MC GILL UNIVERSITY

EMOTIONAL PROBLEMS OF TUBERCULOUS PATIENTS

A study of fifteen tuberculous patients referred for psychiatric treatment during the year March 1, 1950 to February 28, 1951.

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for

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by

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PREFACE

The writer is deeply grateful to all those who have helped to make this study possible. She wishes to avail herself of this opportunity to extend her sincere thanks to Dr. Hugh E. Burke, Medical Director of the Royal Edward Laurentian Hospital for his kindness in making available to her the resources of his clinic; to Miss Rita Brooks, Nurse Superintendent, and to the other members of the staff, for their interest and assistance in gathering material for her.

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CHAPTER I

INTRODUCTION

Tuberculosis[1] as a disease has many characteristics which are common to most of the ills to which human beings are subject. There are, however, certain characteristics that are peculiar to tuberculosis with the potentiality of exerting damaging influence upon human personality. It must be conceded that in any attempt to understand the behaviour of tuberculous patients, it is unavoidable to give consideration to the emotional and psychic components of tuberculosis. Yet, it is in this area that confusion and unfounded generalizations exist. For instance, Jelliffe and Evans[2] describe the personality of tuberculous patients as follows:

> "They are whimsical, have no sense of responsibility and often do not hesitate to spread the infection. The nature of many adults suffering from clinical tuberculosis is that of a child, selfish, self-centered, irritable, easily angered, capricious with their food, will eat only what they like, eating irregularly, and appearing underfed.... Their strong infantile reactions, in that they utterly disregard others, are egotistical, dissatisfied and ungrateful."

The other extreme viewpoint in regard to the tuberculous personality is expressed by Morland in "The Mind in Tubercle"[3], to the effect that since many genius have had tuberculosis, the disease must be a stimulant to creative capacity.

This confusion and misunderstanding have arisen from the failure to distinguish between two different aspects of the disease: one, concerning

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[1] This study is concerned with patients suffering from pulmonary tuberculosis exclusively.

[2] S. E. Jelliffe and E. Evans, "Psychotherapy and Tuberculosis", American Review of Tuberculosis, Vol. 3, 1919.

[3] A. Morland, "The Mind in Tubercle", The Lancet, Vol. I, 1932.

psychic factors which are present in the etiology of tuberculosis, and the other, concerning psychic states which develop in the individual from the very fact that he has tuberculosis.

In considering the first problem mentioned we have to ask such as: Are the tubercle bacilli sufficient to produce the disease tuberculosis, or are there emotional and mental strains which together with the tubercle bacillus, constitute the necessary and sufficient factors in the etiology of tuberculosis?

It has been widely accepted that tuberculosis and its treatment impose many strains and stresses upon the patient and the family group. However, opinion as to the effect of the previous personality upon the behaviour of the tuberculous patient has been somewhat divided.

The treatment of tuberculosis is further complicated by the fact that the personality of the patient who becomes ill may be an unhealthy one. Reaction patterns become exaggerated, and these affect the development and course of the disease. Some patients develop serious emotional disturbances in response to the illness and in many instances psychiatric consultation may be necessary.

The main objective of this study is to explore the theory that tuberculosis alone does not explain the emotionally disturbed behaviour of the tuberculous patients, and that the behaviour is also determined by the character of the patient's personality in the past. This assumption implies that there are certain individuals who can withstand the stresses and strains imposed by the disease and its treatment, while there are other individuals who, due to emotionally unstable and insecure pre-tuberculous personality, break down when they confront the reality of the difficult situation produced by the disease.

The writer is interested in this problem from the point of view of a social caseworker, recognizing that the social worker has a very important place in the team engaged in the fight against the disease. It is the role of the caseworker to seek through teamwork with the doctors, nurses and the other personnel, to alleviate the patient's personal problems and anxieties before they become so acute as to cause chronic uneasiness, restlessness, or discharges against medical advice that would interfere with the patient's chance of recovery.

