individuals during the past twelve years.

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[1] C. J. Stringer, M. D., Director Ingham Chest Hospital. Collection of unpublished articles.

Rehabilitation services are of comparatively recent implementation in the hospital care program. None the less, in just ten years since the service was inaugurated, many changes have occurred. The department has the services of an Occupational Therapist, a Librarian, a School Teacher, and presently, a Social Worker. Direction has varied from that of a Psychologist, a Vocational Counsellor, and a Social Worker, to the present status of no coordinator, as such.

Prior to the appointment of C. J. Stringer, M. D., surgical cases were transferred to the University Hospital in Ann Arbor, Michigan. Under his able direction, a surgical service was inaugurated in the institution in 1938. At the present time, Ingham Chest Hospital is the surgical center for sanatoria located in Marquette, Houghton, Muskegon and Powers. The staff also conducts the surgical program at Ionia State Hospital and Traverse City State Hospital.

In 1948 facilities were such that authorization was initiated to permit admission of non-tuberculous thoracic surgery cases. On January 1, 1955, the name was changed from Ingham County Tuberculosis Sanatorium to Ingham Chest Hospital, the reason being that the progress and character of treatment services and facilities has been such as to make the previous designation incomplete. Since 1948, and especially in the recent two or three years, much of the hospital's work has been concerned with the treatment of chest diseases other than tuberculosis.

The hospital operates in three primary divisions:

1. Out Patient Department: Responsible for the conduct of all hospital activities outside of the hospital, such as; case finding, follow-up studies, operation of the mobile X-ray unit, and contact with other physicians.

2. Hospitalization: Responsible for all activities conducted within the hospital for the care and treatment of in-patients.

3. Rehabilitation: Includes program of occupational therapy, library facilites, education up to college age and medical social service, involving counselling of in-patients prior to return to gainful occupations and adjustive living.

The philosophy involves a faith in the fundamental value and integrity of human life and a conviction that by positive action, services can be employed which contribute to the maximum adjustment and usefulness of the patient.

This is the structure within which the social worker functions. Often the tuberculosis patient enters the hospital with various concerns. He can be helped to work out his own problems and to resolve the confusion of feelings with satisfaction if the social worker's understanding approach is accepted.

Description of the Setting and Review of Literature

Description of the Setting

Ingham Chest Hospital is a relatively small, compact, modern institution with a capacity of one hundred forty one beds. Although it is designated as a general chest hospital, only about twenty percent of the cases are non-tuberculous. The age span of the tuberculous patient is wide. At the present time, April 27, 1956, the

hospital population consists of the following age groups:

Years 0 through 9	13
10 through 19	8
20 through 29	14
30 through 39	13
40 through 49	8
50 through 59	8
60 through 69	11
70 through 79	6
80 and over	2

Of the total patient group, approximately ten are non-tuberculous; fifteen are surgical (tuberculosis transfers and other chest cases), and the remainder are on bed rest and drug therapy. Bed rest implies graduated bath room privileges and occasional modified activity. Patients wear masks at all times when not at their bed side and are prohibited from kissing or holding hands with relatives or friends. They are placed in a single room with private bath or in three bed wards with community bathrooms.

The hospital is constructed on the T plan, which provides for three wings; east, west and south. The physical plant has been improved throughout the years in various ways. Mainly, the improvements have provided more adequate facilities with which to serve a larger number of individuals in need of thoracic care and treatment.

The four floor structure is laid out as follows:

General Administrative offices are located on the first floor as are the Out Patient Department, Observation Ward, and the Pediatrics Ward. The patient is admitted through the Out Patient Department and adults are usually referred to the

second or third floors (male patients to second and female patients to third.) Both floors contain some single rooms and three bed wards. Surgery is located on the fourth floor, along with private rooms for care of surgical patients.

The basement south wing houses social service, including Occupational Therapy, Library, Medical Social Service and School Room. A teacher, trained in special education, provides instruction for patients under twenty-five years of age. This wing also contains an auditorium which augments patient services and provides space for class instruction for nurses' training.

Food service is located in an adjoining building, connected by a tramway. Food is prepared and transmitted to the patients in steam carts. A cafeteria for staff is located in this building.

The above description of Ingham Chest Hospital indicates something of the physical aspects attending the tuberculosis patient. The entire facility would be useless unless manned by efficient, coordinated, well-trained professional and non-professional personnel. From the trained staff the patient learns about the disease, how it spreads and how to avoid infection to others. There is opportunity for X-rays and chemotherapy as well as needed surgical treatment. The total function of the hospital is geared to the care and rehabilitation of the patient.

Because the tuberculosis patient usually requires long hospitalization, it would be impossible for the average individual to bear the costs involved. Therefore, in the State of Michigan, the patient is eligible for care in a tax-supported institution within the county where residency is established. In addition to alleviating the drain on family finances, this factor provides in most instances for care near to family and friends.

Previous Studies and Current Literature

Many articles have been written which offer support and information helpful in this study. The writer has attempted to confine the review to the focus of the study, and in so doing finds that available literature reveals little which would indicate that previous studies are analogous to the nature and findings of this one. Interest in the patient as a "total" organism is considered and reported on in various ways.

Rachel Faude Wood[1], formerly Directress of the Rehabilitation Department in this institution, completed a Masters project in 1952 regarding AMA[2] discharges. Her study included interviews to obtain her data and information gathered from medical and case records. Consideration was given to age groups, family pressures, length of hospitaliz-

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[1] Rachel Faude Wood, "Discharge Against Medical Advice," Research Project, Ingham Sanatorium, Michigan State College, (1952)

[2] Against Medical Advice

ation and the extent of illness involved.

Findings from that study indicated conclusively that discontent on the part of patients was relatively unimportant as a reason for leaving against medical advice. The largest percentage left because of family pressures. Another interesting conclusion which Wood made is that sixty-three percent of the patients who left against medical advice did so within the first five months of hospitalization. Although the focus of that study was different from the writer's, it is conceivable that the feelings and attitudes of the sixty-three percent leaving during the first five months were responsible for the inability to adjust to hospital requirements.

The most valuable social work literary contribution to this study is considered by the writer to be that of Minna Field.[1] She covers what the illness means to the patient plus his reactions to all phases of hospitalization and considers attitudes involving the adjustive problems of the patient.

