The Place of Psychiatry in the Program of a Tuberculosis Hospital*

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Tuberculosis is an illness in which the scale of emotional involvement is of particular interest. Disturbance of feeling is promptly and deeply aroused. The response of the patient is partly the reflected shadow of social myth and superstition; it is partly an awareness of the personal and social implications of the illness itself; and partly it represents an emergence of latent, specifically individual, infantile and neurotic potentialities.

By its very nature, the illness imposes upon the patient the threat of violation of the integrity of his personality, and changes the meaning and direction of his life course. It is a crippling illness in a real sense, since there is so high an incidence among people in the productive years of life. The social stigmatization associated with tuberculosis places the patient in an outcast situation, and the nature of hospital treatment, with its enforced inactivity and dependency, engenders feelings of parasitism and uselessness. Again, where surgical procedures are carried out, feelings of mutilation, of damage to the body image, are common and highly disturbing. In each phase of the illness, there are special reactions of anxiety which present important problems of management and care.

The psychiatric program at National Jewish Hospital, in its steady expansion, has revealed a growing awareness of the major importance of psychological factors in the onset, course, and outcome of tuberculosis. Initiated in 1936 by Dr. Charles J. Kaufman, the previous medical director, it has demonstrated that psychological understanding and management are indispensable in the care of the tuberculous patient.

In previous papers, we have discussed some of the psychological problems encountered in the tuberculous patient. In this paper, we shall review the problem of the administrative integration of psychiatric service in a tuberculosis hospital, from the standpoint of certain general principles in applied psychiatry, as well as

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the specific ways in which psychiatric time is used in relation to these principles.

The first general consideration is that the patient in the hospital finds himself in a situation of group living with relations to the staff which are defined by hospital rules and routines, and by the psychological nature of medical authority. As a result, the role of the patient resembles the dependent situation of the child, and the staff role the position of the parent in a family group. An important aspect of this staff-patient relationship is its ambivalent character. The patient's dependence on the staff for the gratification of his needs for affection and care makes him particularly vulnerable to feelings of frustration and resentment. The expression of such feelings often leads to patients being described as uncooperative and to their discharge as disciplinary problems. The hostility of the patient is thus met not with an effort at an understanding of its origin, but with counter-hostility from the hospital authorities.

A hospital psychiatric service may be oriented to direct work with the patients, and may then be described as "patient-centered," or it may be oriented to the task of helping the people who carry the actual day-by-day responsibility for the patient, and this then is a "staff-centered" psychiatric service.

Our experience has been that a "patient-centered" psychiatric program in a tuberculosis hospital tends to be sterile, unproductive, and unrewarding. It has little or no value as a technique of staff development in comprehensive patient care; it makes no contribution to the problem of the hospital management of the patient; it leaves to one side the possibility of bringing into being a psychologically-enriched view of the illness, and of the experience of the patient with his illness and its treatment.

The attitudes, prejudices, intolerances, and personal problems of the hospital staff are as much a part of the patient's experience with his illness as what goes on in his chest, or for that matter, what goes on in his personality. If medical care is not correlated with consideration for the social and psychological situation of the patient, it reduces itself to technical absorption and tends to lose the dignity of a professional character. Psychiatric care may fall into the same pitfall of technical isolation.

Most psychiatric programs in tuberculosis hospitals begin on a "patient-centered" basis. The service is offered to individual patients or to groups of patients, with attention focused on intrapsychic process, very often without consideration of its relation to hospital living. Most psychiatric problems in the tuberculosis hospital do not require specialized psychiatric treatment but may be handled through the understanding and proper orientation
of the staff. On the other hand, a "staff-centered" program does not exclude direct treatment of the patient by the psychiatrist in the small percentage of cases where it is indicated.

We have found that, given the opportunity, members of the staff are eager to discuss the problems they have with patients, are eager to enlarge their own understanding, and are able to find comfort, reassurance, and help through discussions with the psychiatrist or the psychiatrically oriented social worker which meet them at their own level of thinking and feeling.

In the hierarchy of staff members as parental figures, the physician occupies a special role because of his key responsibility for the medical destiny of the patient. Actually patients are always bringing or wanting to bring their personal problems to the attention of the physician. There are many doctors who are talented in the intuitive grasp of the personal problems of their patients, and deal with them understandingly and successfully. Because of the special nature of the doctor-patient relationship, the patient may often be able to confide more directly and more intimately to the doctor who is responsible for medical management than to any other person, including the psychiatrist.