Interest in this problem stemmed from the writer's previous experiences as a caseworker in a tuberculosis hospital in Puerto Rico, where tuberculosis is considered to be one of the main public health problems[1]. There she realized that in order to do an efficient and conscientious task in fighting and controlling the disease, it is indispensable to understand the patient's total personality, his personal problems and conflicts that enter into and influence his disease.

In this particular study the writer has limited herself to the consideration of the emotional problems of tuberculous patients referred for psychiatric treatment, focusing on two main assumptions:

1- Tuberculosis and its treatment impose a strain upon the emotional and psychic life of the individual.

2- The tuberculous patient's ability to withstand this strain depends upon the character of his previous personality.

In order to test the first assumption the writer gathered information from patients and their relatives in relation to the following aspects:

a- The effect that tuberculosis, a chronic and infectious disease, had upon the patients.

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[1]See Appendix, Table I, Page 69

b- The reactions of the individual to the fact that the disease threatens his life while at the same time he is considered a menace to the security of his family and to the health of the community, at a time when he is in greatest need of moral support and affection.

c- The effect the individual's ignorance and erroneous ideas have upon the patient's final acceptance of his disease and of the prescribed treatment.

In testing the second assumption the writer tried to determine how the previous personality of the patient has affected his reaction to the disease in such a way as to make it necessary to refer him to a psychiatrist. This will be studied in the light of information from the sample group in regard to the following aspects:

a- The character of the relationship between the patient and his family before and after the onset of tuberculosis.

b- The character of the relationship with other tuberculous patients previous to his breakdown with tuberculosis.

c- The patient's attitudes and experiences at his work or at school, and his relationship with his fellow workers before and after his breakdown with tuberculosis.

However, this work will not attempt to evaluate the role of the case-worker in the treatment of tuberculous patients, due to the limitations encountered in securing adequate social casework records for each of the patients in the sample group.

Fifteen selected cases form the sample group. No limitations were imposed as to sex, age and marital status. These are cases of tuberculous patients who have been discharged from the Royal Edward Laurentian Hospital,

Laurentian Division, but who are still receiving treatment at the Royal Edward Laurentian Hospital, Montreal Division, and who have been referred for psychiatric treatment during the year March 1, 1950 to February 28, 1951. This period of time was agreed upon in order to include patients referred to the Royal Edward Laurentian Hospital Psychiatric Clinic, which was started in January 1951. Before the organization of this clinic the Royal Edward Laurentian Hospital referred most of the tuberculous patients in need of psychiatric services to the Allan Memorial Institute of Psychiatry and to the Royal Victoria Hospital Out-patient Department Psychiatric Clinic. Since January 1951, tuberculous patients referred by the doctors and nurses of the Royal Edward Laurentian Hospital for psychiatric treatment, are seen in the new psychiatric clinic of the hospital. These three institutions were used in order to complete the group of fifteen tuberculous patients who would fall within the criteria described before.

Originally, the writer's idea was to use only patients referred by the Royal Edward Laurentian Hospital to the Allan Memorial Institute and to the Royal Victoria Hospital Psychiatric Clinic during the year March 1, 1950 to February 28, 1951. This was sought to be a good year for it would offer fairly recent information in relation to address, telephone numbers and psychiatric evaluation. Only eight cases were available in those settings that would fit into the criteria. This number of cases was not considered sizable enough for the sample group, for it would not give reliable and sufficient material for the study. At this time it was learned that the Royal Edward Laurentian Hospital had organized its psychiatric clinic to serve the tuberculous patients who were referred for psychiatric treatment. From this clinic twelve patients were selected, making up a group of twenty patients.

The sample group was reduced to fifteen patients as follows: One of the cases did not fit into the criteria set up, inasmuch as the patient had never been hospitalized for his tuberculous condition. Two other cases were excluded because they were French-Canadians and did not understand English. Two other cases lived out of Montreal and interviews with either of them or with their relatives could not be arranged.

Due to the small size of the sample group, this study will therefore have no statistical value. The findings and conclusions will concern only the fifteen cases studied and no attempt at generalizations will be made.