At the time she wrote this book, Field was Assistant to the Chief, Division of Social Medicine, Montefiore Hospital, New York. Her ambition in writing this volume was to present the "evolution of a concept of integration of medical and social care of the sick which was influenced more deeply by increased understanding of human behavior

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[1] Minna Field, Patients are People, (New York: Columbia University Press, 1953)

and by broad social changes than by any single historical fact."[1] She develops this by use of case material and her own concepts which were formulated by many years of service in a general hospital. The emphasis is on prolonged illness which is aptly described as "an extension of acute disease over a longer period of time."[2] When actually confronted with diagnosis, the tuberculosis patient is faced with extreme adjustment. The diagnosis is a symbol to which everyone reacts differently, but with basic common confusion. The social problems resulting from a diagnosis of tuberculosis permeate every facet of the individual's life. The threat to the prognostic implications for the patient's future is greatly involved with the relationship between the physical and emotional balance.[3]

The author considers what the illness means to the patient as it interrupts the ordinary pattern of living. She indicates the "life factors" as the determinants of individual differences in reacting to illness. In the discussion of treatment, she considers patient reactions to the illness and to the meaning of hospitalization and past hospital adjustment. In the final chapter, Field states "....no matter what aspect of prolonged illness we consider, we find that facilities for care are either completely lacking or are grossly inadequate

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[1] Ibid., p. 3

[2] Ibid., pp. 78 - 79

[3] Ibid., p. 8

to meet the needs."[1]

Social work with the tuberculous patient is specifically discussed in a paper by Pauline Miller.[2] She was serving as a special consultant to the Medical Social Section, Division of Public Health Service at the time it was written. The focus which Miller used was that of the problems which patients present when faced with a diagnosis of active tuberculosis. She discusses the way a patient accepts the illness as related to his adjustment to hospitalization. The recognition is indicated that the individual determines the movement toward a goal of well-being. The paper was helpful to this present study as it indicated the efforts of the social worker to meet the individual where he is, in his feeling, and recognizes with him his capabilities and capacities to help himself.

The necessity to approach the "patient as a whole" is never of greater importance than at the point of diagnosis of tuberculosis. That the emotional aspects of tuberculosis reveal themselves through physiological manifestations is never more obvious than just following the diagnosis. Up to this point, unless the patient actually suspects tuberculosis, organic malfunctioning is of major importance. At the point of diagnosis, however, the psychic aspects come

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[1] Ibid., p. 184

[2] Pauline Miller, Medical Social Service in a Tuberculosis Sanatorium. (Washington: U. S. Public Health Service Publication No. 133, Government Printing Office, 1951) p. 11

into the picture in often times greater proportion.[1]

A characteristic of the psychic aspect observable in chronic illness is regression and it varies according to the degree of need which the individual is facing. At the time of diagnosis, one could speculate that the individual is suddenly at his greatest point of shock and subsequent dependency. Only as he progresses, do the dependency needs lessen and the patient returns to some degree of adjustment. It is with this initial reaction that the medical social worker is concerned. Understanding the inter-relationship of the organic disease to the individual personality is of obvious necessity to one interested in helping the "patient as a whole."

Any evaluation of needs and services, whether it be in the person or in the material facility used to help the person, is inevitably involved with complexities. The factors to consider are innumerable, creating an even greater necessity to attend to the understanding of inter-relationships. The reaction of the patient to a diagnosis of tuberculosis places much demand upon treatment processes conducive to meet emotional needs. The patient must, of necessity, be helped to alleviate dependency behavior to a degree concomitant to his physical restrictions.[2]

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[1]Harriet M. Bartlett, Some Aspects of Social Casework in a Medical Setting. (Chicago: American Association of Medical Social Workers, 1940) pp. 115 - 140

[2]Frances Upham, "A Dynamic Approach to Illness." Family Service Association of American, New York, (1949) pp. 16 - 17

In considering all reactions, attention is drawn to the person and his behavior as modified by his background. What the individual brings to the initial experience of hospitalization for tuberculosis determines to a great extent, his reaction. Our society has traditionally popularized the concept of hospitalization as a fearful experience which demonstrates the seriousness of illness. Furthermore, the American concept of survival and responsibility is inconsistent with the husky, strong individual succumbing to long hospitalization, which is so often necessary in tuberculosis. Thus, many individuals still regard hospitalization as an indication of weakness and extreme incapacity.[1]

These fears and apprehensions traditionally perpetuated in our society are further accentuated by the forced separation from family, friends and the normal patterns of activity. The demands upon the individual up to this point have been of much magnitude. First, he experiences either consciously or unconsciously, the physical symptoms of abnormal organic functioning. Secondly, the traumatic experience of the diagnosis of tuberculosis which inevitably leads him into this phase of initial hospitalization.[2]

Another tendency noted is that of rejection. Patients often react to the initial hospitalization by completely rejecting the diag-

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[1] Miller, op. cit., pp. 1 - 3

[2] Ibid., pp. 8 - 9

nostic reason. They feel they are hospitalized "just for a check up" and indicate resignation to the necessity of the check up only so that "Then I'd know." This aspect might well be an escape for many from the recognition of reality. However, one is thoughtful of our modern education to appreciate the benefits of hospitalization as a means of securing these tests and routine check up. Therefore, many are emotionally incapable of accepting even the possibility of their being tuberculous and look upon the hospitaliztion as a welcome rest while tests are being run. These patients invariably experience much the same emotion when the initial diagnosis is confirmed by tests as do patients who accepted the diagnosis originally.[1]

To the writer, behavior is not something which can be tabulated, coded and placed into convenient slots to be reviewed for future prediction. It can, however, be indicative of clues to which the social worker tunes the pace of service. It was with this thought in mind that consideration was given to pursue this type of study.

Initially, the hospital is built for the specific purpose of serving the physically ill individual by helping to restore his health. The objective is to offer to the patient the opportunity to combine his own strengths and resources with medical care to attain maximum health. The initiation of medical care implies the use of services, skills, and facilities of many disciplines. The hospital can only offer services

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[1] Field, op. cit., pp. 81 - 84

if these disciplines are coordinated and synchronized. The various services involved are many and the inter-relationship complex. The medical staff, combined with the nursing staff, offer treatment in accordance with physical needs. The clerical and technical (laboratory workers, X-ray technicians) staff supply the facilitating services. The food service staff serves in still another capacity as does the maintenance staff. All are coordinated to serve the patient under the direction of administration.

