The Role of Counseling Psychology in a Tuberculosis Hospital

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Introduction

This article is intended as an architect’s sketch, or a blueprint for a counseling program rather than a finished structure. Oversimplification of complex situations is readily admitted. If it serves to stimulate a little thought about a finished structure or about the material with which it might be built, then it will have served its purpose.

The Problem

No one will dispute the desirability of fitting the round peg in the round hole and the square peg in the square hole. But it is easy to forget that when the peg is a human individual and the hole is a niche in human society neither is perfectly round nor square. Nor are their shapes constant. Adaptations in both the individual and society are continually needed to make better “fits.” The attempted adaptation frequently results in a poorer fit below the surface even though the fit at the surface appears to be good. The peg becomes wobbly, or bent, or so loose it falls out, or so tight it cracks. These attempted adaptations have often shaped the peg—the human individual—in a fashion that limits greatly the number of holes he can fit. Further adaptations—more realistic ones—are often necessary.

Vocational counseling, attempting to facilitate better adaptations, is replacing vocational advising with its emphasis on finding a ready-made hole that the peg can fit.

Nature has endowed man with a remarkable power of adaptability. It has been estimated that the average individual is physically and mentally equipped to fulfill the requirements of about 30 job families with approximately 30 variations of jobs in each family, making possible a total of 30 times 30, or 900 occupational possibilities.4 The gifted individual is even more fortunate. The field of choice is somewhat narrowed for the man handicapped by tuberculosis but still offers him considerable choice.

The greatest constrictor of a man’s field of occupational choice is not his physical and mental capacity, but his pattern of acquired attitudes and emotional needs. This limits the variety of activities that can yield him satisfaction. Being acquired, or learned, they can be re-learned, or “un-relearned,” or re-oriented. For the tuberculous patient the re-orientation of some of his attitudes must often be a primary goal of vocational counseling.

There are at least two reasons for this. The first and more obvious is that the removal of some of the constricting effect of personal attitudes

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will open up more occupations from which the patient may choose, thus increasing his chance of selecting a vocation that is physically compatible with his condition and one that offers a reasonable degree of employment security.

The second, and perhaps more important reason, is that these attitudes and emotional needs influence the man's total behavior, both at work and after working hours. He cannot leave one set of attitudes at home and take another set to work with him. He can deny expression to some of his attitudes and needs at work, but they will seek expression after working hours. They seek expression in behavior. Therefore his attitudes must be those which will stimulate behavior consistent with his tuberculous condition. Then his attitudes can be expressed through occupational activities consistent with his physical condition, and these activities can then satisfy the emotional needs which are associated with his attitudes. In other words, he can gain satisfaction from an appropriate occupation.

Vocational counseling, then, must deal with attitudes. In fact all counseling whether it be aimed at vocational adjustment, marital adjustment, or adjustment in any other situation, deals with attitudes and attitudinal changes in people. Vocational adjustment is merely one aspect of a broader process of personal adjustment.6

Vocational counseling assists the individual to recognize some of the attitudes and biases he holds, and the influence of those attitudes on his vocational scheme of life. But his vocational life can no more be separated from his whole life pattern than the mind can be separated from the body. Each man's attitudes are all interrelated and integrated in his personality. Their unique configuration in each person is the basis of his individual personality. Thus in vocational counseling it becomes necessary to deal with attitudes toward family, toward authority, toward social institutions, and hundreds of things not directly associated with a specific occupation. And in tuberculous patients many of the attitudes developed as a result of the disease itself will influence occupational choice and vocational behavior.2

What are some of these attitudes? A few very common examples from the multitude of those existing in vocationally maladjusted people may clarify the preceding and following discussion.

1. "I'm too old to learn a new occupation." This is an extremely common attitude in people from all age groups, even those in their teens and twenties, not only elderly people. It is an attitude, and an unrealistic one. It is not a fact. The fact is that all people do learn and will learn every day they live, and their learning can be directed toward a new occupation if the necessity for it is accepted. The attitude mentioned was itself learned by the individual. It may have stemmed from lack of information or misinformation, or it may have grown out of a previously acquired attitude of not wanting to learn or preferring to live on a pension. If based on the latter preference, it can lead to a dependent state of mind, namely, that "since I cannot learn a new occupation and cannot return to my old one, it is society's duty to support me."
"Clerical work is not a man's job." Obviously this, too, is an attitude with an unrealistic basis. It cannot be a fact, since several million men earn a livelihood wholly or partially in clerical work. A common attitude, this one is particularly unfortunate in the mind of a tuberculous patient, since clerical work is generally compatible with the man's physical condition and is a comparatively common type of work. It is not restricted to any locality, industry, or level of difficulty. It generally requires only a short training period for minimal competence.