In gathering the material, both the medical and the social records from the Allan Memorial Institute, the Royal Victoria Hospital Psychiatric Clinic and the Royal Edward Laurentian Hospital, were studied. These records varied in terms of the emphasis given them and the professionals keeping them. The records from the Allan Memorial Institute and the Royal Victoria Hospital Psychiatric Clinic kept social histories secured from the patients and their relatives by a social caseworker. These records were rich sources of information in regard to the patient's relationship with the family and their personal and family histories. They proved to be very helpful in corroborating the main assumptions of this study.

The records from the Royal Edward Laurentian Hospital included the physician's annotations and very good histories recorded by the visiting nurse of her contacts with the patients and their families since the patients first came to the hospital. They included personal and family histories that were valuable in helping to determine the patient's personality before his breakdown with tuberculosis. They also constituted written evidence of the reactions and attitudes of the patients and their families when tuberculosis was discovered.

But these records also have limitations, for they were written by professionals who were focusing their own fields of interest. Consequently, the social casework point of view was missing in these records. Another limitation attached to this method of collecting material is the difficulty of human beings to write about other human beings and be completely objective. Their biases, prejudices and feelings influence the material to be recorded and the way of writing it.

Another source of secondary material used was the current literature dealing with the emotional and psychiatric, as well as the social and medical aspects of tuberculosis. Through this literature the writer became acquainted with many studies carried out by psychiatrists and phthisiologists concerning the emotional problems of tuberculous patients. The most recent work was finished in England in 1949, by Dr. Eric Wittkower[1], and covers three years of psychiatric research on 785 tuberculous patients. His conclusion is that "it may be safer to assess a patient's prognosis on the basis of his personality and emotional conflicts, than on the basis of the shadow on the film."

Miss Deborah Levy[2] also wrote about the emotional problems of tuberculous patients from the standpoint of the medical social worker, dealing especially with cases labelled as "Non-cooperative" by the Royal Edward Laurentian Hospital.

The main source of primary material was the patients and their relatives. Interviews with the patients, whenever possible, or with the relatives, followed the study and analysis of the records.

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[1]Eric Wittkower, A Psychiatrist Looks at Tuberculosis, National Association for the Prevention of Tuberculosis, London, 1949.

[2]Deborah Levy, "Social and Emotional Problems in the Treatment of Tuberculosis", Unpublished Master's thesis, McGill University, Montreal, 1949.

Information gathered from these interviews as well as from the medical and social records, has both its strengths and limitations. In seeing the patients and their relatives it was possible for the writer to get a better picture of the patient and the emotional and physical environment in which he is actually living. On the other hand, the information requested concerned events that happened many years ago. This is an important limitation, for the human mind is liable to forget or distort many of the reactions and feelings that were present when the disease was diagnosed. In securing information that would throw light on the patient's pre-tuberculous personality, the writer had to be aware of the possible lack of objectivity due to the informants' biases and feelings. It was observed that, even when patients tried to be as acurate as possible, on certain occasions it was very hard for them to express their feelings. The discussion of the painful and difficult situation they had undergone was very hard and, consequently, the information gathered may lack objectivity.

Material gathered from relatives may also be affected by the nature of the relationship existing between the patient and the family group at the time the disease was discovered. The information may also be colored by the actual feelings of the informant toward the patient and by the relatives' own attitudes toward the disease.

Taking into consideration the limitations and the possible lack of objectivity in the material thus gathered, the writer tried to supplement one source of material with the other. She used valuable clues from the medical records kept by doctors and nurses who have known the patient since his breakdown with tuberculosis. She also made use of the social and the medical records of the eight patients selected from the Allan Memorial Institute and the Royal Victoria Hospital Psychiatric Clinic. These

records gave more information about the patients and their families from the social caseworker's viewpoint, since these patients were seen by a social worker at least once. The writer also availed herself of the opportunity to use two cases in the sample group whom she had carried as part of her case load while she did her field work at the Allan Memorial Institute and at the Royal Victoria Hospital Psychiatric Clinic. She analyzed and studied these cases carefully and thus gained a broader insight and understanding of the other sample cases than would otherwise have been possible.