All of the afore mentioned personnel combine to attend the patients' needs. A noticeable omission, however, is that of social services which contribute to the needs of the patient by understanding him as a person, and how he feels about this particular illness. This differs from, and yet compliments, the physician's treatment, in that medical treatment is administered without particular attention to the individual's background or social history. The physician treats the individual and the organic anomaly, and the social worker compliments this by considering the individual as the whole person. What he brings by way of background, plus his responsibilities, aims and goals, are considered along with the illness.[1]

The physical equipment, organization of the hospital, and the specialization necessary to an efficient, successful hospital, often result in frightened, confused, dependent, or antagonistic

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[1] Bartlett, op. cit., pp. 11 - 29

patients. The social worker attempts to help the patient relate more positively to the complexities of hospital life. To adequately meet the patients' needs the worker must, therefore, be aware of the needs and know of skills by which to meet these needs. The major areas of patient concern involve the need to adjust to hospital living; understanding hospital procedures; fear of treatment; fear of surgery and the fear of post-hospital adjustment.

The services offered in the institution will be accepted as opportunities toward getting better or resented as authoritative restrictions. The patient inevitably goes through this experience with a positive, healthy growth, or with a negative, resentful, arbitrary approach. The way he uses the experience is important, not only to himself, but later to the community he represents. The movement of any individual hinges upon his or her determination. The goal is elusive, the time required unknown, and even the most healthy, mature, individuals battling tuberculosis may lose sight of their goal.[1]

It is with this individual, the long-term tuberculosis patient, that the study is concerned. The social worker's role is to understand, and help the patient establish himself within the physical and emotional limits he represents. There are ways to help in this adjustment and to be effective, the social worker must first understand what the illness means to the patient.

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[1]Harold Nitzberg. "Rehabilitation of the Tuberculous - A Casework Process." Social Casework, XXXI, (Feb. 1950) pp. 61 - 64

CHAPTER III

Methods and Procedures

The findings of this study evolved from the use of the following tools, techniques and procedures:

1. The selection of patients
2. The introductory interview
3. The controlled interview
4. Use of the medical and social case histories.

Each of these items will be considered separately and in the order used in the study. Attention will be given to the development and use of each.

The Selection of Patients

On December 21, 1955, a study of the hospital population was made by Idella Dukes, Chief Medical Social Worker and the writer. From eighty-one pulmonary tuberculosis patients, forty-two were selected for the study. Selection was based on the following criteria:

1. All under nineteen years of age were excluded.
2. Patients nineteen through seventy-five years of age were evaluated by Idella Dukes. She had previous contact with all and the selections were based on her knowledge of the patients' condition. Excluded were: patients physically handicapped through deafness, blindness, too ill or mentally incompetent.

Of the forty-two patients selected for the study, nine were discharged or left AMA[1] before being interviewed and three refused to participate.

Of the three patients refusing to take part in the study, two were

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[1] Against Medical Advice

women and one man. The man, aged sixty, was interned on the Observation floor in a locked room as a result of legal commitment. Initially, he was receptive to the idea of the study and invited the worker to sit down, while comfortably situating himself. As the first question was asked, he sat up and stated, "On second thought, I want no part of this." He went on to relate his extreme anger at being housed in a locked "cell" and showed hostility over his inability to obtain a medical discharge. Aware of his emotional state, the worker indicated understanding and reminded him that it was his privilege to decline. However, should he reconsider, he could feel free to have the nurse call for a later interview.

The two women patients who refused, did so rather subtly, by constantly indicating suspicion. When appointments were made, they repeatedly excused themselves as unable to participate. One of these women made four appointments and on each occasion refused for physical reasons. The other patient could never bring herself to openly refuse, but her apprehension was so obvious as to cause her name to be withdrawn from the study.

From the remaining thirty-three patients selected for the study, the following facts were compiled:

1. The age range is from nineteen to seventy-five years.
2. There are twelve females, ages twenty-three to seventy-five years.
3. There are twenty-one males, ages nineteen to sixty-eight years.
4. Of the total group, eighteen are married.
5. Of the eighteen married, fourteen have from one to sixteen children.

Each patient was contacted on two occasions. The first during the introductory interview, which lasted about five minutes. The second contact was during the controlled interview which lasted no less than one-half hour and no more than one hour, the average lasting about forty-five minutes. Although it was discovered that questions permitted the patient opportunity for catharsis, no therapeutic aim, per se, was intended in the research interview.

The Introductory Interview

A brief bedside contact with each of the patients selected for the study gave opportunity to introduce the worker and invite their participation in the study. About five minutes were spent explaining that they would be given the opportunity to express their feelings regarding specific questions. In each instance it was indicated that they were not obligated in any way to participate if they preferred not to do so. After relatively few patient contacts, however, the hospital "grapevine" portrayed a rather complete summary of the process involved, which resulted in a veritable eagerness on the part of the other patients to participate.

The Controlled Interview

Any consideration of attitudes implies interest in what an individual perceives and how he behaves. Much literature has indicated that behavior is directed by acquired attitudes. These attitudes, whether widely socially accepted or unique to one individual, are considered to

be the result of experience.[1] Therefore, to discover attitudes, one must know something of the individual's life history and personality. The most direct way to explore this area seemed to be to create open questions, which, when used in an interview situation, would allow the patient to project his attitudes and feelings into the answer. In so doing, the writer might expect the reactions to be spontaneous and revealing.

Discussion with Idella Dukes, Chief Medical Social Worker, and other members of the hospital staff served to narrow the focus. It was decided to devise questions which would indicate pertinent data in the patients' history, while specifically structuring them to bring out the patient feelings and attitudes. Attention was given to the order and type of questions. Efforts were made to avoid vague or obscure questions and to eliminate the use of technical or unfamiliar words. Considering that many individuals like to talk about themselves, it was decided to begin with the patient and discover what he thinks about most.

As the controlled interview was the major tool employed, it is well to consider how and where it was conducted. Following the introductory interview, the worker made plans to schedule appointments with the patients. At the appointed time the worker accompanied the patient to a private interviewing room. Every effort was made to create

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[1]Boring, Langfeld, Weld, op. cit., pp. 560 - 567

an atmosphere of acceptance and rapport. At the beginning of each interview the patient was reassured that the information given would be held in confidence. On some occasions opportunity was given for the patient to reduce observable tension by general discussion or questions in which he might indicate interest in order to prepare for maximum participation in the interview.