But an attitude like this example precludes choice of, or training in such an occupation. Even if the attitude is repressed to the subconscious to permit the work, it may retain its damaging qualities. The attitude, seeking expression as a liquid seeks its own level, may motivate behavior to emphasize the man's manliness: He may go mountain climbing, or keep late hours "drinking with the boys," or otherwise overtax himself to maintain his manhood in his own perception (and, he presumes, in the perception of his fellow men).

3. "I'm a strong man. I have stamina. I can outwalk, out-lift, and out-work any man in the crew." Before his tuberculosis, this attitude may have been realistic. It may have been a fact as well as an attitude. After having contracted tuberculosis it is no longer fact. And if the attitude still persists, even subconsciously, it probably indicates that the man's strength has served to compensate for some other felt inadequacy. The compensation may be even more needed if tuberculosis has served to increase the feeling of inadequacy. Further compensation, by denying the disabling effect of tuberculosis, may motivate feats of strength and stamina to demonstrate to himself (and presumably to the world) that he is as good a man as he ever was. Since the man feels good physically, this is easy to do and self-convincing is easy. But in a short time the result may be disastrous.

Conscious awareness of the attitude and the source of its development may either enable the person to change it, or may make it possible for a different compensation to replace the old one. Mental, educational, or economic feats might displace the feats of strength, for example.

The Aim of Counseling

What can be done about attitudes in tuberculosis patients? Probably nothing, if we don't discover what they are and from where they came. But we can discover a significant number of them and we can trace the development of some of them. And they are not permanent, rock-bound, immutable traits, for we continue to form and re-form them every day we live.

Some attitudes are much easier to influence than others. Those which are being formed from day to day in the hospital are in their infancy and their growth can be influenced a great deal by the total hospital environment. Ordinarily they cannot be directed in their growth (their development is a growth process) to any appreciable extent by any one person, although sometimes one person influences another tremendously.

If the whole hospital environment is much more influential than any
individual, it follows that the whole staff—doctors, nurses, attendants, and all others—must influence the formation of a positive, optimistic approach to vocational problems. Without their help, the vocational counselor is seriously handicapped.

The newly forming attitudes must grow in the humus of thousands of older attitudes. These older, long-established, "matured" attitudes are much more difficult to modify. But as necessity is the mother of invention, so is it the mother of change; and the very necessity for change, when perceived in a realistic, undistorted way, can be a powerful tool in effecting at least some change. Enough has been done to demonstrate that the attempt is often not as futile as it appears to be beforehand.

What is the function of the counselor, then, in this total hospital environment?

As the patient begins to think about his problem, conflicting decisions come up. They are accompanied by emotions; the emotional conflict may be quite marked, since the life and well-being of the individual is at stake.

Conflicts arising may resemble these: "I can't go back to my former occupation, but for economic reasons I must resume it." "I need a light trade to protect my health, but that's impossible to start at my age." "I don't feel able to go back to work yet, but my family will think I'm slothful if I don't." "The doctor thinks it would be risky for me to leave the hospital this early, but I need to be home." "Hospital regimen is tough, but what's better about the world of work and worry?"

Such conflicts demand resolution in the patient's own mind one way or the other as soon as possible. Once resolved, related conflicts tend to be resolved in the same general direction.

The "peaks" of such conflicts may be considered "critical points" in personal adjustment, (and in vocational adjustment too if the conflict relates to earning a living). The maximum benefit of individual counseling might be obtained during these critical periods, by influencing the beginning direction which the resolution of conflicts will take.

The conflicts here regarded as "critical points" are not necessarily the highly emotionalized, obviously crippling states of mind that are usually associated with psychiatric treatment or abnormal psychology. Rather, they are the ordinary, everyday conflicts that are more often referred to as problems of decision. They are the ordinary conflicts which are generally resolved to the personal satisfaction of the individual without help, but are often resolved in socially unacceptable ways or in ways that lend immediate relief without regard for long-range planning. They are the ordinary conflicts whose maladaptive resolutions may lead to irregular discharges, dependency on public welfare, and other problems in society.