However, it is misguided, and even somewhat naive to expect a physician who is untrained in psychiatry to be able to understand the personality structure of the patient, the dynamics of his reaction to his illness, his medical care, and his hospital experience, or the interplay of personality in the staff-patient relationship as it affects the patient's response. While we have found considerable variation in psychological flair and capacity among our staff physicians, there is little doubt that the opportunity to share in the psychiatrist's thinking and to make use of the psychiatrist's time for consultation on cases is of great value.

Certainly the physician without thorough psychiatric training and particularly without extensive training in the discipline of psychotherapy runs the risk of allowing the patient to develop unconscious, intense emotional reactions which must be handled to avoid psychological damage. These are reactions such as acute episodes of hostile, irritable, spiteful behavior, or completely submissive attitudes of devotion and love, like the "crushes" of the adolescent, sensitizing the patient to every gesture and imagined whim of the doctor. These reactions are the result of retained infantile impulses, which are generally kept under cover but which may break through in any intensive doctor-patient relationship. As a result of his training, the psychiatrist is able to recognize these manifestations, and to make use of techniques which will either keep them under control or allow them to be dealt with skillfully as they appear.
We see the role of the psychiatrist, then, as that of participant in the common effort of general care of the patient, as a member of the clinical team of the hospital, in which each professional group, including the physician, nurse, social worker, psychologist, occupational therapist and vocational adviser, contribute from their own professional training and experience, and by the use of their own professional methods, to the welfare of the patient.

From the point of view of the psychiatrist, the contribution of the psychiatrically oriented social worker is particularly important. In addition to rendering direct social and personal services, the social case worker is in a position to offer the patient a unique continuity of interest in relation to such problems as his separation from family, adjustment to hospital routines, family needs, and preparation for re-establishment in the community. Furthermore, the social worker has received extensive instruction during her school experience in modern, dynamic, psychiatric concepts, and has, at this point, more training than the physician in the observation and understanding of personality processes. Psychiatric services can therefore be most effectively deployed in terms of the concept of participant psychiatry in hospital settings where psychiatrically oriented social service is soundly developed.

From the vantage point of this general introduction, we shall now discuss the specific ways in which psychiatric services are employed at the National Jewish Hospital. There are four main types of activity, including consultation, teaching, treatment, and research. These activities are all inter-related and interdependent, and all represent important elements in a program of psychiatric services in a tuberculosis hospital.

Consultation: In many ways, this is the most basic contribution of the psychiatrist. The two main groups to whom such consultation is available are the physicians and the social workers, and these are the staff persons who deal most directly with the personal problems of patients. The psychiatrist may interview the patient and then discuss the case with the interested staff member, or more commonly, the discussion is on the basis of case material presented by the doctor or worker. Since the emphasis is on helping the staff person in his problems with the patient, recognition must be given to the person's own way of dealing with interpersonal problems, the extent of his understanding, his limitations in understanding, his own feelings about the patient's behavior, i.e., what it means to him; whether he is over-identifying with the patient's problems, or rejecting the patient and unable to accept the problems. These are all considerations which influence the psychiatrist's activity, and it will be of interest to the psychiatrist to explore how far the staff person can go in recognizing
his own role in the relationship, to what extent he can be helped with prejudicial attitudes, and most important, to attempt to relieve anxieties which he has developed in his dealings with the patient.

Teaching: Although consultation is the core of the psychiatric service, a program of education in psychiatric thinking is carried out through seminars and group discussions, with the object of procuring acceptance from the staff of certain basic principles, for example, (1) that behavior is always meaningful, motivated, and dynamic, i.e., a product of interaction of personality forces; (2) that there is an intimate relationship between the patient's emotional life and what happens to his disease; (3) that the interests of comprehensive medical care require that proper consideration be given to the patient's personal problems and his emotional difficulties; and (4) that the patient's experience in the hospital, in his relations to staff, is important to the course of his illness.

Psychosomatic seminars are held regularly, and are attended by all members of the professional staff. In addition, courses in psychosomatic problems are given to student and graduate nurses and to occupational therapists by the chief social worker.

In passing, it might be mentioned that an educational program is also carried out for patients. Its purpose is to orient patients at every phase and in every respect of their disease and its management, including consideration of emotional attitudes and problems; its productive results are described in another paper.