The procedure of the controlled interview was not a question and answer technique, but a structured interview. To illustrate this process, consider the responses of a mother of five children, whose diagnosis is far advanced pulmonary tuberculosis, when asked, "what do you feel caused your illness?"

> "Overwork, I guess. I had four children to take care of by myself as my husband was in the service. We had moved out on a farm in the country. There was a pump, but it didn't work because soon after we moved there the kids threw sand in it, so I had to lug water from a neighbor's house about one-half mile away. The kids were all pretty young and couldn't help much. I was tired all the time and so run down. It must have been that because the only person I ever knew who had tuberculosis was a neighbor. She lived next door to us about ten years before I ever got sick. I took care of both her and her little girl and didn't know they had tuberculosis until after they died; she never told me."

Another response to the same question was that of a man who indicated his feelings as to how he became infected as follows:

> "Oh, just exposure, I guess, and a swift life. I've been the kind of fellow with questionable habits on the outside. I have no family and so no responsibility. Life for me wasn't involved. I drank heavily and was partying all the time. It's unbecoming to think of that life now; it doesn't even occur to me when I'm not with others of the same crowd. Say, Mrs. P., mind if I ask you; could you get tuberculosis by neglect or exposure?"

I told him this was an interesting question and asked if we might consider it at another time and he was agreeable.

These excerpts of interviews illustrate the writer's belief that this type of structured interview offers material of an evaluative nature different from that obtained by use of a questionnaire. All of the interviews were conducted and evaluated by the writer and the findings are discussed in the following pages.

Medical and Social Case Histories

These records were used mainly to obtain factual material such as date of admission, diagnosis, age, sex, marital status, family, occupation and schooling.

CHAPTER IV

Presentation and Analysis of Data

In order to adequately present the findings of this study, each question of the controlled interview was broken down into general responses. The questions were evaluated individually and the major responses tabulated. The limitations of such a procedure are recognized as those involving the elements of personal equation and subjective judgement, wherever one person does the evaluation, as did the writer. Conscious effort was made to avoid analytic interpretation of the interviews with the patients, which were, as far as possible, recorded verbatim and the evaluations made in accordance with the reactions as stated by the patient.

The first part of this chapter will be devoted to discussing data obtained from specific questions.[1] The question will be stated and the general classification indicated. Not every question will be used in this manner, as some elicited answers which did not yield to classification, as will be noted. In some instances sample responses will be included to illustrate feelings and attitudes, as well as to show the writer's efforts at affecting an objective evaluation.

As the data were evaluated it became obvious that the patients' reactions to the controlled interview fell into four major responses, these being:

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[1] See Appendix

1. Reactions to Symptoms
2. Reactions to Diagnosis
3. Reactions to Initial Hospitalization
4. Reactions to services and Facilities

For purposes of analysis the data will be discussed in relation to these four classifications of responses.

Feelings and Attitudes as Revealed by Interviews

Adjustment to hospital living requires much effort on the part of all patients. The bewilderment of quietude and rest periods in a tuberculosis hospital is undoubtedly conducive to feelings of strangeness and loneliness. Furthermore, the presence of technical machinery manned by skilled, white-clad technicians, undoubtedly holds some fear for all on the first admittance. Schedules for meals, rest, visiting, personal care and housekeeping services leave little opportunity for personal attention by staff. One of the patients interviewed mentioned having relatives and friends come from a distance of more than one hundred miles only to be told they could not see him because there were no scheduled visiting hours at that time. Another told of the necessity for eating within an allotted time when throughout his lifetime he had always eaten at a later hour and spent a considerable amount of time eating.

The first question was intentionally placed at the beginning of the interview to encourage the patient to talk about himself. It was felt that in this manner the focus would immediately be patient-centered, while at the same time, a yes or no answer was not warranted.

The answers in most instances were rather terse and contained little elaboration. Predominantly, the patients seemed preoccupied with their plans for the future.

What Do You Think About Most?

	Women	Men
Going Home	1	10
Getting Better	9	5
Future Plans	2	6

At first glance one is impressed with the fact that there is a difference in the focus between the men and the women patients interviewed. Of the total group of twenty-one men, nearly half were anxious about "going home," while only one-fourth indicated much thought about "getting better." Whereas, of the twelve women patients participating in the study, three-fourths were concerned about "getting better" and only one mentioned specific thoughts about "going home." Some typical responses will illustrate this point more clearly:

1. One man said, "Nothing bothers me; just want to go home."
2. Another man said, "I'm anxious about getting out."
3. A father of two children said, "Oddly enough, not about getting out; it's about the future, what kind of work can I do?"

Typical responses from women patients were:

1. "I think too much of tuberculosis all the time. Don't worry though. I'll get better."
2. "I think first of tuberculosis and then about God and death."
3. "Wonder what will happen when I'm released."
4. "Getting well and being able to live again."

Considering that tuberculosis often strikes individuals in the

productive years of their life, it would seem understandable that the male individual would be faced with somewhat different thoughts. He is the wage earner, and as such, is faced with the problem of adequately providing for his family. Therefore, the plans for his future and going home are conceivably realistic. In the case of the female patient the reverse seems to occur, which is fortified by the cultural pattern, that the woman is entitled to care.[1] This incapacity is a veritable preservation of status. The attention which they demand is involved with their ability to be possessive, even in a hospital bed.

Although the first question was answered quite quickly, the second encouraged elaborate replies. In the majority of cases it revealed answers involving other questions. The implications of prolonged illness often present a fearful experience. How the patient reacts to symptoms is determined largely by his personality and his expectations of life which involve his goals and ambitions. Regardless of whether he accepts or rejects recognizable symptoms, he inevitably must alter his way of life. When asked how they discovered their illness, they usually elaborated on whether or not they had symptoms, how they reacted to them, and what they did about them. In their answers, one can begin to understand something of their personality characteristics, a bit about their background, and often their acceptance or rejection of the implications of symptoms, by their reference to duties, responsibilities and ambitions. The question seemed indicative of the following

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[1] Field, op. cit., p. 79

factors:

How Did You Find Out You Had Tuberculosis?