Combining all these materials and considering both their strengths and their limitations, the writer will attempt to explore them to see whether the assumptions aforementioned have any basis in the facts gathered from the sample group.

The writer's original purpose was to interview each one of the patients in the sample group. This could not be done for the following reasons:

Of the fifteen cases that finally formed the sample group, two patients were not interviewed because they were just readmitted to the sanatorium. In one of these cases the writer asked the patient's sister for an interview, but this could not be arranged for she is French speaking and does not understant English. In the other case the father and the two brothers of the patient were working all day and interviews with them could not be arranged.

In three cases the mothers of the patients were seen. These patients were willing to cooperate, but they were working during the whole day. However, they suggested an interview with their mothers who, they said, were as good sources of information as themselves.

Ten patients were interviewed and five of them were alone in their homes during the writer's visit. The other members of the family were either working or out of the house at the moment. In only two cases were there relatives at home when the interviewer called. In one of the cases the patient's wife purposely stepped out of the room so as to allow the patient and the interviewer a better opportunity to discuss his feeling. In the other case the mother remained with the patient during most of the interview, advancing frequent corrections to the patient's information. It is the writer's impression that this patient resented the mother's interference, and her tenseness and difficulty in expressing herself were obvious during the interview.

Two other cases were part of the writer's own case load during her field work. One of these two cases refused psychiatric treatment on the ground that "there was nothing wrong with her."

One of the patients under study expressed her desire to see the writer at the agency where she was doing her practice rather than at home.

The general response of the patients and their relatives to the request for an interview was good. Of the thirteen cases approached by the writer, only two hesitated and asked for some explanation.

Case number ten[1] associated the writer with the visiting nurse, whose supervision she resented. The reason for this feeling was that the patient had just moved to a new neighborhood and did not want neighbours to know she had tuberculosis. It was not until the writer's status and her relationship to the Royal Edward Laurentian Hospital were explained, that she finally consented to see the writer.

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[1]See Appendix, Page 103

In case number five the patient's mother was concerned about her daughter's raction to the interview. The patient was working at the time, but the mother was very willing to cooperate.

The rest of the sample group was willing to see the writer and in the cases where the relatives were seen, they gave the necessary information. Case number nine[1] shows this willingness to cooperate on the part of the relatives: The patient's mother was seen, and at the end of the interview she commented, "I have tried to give you all the information, although I think I have been very mean to my daughter. But if you are going to help in a study, there is no use in pretending that everything is fine when it is not."

The writer was authorized by the Medical Director of the Royal Edward Laurentian Hospital to interview each patient, and careful attention was given to avoid any emotional disturbance as a result of the interview. It was arranged with the staff of the Royal Edward Laurentian Hospital that if any difficult situation were discovered during the contacts with patients and relatives, they would be asked to discuss it with the visiting nurse supervising the case. This was done in two cases.

Each case was approached directly by the writer except for two cases in which it was done through the nurse. The other interviews were arranged by telephone or through brief contacts with the patients when they went to the Royal Edward Laurentian Hospital for their treatment or X-ray examination. In such brief contact the patients were reassured of the confidential nature of the information and a brief explanation was offered as to the identity of the interviewer, her relationship to the Royal Edward Laurentian Hospital and

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[1]See Appendix, Page 100

the purpose of the study. They became aware that even though this study might not benefit them, perhaps it could be of great assistance in understanding and helping other tuberculous patients. In spite of this explanation two patients were worried and associated the writer's visit with "bad news" from the hospital.

The interviews were conducted in an informal way. The schedule[1] formulated served as a guide, but the procedure used was to encourage the person to talk about their experiences and feelings. Only when the information was vague did the writer intervene by asking questions that would help out the person to express his feelings better. In only one case where it was very difficult for the patient to talk freely and spontaneously were questions asked.