Treatment: Our general policy has been to offer direct psychotherapy to any patient who expresses an interest in such treatment. The actual number of patients in psychotherapy is probably greater than at most tuberculosis hospitals, since many patients are referred for the purpose of receiving direct psychiatric treatment, as well as for the care of their tuberculosis. At the present time, there are about twenty patients in psychotherapy. There are some who are being treated by the consulting psychiatrists in connection with the research project, some are seen by the staff psychiatrist, and others are treated by psychiatrists from the Mental Hygiene Clinic of the University of Colorado Medical Center.

A special aspect of psychotherapy is that of helping the patient to adjust to his hospitalization. A number of patients are admitted with marked evidence of reactive anxiety, expressing fear for their future, fears about their family and fears about surgery. There is often marked relief of anxiety after a few psychiatric interviews. We have found that a good deal of this work could be done by social workers under the supervision of the psychiatrist.
In some instances, for example, in four cases of homosexuality being seen by the staff psychiatrist at this time, the training and skill of the psychiatrist are needed to help the patient to accept the limitations imposed by hospitalization and to learn to live with his psychiatric problem during the period of treatment. Problems which require particular understanding are those in which the patient displays marked responses of hostility, dependence, and anxiety. Very many instances of aggressive, defiant, resistive, and negativistic behavior may become acceptable and manageable when understood in terms of these basic responses, which are in constant interaction with one another. Anxiety, for example, may lead to an increased need for evidences of interest and affection from the staff, or to feelings of frustration, with mounting irritability and aggressiveness.

The very situation of dependence which is inherent in being hospitalized creates anxiety in some patients. Others have always had difficulty in accepting authority, and react to routinized and restricted living with hostile feelings, which in turn may produce anxiousness and fears of rejection.

The patient who is constantly seen out of bed, who seems to delight in a display of butt-filled ashtrays, who seems to swagger in an attitude of challenge, may be reacting to feelings of insecurity, testing the physician to gain reassurance that he is accepted anyway, seeking love and care through his devious and painful distortions of behavior. Similar behavior may be found in other patients whose feelings of tension and reservoirs of guilt can only be relieved by provoking criticism and punishment from the staff.

These few examples illustrate the importance of obtaining a clear and full picture of the personality of the patient presenting emotional or behavioral problems. They add weight to our premise that understanding of personality factors is often essential in formulating a comprehensive program of medical care for the patient.

While direct psychiatric treatment has a real place in the tuberculosis hospital, it is also important to stress the need for individualized understanding of all patients, and for psychotherapeutic orientation of the hospital program as a whole. From this point of view, routines and regulations, policies and procedures should be constantly re-examined and reviewed, and subjected to revisions which seem necessary in the interest of protecting the emotional situation of the patient.

Research: A continuous process of enquiry into the relations between tuberculosis and emotional reaction is as essential in the maintenance of high professional standards as is research...
in the biological and clinical aspects of tuberculosis. For the past year, a pilot study in psychosomatic inter-relations in tuberculosis has been under way. We have tentatively concluded that there are no specific trends or patterns of emotional disturbance to be found in the patient with pulmonary tuberculosis but that a statistically significant percentage were in states of emotional upset in relation to current life situations in the period preceding the physical breakdown. There is also some evidence of a positive correlation, as in essential hypertension, between the status of hostility in patients and the course of their illness.

SUMMARY

We would emphasize that all of the aspects of psychiatric service which we have outlined above are important, and need to be effectively integrated in the development of a sound program of psychiatry in a tuberculosis hospital. For example, we would regard it as a forlorn hope to attempt to carry out a limited teaching program in the psychiatric aspects of tuberculosis, and expect that it could then be applied without the continued participation of a psychiatrist and psychically oriented social worker.

We therefore stress the need for continuity of a program as we have outlined it, and also the need to orient such a program on the basis of a concept of participant psychiatry.

Discussion

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You have heard a very interesting paper on the relationship between tuberculosis and psychiatry in a big hospital. I shall discuss the subject from the general aspect of all patients with tuberculosis, those who are cured and those who are not, and the approach necessary to keep them happy and satisfied. I have stressed for years, in lectures to doctors, students and nurses, that tuberculosis is a three-fold entity; primarily a pathology; next a sociology; and third, a psychology.

I might cite a case with an interesting psychologic slant. This woman was in a sanitorium—not as large as the National Jewish, but it had 60 beds and a considerable number of patients. Her husband said to me one day that he had attended one of Aimee McPherson's sessions, had seen her cure a child of deafness and wanted to take his wife to see her. I presume you all remember Aimee—she was an evangelist who worked entirely on personality.