	Women	Men
Routine X-ray	4	14
Symptoms - Tuberculosis not suspected	6	14
Symptoms - Tuberculosis suspected	6	7

The patients who had routine X-rays are those who had health examinations to meet employment requirements, who voluntarily used the services of the mobile X-ray unit of the hospital. The remaining fifteen patients interviewed were discovered to have tuberculosis as a result of various routine X-rays, such as general surgical cases who, under the present system of hospital treatment, are routinely given chest X-rays; prenatal examinations; school examinations or induction examinations for United States service. However, the writer did observe that those individuals whose illness is not discovered routinely, usually do not seek help until the symptoms become rather severe. The tuberculosis patient interviewed in this study who may or may not have suspected this illness, but those who learned about it as a result of a routine X-ray, had various feelings about the method of discovery. Some typical responses were:

1. "Imagine going to apply for a food-handler's card and after my X-ray being told I had tuberculosis. I was just floored."
2. "The doctor just sent me in for a rest and an X-ray was made. When he told me tuberculosis, all I could say was, 'You don't mean to tell me tuberculosis!' I was shocked.
3. "I felt I had it..sort of intuition I guess, so when he told me I wasn't surprised."
4. "Was taken to hospital with pneumonia. I couldn't

"understand why they found tuberculosis when pneumonia was what I went in with."

5. "I never had one symptom. Always worked fourteen to sixteen hours a day and home at night. Went for a routine X-ray for a job and when they told me I had tuberculosis I thought they were lying, and still do."
6. "I was getting along fine, working in the shop and on the farm, and when the foreman came along and said, 'Take an X-ray', I did. Never so shocked as when the doctor said I had tuberculosis. Sure think that mobile unit is no good."
7. "Never so upset in my life as after I had that X-ray at the shop. Don't know how they can tell like that."

When specifically asked about symptoms and how they felt about them, most patients rationalized them as due to cigarette cough, weather conditions or overwork. The writer was aware that many patients had worried but most ignored or sublimated these worries by rationalization as mentioned. For purposes of this study, the attempt to group symptoms into classifications seemed less meaningful than to list some actual verbalizations which the patients shared. In this way the reader can more readily identify attitudes and feelings. Typical answers were:

How Did You Feel About Your Symptoms?

1. "I wasn't worried, but I wondered...."
2. "Plenty worried, thought I'd better see my doctor."
3. "Scared, but hated to go have an X-ray."
4. "I knew I should see a doctor, but I was so worried."
5. "Didn't feel they were important."
6. "Worried when I coughed, but didn't really think it was serious."
7. "I figured there might be something wrong, so I went to a druggist who gave me vitamins and cough syrup. Never thought of going to a doctor, though."
8. "I was frightened, but never thought of a doctor."

Obviously, the patient with symptoms which caused concern but which were not severe enough as to immediately incapacitate the individual, had much conflict about seeking help. All individuals who submit to treatment are faced with major changes and it is not too surprising that patients deceive themselves about the nature of their symptoms.[1]

The usual reaction to the diagnosis of tuberculosis is shock or the feeling of being overwhelmed by a condition, the implications of which cannot be fully realized.[2] The individual is in a sense alerted to danger, therefore, he responds with fear. Indications are that even though the patient knows very little of the implications which tuberculosis holds for the individual, he does recognize the traumatic circumstance involved. When asked:

How Did You Feel When You First Learned You Had Tuberculosis?

	Women	Men
Extremely depressed	5	13
Shocked and Uncertain	8	9
Resigned and Frightened	6	7
Relieved but Unhappy	1	3
Angry	1	0

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[1] E. D. Wittkower, H. B. Durost, and W. A. R. Laing, A Psychosomatic Study of the Course of Pulmonary Tuberculosis, (Washington: U. S. Department of Health, Education and Welfare, 1955) p. 205

[2] Eugene Pumpian-Mindlin, M. D. and Samuel Futterman, M. D. The Role of Emotional Problems in Tuberculosis, A paper presented at the Institute for Social Workers on Medical and Social Aspects of Tuberculosis, May 9-11, 1950, (Washington: U. S. Department of Health, Education and Welfare, 1950) p. 4

There is an over lapping of some responses because many persons reported various reactions. Of the total group of thirty-five persons interviewed, all but one indicated consternation regarding the diagnosis. It is felt that the patients' initial reactions tend to become a behavior pattern which may conceivably influence all later attitudes and reactions.[1] Furthermore, his emotional reactions to the illness may well play a decisive role in his physical progress. The following are excerpts taken from specific interviews and demonstrate the extreme emotional implications which the discovery of tuberculosis elicits on the part of many individuals:

1. "Terrible; I cried and thought I might as well die right then."
2. "I stiffened, thought of my family; everything was upside down."
3. "Mad at the world in general."
4. "Terrible blow which hit me."
5. "Terrible thing; I felt I'd be a semi-invalid the rest of my life. Could not study music nor follow nursing."
6. "Completely stunned."
7. "Wanted a dose of poison. Felt desperate."
8. "Depressed, couldn't believe it; disgusted."
9. "Didn't even register."
10. "Like committing suicide. Afraid, heartbroken."
11. "I'd like to have died right then."

Many individuals, when given a diagnosis of tuberculosis, understandably experience an initial shock. Although depression and ap-

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[1] Jules V. Coleman, M.D. "Attitudes of Professional Personnel in the Treatment of the Tuberculous." Washington D. C.: U. S. Department of Health, Education and Welfare (1954) p. 4

prehension seem to be found in varying degrees of intensity in most of the patients interviewed, the night following the initial diagnosis was traumatic for all. Anxieties regarding leaving home, families and friends, plus the recognition of reality factors created intense reactions. The responses to this question indicate the recognition of the reality factors and some of the accompanying attitudes. To evaluate the answers to this question without losing the essence of feeling tone which the patients related, the following excerpts are illustrative of reactions most indicative of patient feelings and attitudes:

1. "I cried until I was sick."
2. "I couldn't eat, just felt awful."
3. "The night was the worst I ever put it. I woulda blowed my head off if I'd had a gun."
4. "I thought all night long, my wife cried, and I felt horrible."
5. "Couldn't wait to get to the hospital. I thought of death and felt I'd infect the children."
6. "Very upset about leaving my husband, wondered how he would manage meals and home, but I was resigned."
7. "Didn't sleep. That night seemed like 1,000 years. Worried about leaving family, everything seemed terribly upside down."
8. "Took everything into consideration. By morning I knew there was no alternative but to come."
9. "Felt filthy dirty. Knew I'd not get near my family."