Obviously all patients do not require the same assistance in resolving their ordinary conflicts. Many come into the hospital with a history of good personal adjustment. They are people who have learned adequate habits of viewing themselves and their situation quite objectively, and have consequently resolved their problems in a realistic fashion. They
may need little or no psychological assistance, though they may need information. Others enter the hospital with a background of maladjustment. Their adjustment habits are faulty and inadequate, and need to be re-learned through guided practice in adjusting to each little problem situation that presents itself in the hospital environment.

A four-point counseling program might be proposed to facilitate the learning of adequate adjustment habits:

First, the counseling psychologist should take an active part in patient education and in the staff’s in-service training. A counseling program is broader than the counselor; it requires cooperation of doctors, nurses, social workers, and other staff members who are daily influencing patients in their routine contacts. Through effective education the entire staff can become more effective in influencing patients, and patients may be induced to seek competent help in resolving their problems. Thus the patient identifies his own conflicts, which he probably can do better than anyone else since he alone experiences his own feelings. And each staff member can refer the patient to the person best qualified to help with any particular problem—the doctor, the vocational counselor, the social worker, or some other individual.

Second, conflicts may often be detected by routine contacts, aided by psychological testing, at times when such conflicts are highly probable. One such time is probably early in hospitalization, after the immediate emotional impact of the diagnosis has worn off. Another might be likely to occur when discharge from the hospital is imminent, when the patient goes to the ambulatory ward for the finale of hospital treatment. Perhaps there are others, and certainly there will be a great variance from patient to patient.

Third, counseling referrals may be made through ward rehabilitation conferences. The combined evaluations, discussion, and referral of several staff members should make more effective referrals, and at the same time contribute to the educational efforts mentioned in point one.

Fourth, the counseling psychologist should offer leadership in the application of effective counseling techniques by all professions represented in the hospital. Effective counseling has evolved from theory and techniques developed by several disciplines, notably psychiatry, psychology, social work and education.* These disciplines offer leadership, not monopoly. Only through utilization of available knowledge by all professions can society—and hospital treatment—make maximum progress.

Counseling As a Learning Situation

The basic tool of counseling is the interview. Tests are interview aids. It is through the interview that the patient can become aware of some of his biases, prejudices, and personal needs—some of his illogical attitudes and the source of their development.

*The reader who is interested in techniques for his own use and development would find a stimulating and thought-provoking “point of view” presentation in Rogers. Thorne has written an eclectic introduction to counseling methodology with a more traditional approach.
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Awareness of his own attitudes may often suffice to enable the patient to recognize the illogical foundation on which the attitude was built. Counseling seeks to help the patient become aware of the attitudes which are unrealistically blocking the resolution of his conflicts. Perceiving the problem in a realistic way, including the attitudes involved, brings a realistic resolution of the conflict.

To illustrate, consider the sample conflicts mentioned above. The first, "I can't go back to my former occupation, but for economic reasons I must resume it," has a fact versus attitude element. "I can't go back to my former occupation" is a fact (assuming that preservation of health is vitally important) which has been well demonstrated by the sad experience of many others. But there is an "out" because it is also a fact that a few tuberculous patients have successfully resumed such work. That little "out" enables the attitude "I must resume the old occupation" to prevail over the fact of high probability of breakdown.

The patient perceived these alternatives as conflicting facts, not as fact versus attitude. The one "fact" was irrefutable while the other had a "maybe" attached. However big the "maybe" is, in his perception the conflict could be resolved in only one way.

Suppose he had perceived his need to return to the old job as a feeling based on immediate economic need and weighed it against the value of health. Or suppose he had considered long-range economic needs along with immediate needs. Perhaps a different occupation utilizing much of his skills and experience could have been suggested that would not entail a severe drop in wages.

Or he might have perceived (in some cases) his old occupation as a means of meeting a prestige need. This perception could have led to a search for another means of gaining prestige, or it could lead to an insight that the need which the job originally satisfied has long since vanished.