This study was made feasible through the writer's association with the Psychiatric Clinic of the Royal Victoria Hospital and with the Allan Memorial Institute where she was doing her field work. Her relationship with the Royal Edward Laurentian Hospital was arranged through the Director of the School of Social Work of McGill University. The Royal Edward Laurentian Hospital was known for many years as the Royal Edward Institute. Actually it has two divisions: the Royal Edward Laurentian Hospital, Montreal Division, whose main function is that of an outdoor clinic for diagnosis and ambulatory treatment. It also includes supervision of homes and of the patient's families by the visiting nurse. The Montreal Division has approximately 52 beds for surgical patients.

The Laurentian Division at St. Agathe is the sanatorium, with a capacity of 350 beds.

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[1]See Appendix, Page 121

This is a private institution receiving provincial and Dominion grants to subsidize its work. The services rendered are offered to both Catholic and Protestant, and English and French speaking population.

Recognizing the need of treating both the mind and the diseased lung, the Royal Edward Laurentian Hospital started a psychiatric clinic for its patients in January, 1951. This clinic is held two afternoons weekly and every two weeks one of the clinics is held at the Royal Edward Laurentian Hospital, Laurentian Division.

The Allan Memorial Institute of Psychiatry is a private, voluntary hospital. It constitutes the psychiatric department of the Royal Victoria Hospital. This institution was opened in 1944 and is housed in a building separate from the main hospital. It contains two women's wards and one men's ward. It also operates a day hospital for out-patients. The bed capacity for the hospital is sixty-five beds. In addition, twenty-two patients are accepted in the day hospital.

It is also a research teaching centre where psychiatrists, psychiatric nurses and social workers receive training. The clinical staff consists of psychiatrists, psychologists, nurses and social workers.

Referrals are accepted from the psychiatric clinic of the Royal Victoria Hospital, private doctors and community agencies. There are no restrictions as to religion or race.

Hospitalization is usually for a short term, ranging from four to eight weeks. The patients are mostly neurotics rather than psychotics. Services are offered to adult patients over sixteen years old.

The psychiatric clinic operates as an out-patient department of the Royal Victoria Hospital, but is staffed by personnel from the Allan Memorial Institute. It is run two afternoons weekly. As is the case at the Allan

Memorial Institute, the clinic has no restrictions as to race or religion and only adult patients over sixteen are admitted.

Referrals are accepted from other clinics in the hospital, private doctors and community agencies. Self-referrals are also accepted.

The distribution of the sample group as to the identification data is very significant and interesting.[1]

Of the fifteen cases studied, fourteen were referred for psychiatric services after the onset of tuberculosis. Only one case was referred for psychiatric treatment before tuberculosis was detected.

The sources of referrals of patients to the Royal Edward Laurentian Hospital are numerous, as is shown from the following table:

TABLE NUMBER 1

Sources of Referrals of the Sample Group of Fifteen Cases to the Royal Edward Laurentian Hospital

Sources of Referrals	Number of Patients
Total	15
Family Doctor	3
Contact Examinations	3
Routine Examination at Work	3
Anti-tuberculous League	2
Self-Referral	2
Children's Health Association	1
Allan Memorial Institute	1

[1]See Appendix, Table IV, Pages 72 & 73

One of the cases has been suffering from tuberculosis since 1934. The most recent case was referred to the Royal Edward Laurentian Hospital in 1950. The average length of the disease for this sample group is approximately six years and four months.

The group included twelve females of whom seven were married, and three males of whom two were married.

The age range varied from nineteen to forty-three years, an average of twenty-nine years. Thus, it may be said that it was in the most productive years of their lives that these patients were suffering from the disease.

In regard to religion, the sample group included eight Roman Catholics, six Protestants and one Greek Orthodox. The languages spoken by the patients also suggested diversity of cultural backgrounds. Ten out of fifteen were English speaking. Three were French Canadians, one was Polish and another Russian. These last five patients did speak English, although with some difficulty.

Two of the fifteen patients were only children in the family, five patients were the youngest, and in six cases they were the eldest in the family. One patient was the second in the line of seven siblings and the other was the third in a family of five.

Seven of the nine married patients in the sample group had children, their ages varying from two to twenty-three years. The average number of children for the group of married patients is 1.2, and for the sample group it is .73.