The night for most patients seemed interminable, but by this time all indicated some feelings regarding the responsibilites which they held in relation to their knowledge of the illness. It would seem that the first forty-eight hours in the patients' adjustment is a crucial time. The availability of skilled services to help patients express some of their anxieties and attitudes might conceivably free

him to view reality and face the future more positively. During this initial period, the patient often loses himself in a conflict of emotions. These involve the requisites of isolation by which to protect his loved ones and society in general, and the need for sustained help and increased affection at a time during which the very nature of the illness dooms him to a certain amount of rejection.[1]

When questioned about how the patient felt at the present time about the illness, a change in the feeling tone of the interview was noted. The vividly recalled emotional connotations which were related by the patients up to this time were undoubtedly involved with initial reactions to the diagnosis and resultant interruption in his ordinary pattern of living. How the individual perceived the illness was initially of more importance to him than was his actual clinical state. When discussing his present feelings, one notices diminished emotional involvement and something of the adjustments which the patient had made to the total situation.

In support of this, attention is drawn to the fact that the average length of hospitalization of this total group of patients was approximately eight and one-half months. The twelve women interviewed represent an average of seven and one-half months in the hospital, and that of the men, nine months. No patient had been hospitalized less

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[1] Edith G. Seltzer. "Personal Problems in the Treatment of Tuberculosis." The American Review of Tuberculosis. Vol. XLIX No. 6 (June 1944) p. 3

than three months and only one individual had been in the hospital as long as twenty-two months. Therefore, it is conceivable that these individuals represent a considerable amount of hospital time prior to the interview during which they had presumably made adjustments, either healthy or unhealthy. Evaluation of the question under consideration will no doubt make this more meaningful:

How Do You Feel Now About Your Illness?

	Women	Men
Confident	9	15
Worried	0	3
Uncertain	3	3

There are admittedly many dynamics involved in the observable changes which the reactions to this question indicate. Physically, the patients represent progress, implied by exposure to general hospital care such as, chemotherapy, bed rest and, in some instances, surgery, and the expected adaptation to hospitalization. All of which is complimented by the social worker's ability to understand the individual and to enable him to accept the limitations involved and by so doing affect personal change.

From this point on, the interviews were concerned with the patients' reactions to the care received. To understand the patient's frame of reference regarding feelings and attitudes, the initial part of the interview was devoted to the total personal situation. Application of this knowledge in this particular study involves the specific way in which the person conceives of the present treatment program.

The patients were now offered the opportunity to express themselves regarding treatment.

How Does Your Hospitalization Help in Getting Well?

	Women	Men
Medical Treatment	6	13
Forces Rest	7	12
Does Not Help	2	3
Routine	1	3

Obviously, many answers involved more than one reaction. The men interviewed seemed realistically aware of the fact that many of them would not rest at home.

Following this, the patient was asked:

What Do You Enjoy Most About Hospital Life?

	Women	Men
Handicrafts	3	9
Rest and Reading	7	7
Company of Other Patients	2	6
Nothing	2	2
No Demands	1	2

Of the total group, only four indicated they enjoyed "nothing" about hospital living. Some had difficulty deciding, as basically all reflect a normal degree of rejection of hospitalization. However, all but the four mentioned expressed preferences, including more than a single response.

The writer believes that the total staff approach to patient care may have meaning for the patients' adjustment in the hospital. Considering that first impressions may be lasting, the patient was asked:

What Was Your First Impression Of Hospital Staff?

	Women	Men
Confidence	5	8
Very Kind	5	11
Uncomfortable	3	3
Unimpressed	1	2

Many of the patients who indicated confidence in the staff also reported them as being kind. The majority experienced pleasant staff contacts, and were in most instances quite anxious to share this with the interviewer. Some typical answers were:

1. "I was lonely and felt strange. The staff was very fine; everybody I met was so nice."
2. "I was in bad shape and everyone was swell."
3. "Real nice, made me very comfortable."
4. "Very nice."
5. "Not too comfortable, but quite decent."
6. "So nice, gave me confidence."
7. "I was made comfortable; they were so kindly."
8. "Very comfy; the nurse was a darling."
9. "Very reassuring and nice."
10. "I was in tears and they didn't sympathize, but made me very comfortable."

Many questions were helpful in interpreting the findings generally, but seem to lend little by way of specific presentation. The remaining question of importance seems to the writer to be that involving the patients' suggestions regarding changes. The question was posed as follows:

What Changes In Hospital Routine Would You Suggest To Help You Recover Faster?

		Women	Men
1.	More individual time with doctors	5	12
2.	Need more orientation	5	11
3.	Outdoor activities	3	11
4.	Church for both positive and negative patients	3	1
5.	Satisfied	1	2

		Women	Men
6.	Some type of recreation room	0	5
7.	Separation of positive and negative patients	0	6
8.	Group orientation during first month	2	3
9.	Eliminate weekly rounds	4	1

Interest is immediately aroused when one notices the omission of any reference to food services. The writer is aware of the tendency of patients, even in general hospitals, to complain about having the same food day after day. However, when given the open opportunity of expression, there were very few complaints regarding food services at Ingham Chest Hospital among the patients interviewed. To show that food was mentioned, however, the following comments may be of interest:

Women

1. "I enjoy the food very much but have to eat too fast."
2. "Food is grand."
3. "Wonderful food."
4. "Food is fine considering that you can't please everyone."

Men

1. "Food is very good."
2. "Food is good and Miss Henderson watches to see we get what we like."
3. "Excellent food only sometimes too much."
4. "Food is best in the county."

These comments are interesting in that a symptom of tuberculosis is poor appetite. Olive Henderson, Directress of Food Service, visits the rooms during meal time and tries to meet individual needs whenever possible. The patients react positively to this individualized attention.

Concerning the other factors which the patients discussed in this

question, one must realize that the very treatment of tuberculosis involves impatience on the part of the individual. "In their fear of what the illness may do to them, patients frequently react to enforced bed rest with hostility, for they feel that treatment which might be beneficial is being withheld."[1] The social worker must, therefore, recognize that the reactions are often distortions of basic feelings and anxieties. Some of the interviews were indicative of this fact and the efforts of the writer were to identify in so far as possible, the common feelings and attitudes held by the group. The reactions overlap somewhat, as in previous questions, but those listed seemed, to the writer, most pertinent to this study.