There are many other possibilities. But all of them are difficult for the patient to accept after his initial conflict has been resolved. He fights against re-opening the healed sore. But while the conflict is actively disturbing him, the patient is receptive to any suggestion that offers relief from the tension.

Counseling seeks to help the patient become aware of some of his feelings of need and the distorted perceptions based in part on those feelings. It is possible then for him to perceive his situation more realistically and base his actions a little less on emotion and a little more on reason.

But the most important outcome of counseling is not the resolution of each separate conflict. More important is the learning that occurs: The patient has learned to view himself and his feelings a little more objectively, and thus make a more adequate adjustment to a disquieting situation. Each new adjustment in which objective self-study is utilized serves to build habits of realistic adjustment. They are habits of apprais-
ing each situation more objectively, and will begin to operate in non-
vocational problem situations as well as vocational.

Vocational counseling thus becomes a vehicle for training in all sorts
of personal adjustments. Counseling in other areas (family problems,
religious, or financial problems, etc.) could serve as a vehicle too. Probably
the principal advantage of using vocational problems as a vehicle lies
in their concreteness, ready acceptability by patients, and the fact that
self-support through gainful employment is the capstone of the rehabili-
tation process.8

Conversely, adequate non-vocational adjustments result in the learning
of habits which facilitate vocational adjustment. These are the habits
that are commonly referred to as attitudes. Attitudes are mental habits—
habitual thoughts—which are acquired according to the same laws of
learning that operate in acquisition of arithmetical skills or reading skills.

Attitudes may be regarded as learned habitual thoughts. They are
susceptible to change, or re-learning, according to the same principles
of learning by which they were originally acquired. How? How does a
child learn correct arithmetical habits? By practice over a long period
of time—by drill—and most efficiently by purposeful practice such as he
gets when he counts his own marbles, divides his own money, or adds his
own scores while playing a game. In short he learns his arithmetic through
experience in applying correct arithmetical habits to his own problems.

Likewise, through guided experience in problems of human adjustment
and human relations he learns habits of personal adjustment. He learns
habits of appraising himself and each problem situation in which he
becomes involved with greater objectivity—habits of acting rationally
rather than impulsively by successfully solving his problems through
objective reasoning and recognition of his emotional attitudes or feelings.

Unfortunately, erratic habits can be learned too. Adults today don’t
often display erratic arithmetical habits because their early practice
was guided with reasonable efficiency. But guidance in the development of
social attitudes has often been lacking. Erratic habits of adjustment in
adults are quite common. Can they be relearned or correctly learned at
this late date? Who would suggest that any adult of normal intelligence
cannot learn arithmetic if he has failed to learn it or has learned it in-
correctly? Is it less reasonable to expect adults to learn new or correct
thought habits relating to personal adjustment?

Of course the learner must first recognize and accept the incorrect-
ness or inefficiency of his original set of habits, whether they be related
to arithmetical problems or personal adjustment problems. The new
learning must serve a purpose for him. It should offer him promise of
helping himself out of fresh difficulties and problems as they arise.

When is the tuberculous patient likely to accept in his own mind the
inadequacy of his own set of adjustment habits? Probably when they fail
to help him solve a problem—when he is frustrated—when he has an
emotional conflict. Many an experienced chronic patient can then offer
him a solution but from a societal standpoint it may be another incorrect
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or ineffective one. The blind will lead the blind if leadership with vision is unavailable.

Counseling can offer the patient relief from his conflicts by providing him realistic help when he needs it. The patient must learn that help is available or he cannot request it.

Counseling—not counselor—was suggested. Let that be re-emphasized. Counseling is not a monopoly of psychology, nursing, medicine, or any other profession. It is a skill that could be utilized by every professional employee on the hospital team, as implied by Beauchamp in his plea for total hospital effort in patient education.¹

The Place of Psychological Tests and Vocational Information

Where does aptitude testing fit into the picture? Testing is indicated only when it can answer a question for the doctor or the patient, or counselor, or all of them. A psychological test is a systematic procedure for comparing the behavior of two or more persons. "That there aptitude test that'll tell me what I'm best suited for" just doesn't exist. No test can replace logical thinking, but many tests can yield helpful information with which to think. Psychological tests and measurements relate to vocational "diagnosis" in somewhat the same fashion that medical tests and measurements relate to disease diagnosis. The I.Q. Score, a finger dexterity test score, or an interest measurement are useful pieces of vocational information, just as tuberculin tests, pulse rates, or body temperatures are essential pieces of medical information.