The educational level of the whole group is not very high. Only one case went as far as second year of college education. One person attended school only up to second grade. The average period of schooling for the group is about seven years.

The diagnosis for the tuberculous breakdown is scattered as follows: Four patients had minimal pulmonary tuberculosis; seven patients had moderately advanced pulmonary tuberculosis; and four patients had far advanced pulmonary tuberculosis.

The prognoses were not stated in the medical records.

Although many cases presented combined psychiatric features of clear-cut conditions, for the convenience of this study they were distributed as follows according to the main psychiatric features shown by the patients:

TABLE NUMBER 2

Distribution of the Fifteen Cases in

Terms of Psychiatric Features Shown by the Patients

Psychiatric Features	Number of Patients
Total	15
Depressive Features	6
Hysterical Features	3
Anxiety States	3
Obsessive Compulsion	2
Schizoid personality	1

The occupations of the patients in the sample group previous to their breakdown were varied. In only one case did the patient work in her job steadily for over two years.

The average family income for the group was approximately $43 a week and only two cases did not have any income at all. Only one patient was a clerical worker; the other patients who were working before the tuberculous breakdown were unskilled laborers.

The living conditions of the whole group were, in general, fairly good. They lived in apartment houses with sufficient number of rooms fairly well furnished. In only one case did the writer find that the apartment was too small, dark and unfit for the patient and his wife to live in. In another case the home was overcrowded and the furniture was inadequate. In but one case did the family own the house.

In this sample group every patient was known to at least two social agencies. Only four patients received financial aid during the illness to make up for the lack of income to support the family. Each one of the cases in the sample group applied for Q.P.C.A.[1] regarding hospitalization.

The plan to analyze and present the material gathered will be as follows: The next chapter will discuss the medical aspects of tuberculosis. This will be a theoretical chapter dealing with the diagnosis, treatment and control of the disease. The third chapter will be an analysis of the case material gathered, in terms of the stresses and strains imposed by tuberculosis upon the behaviour of the tuberculous patients selected for the sample group. The influences of the pre-tuberculous personality upon the behaviour of this small group of patients will constitute the fourth chapter of this thesis. The last chapter will contain a summary and the conclusions obtained from this study.

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[1]Quebec Public Charities Act, passed in 1925. Chapter 189 provides for care of the hospitalization of the "indigent" person. In division 1, section 3, the Act explains: The word indigent means any person treated in a hospital or admitted to any other public, charitable establishment recognized as such by the Lieutenant-Governor in Council under the provision of this Act, or in any hospital, home refuge, creche, sanatorium or public charitable institution, who cannot either directly or indirectly provide for his maintenance either temporarily or definitely, by himself or by persons bound to give him support or to care for him and who is domiciled in the Province of Quebec.

CHAPTER II

MEDICAL ASPECTS OF TUBERCULOSIS

Tuberculosis is a social and emotional, as well as a medical problem. It is absolutely indispensable to understand the medical aspects of tuberculosis if we want to help out the patient in his difficult situation. We have to consider what tuberculosis, with all its stresses and strains, means to the individual, if we want to understand the behaviour of the tuberculous patient. For years, in tuberculosis, the patient was approached just as a diseased pair of lungs. Fortunately, this attitude has been changing and now all the personnel involved in the diagnosis, treatment and rehabilitation of the tuberculous patient are conscious of the fact that we have to think of the patient as a total person. Little by little we are coming to realize that the patient's personality is an important factor in the etiology, course and prognosis of all chronic organic illnesses.

In this chapter the writer will present a brief account of the history of tuberculosis, and a general discussion of its diagnosis, treatment and prevention.

Tuberculosis differs from most other organic illnesses in that it is and infectious disease. It constitutes a threat not only to the patient's own life, but to the health and security of his family and of the community. Other factors that should be considered are the superstitions and taboos that still surround tuberculosis. A definite stigma is attached by the public to the sufferer from the disease.

The nature of tuberculosis is a problem which has concerned mankind since thousands of years ago. Twenty-five hundred years ago Hippocrates said, "The spitting of pus follows the spitting of blood, consumption follows the spitting of this, and death follows consumption."