The consideration of the interview questions has been meaningful for this portion of the study. The reader can undoubtedly realize the value of this type of controlled interview in the study of attitudes and needs. The evaluation ultimately indicated four observable areas to which the patient reacted:

1. Onset of symptoms
2. Diagnosis of disease
3. Initial hospitalization
4. Services and facilities

Therefore, the remainder of the chapter will be devoted to evaluating the interviews as they relate to these four factors.

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[1] Field, op. cit., p. 82

Evaluation Of The Interviews

Reactions to the Onset of Symptoms

The onset of tuberculosis is usually characterized by gradual, imperceptible, insignificant, early symptoms. Oft times the individual feels only a general fatigue and malaise which is easily rationalized as attributable to environmental causes. When the symptoms become sufficiently severe as to force recognition of the need for medical attention, the disease is often well advanced.[1] Of the patients participating in this study, only five reported having experienced no symptoms. However, by contrast, ten of the remaining twenty-eight patients, all of whom reported symptoms, suspected tuberculosis. This indicates the insidious onset of the disease, which knowledge contributes to the recognition it receives as a grave problem in public health.

Reactions to the symptoms ranged from concern to extreme fear. The degree of emotional involvement was invariably determined by the occupational and familial demands upon the individual. The patient who had a large family dependent upon him or her for support and care showed a greater degree of emotional reaction to symptoms, regardless of rejection or concern for their meaning. The reactions showed little tendency towards a realistic approach on the part of the individual to the initial symptoms, even though they suspected tuberculosis.

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[1] Flanders Dunbar, Mind and Body, (New York: Random House, Inc., 1955) pp. 231 - 239

Another observation was that the greater the degree of emotional concern, the more intense were the symptoms. The patients interviewed who had been diagnosed as far advanced cases were seventeen in number, and of these, fourteen indicated much emotional concern of the symptoms. Again, the study seems to confirm social work philosophy: that the individual's ability to cope with a situation hinges upon the emotional reaction to a given aspect, all of which is modified by the patient's life experiences.

Reactions to Diagnosis

Regardless of the number of symptoms, the way the individual felt about them was directly influenced by the background which determined these feelings. "It has not been sufficiently stressed that there are emotional patterns which are related to eating habits, appetite and nutrition, and that these may be responsible for the underweight with which many cases of pulmonary tuberculosis begin. Furthermore, the shallow respiratory excursion seen in certain neuroses may play some role in this disease. These, and probably other emotional factors, should be considered in the etiology of pulmonary tuberculosis."[1]

The questions answered regarding the patients' feeling subsequent to and following diagnosis revealed more feelings and attitudes than found any place else in the interview. The ability of the individual to inhibit and sublimate physical limitations seemed lost, or so

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[1] Weiss and English, op. cit., p. 615

seriously affected as to create a veritable regression to complete dependency. The patients indicated apprehension, anxiety, doubt, anger, and a gamut of emotional reactions, all of which can be termed to a certain degree, regressive and child-like.[1]

Reaction to Initial Hospitalization

After many attempts to evaluate this area, the writer recognized that we were actually not solely concerned with the reaction to initial hospitalization. The reactions, as such, mean very little, except as they are related to the individual. A glance through the evaluative summaries brings out such words as depressed, resigned, worried, heartbroken, lonely, and others. These by themselves, mean very little. However, when one considers that a twenty year old male of recent migration from Mexico, married, with two children, reporting a third grade education, reports he felt "Strange and lonely" upon his initial admission, the words assume specific significance.

For all patients hospitalization necessitates the commending of oneself into complete dependency. The change to unfamiliar surroundings, new routines and fear of the unknown, all tend to place the patient in a new world - that of a tuberculosis patient. A statement by one patient interviewed in this study, portrays very well the initial feelings of change when he said, "When my daughter left, it felt like the door closed on the best friend I had in the world."

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[1] W. A. White, The Meaning of Disease, (Baltimore: The Williams and Wilkins Company, 1926) p. 179

Here is one individual summing up in one sentence the complete feeling of being shut off from the world. Even by the use of the word "had" in the last phrase, he expressed much emotional connotation.

Reaction to Present Services and Facilities

In the attempt to discover the needs and attitudes of the patients, we have explored something of their background and reactions to the total illness. Now it seems conceivable to expect that in the individual approach we may learn something further about the patients' needs by exploring how he either accepts or rejects hospital services. The effective administration of a busy hospital demands routine to best serve the patient population. The pressures which routine implies often affect the individual patient by encouraging dependence. It sets up a schedule which is easy to follow and not infrequently, hard to break. This situation is rather clearly portrayed by Henry B. Richardson, M.D. when he says: "Entering a hospital does two things; the patient goes into a protective environment and he leaves the responsibility and stimulation of the home...At the hospital his clothes are in a bag, his pajamas belong to the hospital, food is brought to him regularly, and the only thing he has to do is to carry out orders and this with an entirely passive attitude...The patient starts from the environmental age of a young child in terms of responsibility."[1]

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[1]Henry B. Richardson, M.D. Psychosomatic Factors in Convalescence. (New York: Academy of Medicine, 1940) p. 144

Many interviews portrayed vivid feelings of frustration at the unavailability of the out doors. The sudden restriction to one room wherein three people are housed, is to some, analogous to their conception of prison. Many of the patients worked on the outside as laborers and farmers, and the restricitons to them are further indications of the already serious illness.

The lack of understanding of hospital procedures was evidenced in almost every patient interviewed. At time of admittance, most had pleasant memories of staff treatment and then, as one patient related, "It starts." They are taken through the Out Patient Department, sit while X-rays are developed and often hear their names repeated in the adjoining room, while not able to hear what is said about themselves. Then a doctor advises, "You better stay a while." They are taken upstairs, handed a mask, a pair of pajamas, and told to go to bed.

Tests and examinations often do not start until the following day, during which interim the patient is cautioned not to do many things, but seldom is told why he is restricted. The "patient grapevine" starts along about this point in time, and he may learn he is to be here for "Six months to a year," and is considered a positive tuberculosis patient until his tests return and prove him negative, about eight to ten weeks hence. Very probably he has been told little of the meaning of tests, positive-negative, or why he must rest from twelve-thirty to two-thirty in the afternoon.