Testing can also be a useful aid in obtaining a personality description which may assist the staff in planning treatment and rehabilitation programs for many patients. It can be a screen for early detection of many individuals who need help in personal adjustment. Testing is an aid; it cannot replace clinical interviewing, but only supplement it. Tests can sometimes be useful interviewing aids, like catalysts in the human interaction of the interview. Tests can be great timesavers in gathering some kinds of information which might be obtained through interviews only at greater time expense.

Vocational "diagnoses" and personality descriptions can be and often are rejected by the patient just as disease diagnoses are sometimes rejected. The individual can shop around for the answer he wants, and often does. The charlatan can then become the expert in the mind of the person to whom his advice appeals.

Test data must be combined with many other kinds of information that are also important in analyzing the vocational potential of an individual. Such things as the employment outlook for various classifications of workers, the accepted entrance channels to a given occupation, educational or age qualifications demanded by society or industry are highly important. Often factual information such as this is difficult for the patient to accept too, since it frequently destroys a vocational or rehabilitation plan that seems sound in every other respect, killing the plan that seemed to offer the patient security.
For example, a plan depending on initial part-time employment is frequently unsound, simply because such employment can rarely be found. Or a patient depending on a highly competitive field such as the fine arts is likely to be blocked by the reality of unemployment although this may be difficult to accept until he has passed the planning phase and comes face to face with the fact.

Many a patient has selected for himself a skilled trade goal, only to find that the route to attainment is through apprenticeship, and that apprentices are seldom accepted regardless of potential skill after the age of 20 or 25. Such facts are often resented and rejected by the patient. Occasionally an individual will take the attitude, "I'll show 'em, I can make the grade my way too!" And well he might, in an exceptional case; but success in planning vocational rehabilitation cannot depend on the exceptional case when surer ways are available.

Psychological testing and occupational information will be much more useful if the patient is prepared by adequate education to use them intelligently. Their usefulness is reduced greatly when vocational guidance is limited to testing only, with a terse advisement based largely on one interview subsequent to test analysis.

The basic problem of counseling, then, is not to test and advise, but to assist the individual to learn to adapt more efficiently. Tests are useful tools in the process. But the principal tool is the interview.

RESUMEN

El consejo vocacional para los tuberculosos no consiste sólo en el simple consejo para buscar determinada clase de trabajo. Debe ser un consejo psicológico con la mira de modificar la conducta del enfermo y sus capacidades para adaptarse a condiciones cambiantes y situaciones propias de problemas nuevos. Debe tratar de modificar muchas de las actitudes básicas que motivan la conducta.

Una actitud sistemática para este fin implica un programa—organizado de consejo psicológico en cooperación con personal médico, de enfermeras y de otros profesionales del hospital.

Ese consejo se describe como un esfuerzo de re-educación para ayudar a los enfermos y a resolver sus problemas más objetivamente y de manera más racional.

Se discute el lugar que las pruebas psicológicas y la información ocupacional desempeñan en el programa completo del consejo vocacional.

RESUME

Le service de reclassement professionnel du malade tuberculeux ne doit pas être un organisme où l'on donne simplement des conseils pour chercher une certaine catégorie de travail. Il doit devenir un organisme psychologique, ayant pour but de modifier la conduite du malade, et de développer sa faculté de s'adapter aux conditions modifiées et aux nouveaux problèmes que pose sa situation. Le but de cet organisme est de modifier beaucoup des attitudes fondamentales sur lesquelles le malade avait basé ses projets.
L'auteur demande que cet effort soit poursuivi systématiquement et intégré à un programme organisé de directives psychologiques, avec la collaboration du personnel médical, infirmier et des autres membres de la direction de l'Hôpital.

Ces directives psychologiques sont présentées comme un effort de ré-éducation pour aider les malades à voir eux-mêmes plus objectivement les problèmes qui les concernent et à pouvoir ainsi les résoudre plus rationnellement.

L'auteur discute la place du test psychologique et de l'enquête professionnelle dans le cadre du programme de reclassement professionnel.

ZUSAMMENFASSUNG


REFERENCES