After the patient has been hospitalized several days, he knows

when meals arrive, and accepts rest period as imperative,wears his mask, and now comes a Friday morning, better known as "Rounds Day." During the early part of Friday, the Medical Staff, comprised of the Administrator, his Assistant, the Resident Physician, the Supervisor of Nurses, and the Chief Social Worker, together make complete rounds of the hospital, seeing every patient. This is immediately threatening to the majority of patients. The attention which he may experience may well be considered with importance when he views the Administrator and his staff. He is invited to participate in the discussion occurring across his bed, but the apprehension he feels by the total situation often causes questions to elude him.

The team approach is for the most part of great importance to the patients' well being, but the experience of rounds to many patients is very frightening. The scientific contribution which this group on rounds can make to the patients' welfare is of minor significance to the individual as compared to the frightening picture which the team makes at a given moment.

Nor are these regular services the only ones to which the patient must adjust. During this period he is continuously conscious of the length of hospitalization as defined by the illness. Little time is spent explaining to him what to expect in treatment. Monday comes and is better known as "Shot Day." The new patient may not be ready for shots, and no one explains; he waits, sometimes many days, until the medical recommendation is written for medication. The unknowns involved are, for the patient, ususally very threatening.

By considering the degree of threat which patients experienced and shared during the interviews we have viewed some of the depths of attitudes and feelings involved. Reactions noted in the interviews indicated consternation and despair subsequent to diagnosis and during the initial hospitalization. There was a positive change observable in the answer to those questions involving the patients' feelings at the time of the interview.

CHAPTER V

Summary and Conclusions

This is a study of patient attitudes and needs subsequent to diagnosis and during hospitalization in Ingham Chest Hospital. The problem was selected as a result of the realization that to adequately fulfill the enabling role one must attempt to understand the individual. It was believed that feelings and attitudes regarding the illness would be a basis for better understanding the patients. It was assumed in this study that pulmonary tuberculosis patients have attitudes and needs peculiar to, and resulting from the illness and that there are services by which to meet these needs.

Thirty-three individuals were selected for the study out of a total of eighty-one pulmonary tuberculosis patients hospitalized on December 21, 1955. The criteria for selection was that the patients had pulmonary tuberculosis and there were no handicaps such as deafness, blindness, illness or mental incompetency. The ultimate age range was nineteen to seventy-five years.

The major tool used was a controlled interview, structured to include open end questions which would elicit the feelings and attitudes of the patients subsequent to diagnosis and during hospitalization. In so far as possible, responses were recorded verbatim. The interviews were evaluated by the writer and grouped into four major areas; reactions to symptoms, reactions to diagnosis, reactions to initial hospitalization and reactions to services and facilities.

The questions asked early in the interviews resulted in eliciting negative feelings regarding pre-diagnostic symptoms, diagnosis and plans for hospitalization. Reactions included such feelings as depression, rejection and hostility to the discovery of the illness and necessary hospitalization. Questions asked later were focused to reveal feelings which the patient had at the time of the interview, and a noticeable change occurred in responses. Reactions were more positive as indicated by confidence towards getting well, and less depression on the part of those interviewed. Also, the patients showed motivation to make plans for the future which might conceivably indicate more healthy attitudes.

It would be only fair to reiterate at this point the understanding on the part of the writer, that reactions to interviews may possibly be distortions of basic feelings. However, during each evaluation, active effort was made to avoid interpretation on any level except the surface reactions. The assumptions of this study seem to have been supported, because if patients' needs had not been met in some degree by the services and facilities of the hospital, a change in attitudes could not have been observed.

The writer believes the most significant finding of this study to be the indication that a positive change in attitude of the patients interviewed occurred during hospitalization. There are conceivably many factors involved in this change of attitudes which this study was not designed to discover. However, the following findings may have contributed to the positive change observed:

1. The present admittance procedure seems to have a positive reaction on the patient.

2. Staff contacts are pleasantly recognized by the patients; such as the personalized attention by the dietician.

3. The regular medical care received by the patient is accepted positively as necessary to their regaining of health.

4. In general, the patients in this group believe the craft and Vocational Rehabilitation program to be most helpful and should be continued.

The findings further suggest the following considerations:

1. Social casework services would be helpful to the patient at the time of diagnosis and initial hospitalization.

2. Orientation procedures might be reviewed and reorganized to more fully meet the patient needs.

3. The practice of hospital rounds might be reconsidered to discover whether or not the process could be restructured to alleviate patient anxiety.

4. Patient services and program may be reviewed to consider the inclusion of limited "Outdoor activity"[1] if the patient's physical condition warrants such a program.

5. A review of doctor-patient contacts might be made to determine whether the patients' requests for "More individual time with doctors"[2] is necessary.

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[1] See page 37, Chapter IV

[2] Ibid.

A P P E N D I X

QUESTIONS USED AS BASIS FOR CONTROLLED INTERVIEW

TO DISCOVER

ATTITUDES AND FEELINGS OF PULMONARY TUBERCULOSIS PATIENTS

1. What do you think about most?
2. How did you find out you had tuberculosis?
3. What do you feel caused your disease?
4. What symptoms have you had?
5. What kind of symptoms have you had?
6. How did you feel about your symptoms?
7. Did you think your symptoms might mean tuberculosis?
8. Who first told you you had tuberculosis?
9. How did you feel when you first learned you had tuberculosis?
10. How did you feel the night following your diagnosis?
11. How do you feel now about your illness?
12. How does your hospitalization help in getting well?
13. What do you enjoy about hospital life?
14. Who made the plans for you to come to the hospital?
15. What was your first impression of hospital staff?
16. What did you think of during your first day in the hospital?
17. How many friends have you made here in the hospital?
18. Do you make friends more easily now than before?
19. How do you spend your time in the hospital?
20. Do you participate in allowable hospital activities?
21. Do you know much about tuberculosis?

22. How did you learn about tuberculosis?

23. Do you think you would like to learn more?

24. How would more knowledge help you?

25. How do you feel about entertainment brought into the hospital?

26. What changes in hospital routine would you suggest to help you recover faster?

27. What do you miss most by being in the hospital?

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