In the second century, Galen suspected the danger of infection and warned against it. In the nineteenth century Villemin confirmed Galen's observation by means of inoculation, but it was not until 1882 that Robert Koch, a German physician, proved that something extrinsic to the body, some kind of parasitic forms were the cause of tuberculosis. He isolated the germs and after many experiments was able to demonstrate that these isolated germs, which he called tubercle bacilli, are capable of reproducing the morbid process of tuberculosis when they are again introduced into the animal body.

Since then, considerable progress has been made as to the diagnosis, treatment and control of tuberculosis; although, if we consider the hours spent by many investigators, in many laboratories in different countries of the world, it seems discouraging that there still should be so many gaps and questions in regard to the development and course of tuberculosis. This, however, constitutes a challenge to all those interested in doing further research in this area.

Tuberculosis has been long known by other names, such as phthisis, consumption and emaciation, and "wasting" was considered to be what today we know as pulmonary tuberculosis. It is this aspect of the disease that we are to consider in this work, for it is the one which presents the most serious medical, emotional and social problems. This is clearly indicated in Table II[1] referring to deaths and death rates for tuberculosis (all forms) in Canada for years 1945-1947.

Man may be infected with the tubercle bacillus by both human and bovine bacilli, but the chief source of infection is from an individual with tuberculosis in the open stage. The articles in the environment of the patient and

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[1] See Appendix, Page 70

the air in which bacilli are found are the principal sources of first infection in man. The routes by which the bacilli enter the body are multiple. They may enter by inspired air, food, swallowed saliva and in very rare instances, through skin wounds.

Tuberculosis has different phases produced by the same micro-organism but under different immunologic condition. The primary complex or first infection may be caused by the invasion of a few bacilli in the non-immune host and the process is normally without symptons.

An extension of this primary complex or the invasion of bacilli from an exogenous source may result in re-infection or active disease.

Usually, but not necessarily always, primary infection takes place during childhood and its spontaneous healing should be a most important factor in the prevention of tuberculosis. There is general agreement that practically one hundred percent of children who associate intimately with tuberculous patients for any considerable period of time react to tuberculin. But the percentage of infection does not mean tuberculous disease. In only a small number of those infected is the disease present or imminent.

The primary infection is usually found in the lung, and it rarely produces symptoms. However, as mentioned above, it may extend and cause active disease. It usually runs the complete course from infection to healing without being of clinical or social significance, but it establishes a specific defense against reinfection or secondary tuberculosis. Only when the number of bacilli causing reinfection is unusually large and when conditions of the body are favourable to their implantation, is the reaction dangerous.

Reinfection means any infection of the tissues after the immunity mechanism has been established by the primary infection.

The reinfection type of tuberculosis in a naturally immune person requires that the invading bacilli be present in quite large numbers or that they find particularly favorable conditions on the part of the host. How large or how favourable is yet to be known. Years may pass between the first infection and the time when the disease makes itself known by symptoms recognized by the patient or his family.

Exhaustive influences such as those resulting from a disease, pregnacy, changes caused by malnutrition, living under unhygienic conditions. excess of various kinds, worry and the tiredness of overwork, bring about changes in the resistance of the body to the invasion of the bacilli, and make conditions favourable for the development of the disease.

> "Under conditions in which the defensive forces of the host are depressed, fewer bacilli are required to produce infection than during conditions of normal health, and the resulting infection spreads more rapidly. As a particular convincing illustration of the effect of stresses one needs only to cite the effect of World War I on tuberculosis. According to Dublin, the death rate in certain German cities was 157 per 100,000 in 1913, but rose to 287 in 1918. In Warsaw the death rate rose to 1,400 per 100,000 in 1918. With improved conditions such as were established after the war, better food, less mental, emotional and physical strain; and a return to normal living, the death rate again declined to about the prewar rate."[1]

The clinical history of the acute type of tuberculosis is that of a sudden onset, often with symptoms of a cold or bronchitis. Small lesions may produce no symptoms, but if the lesion is large it may be accompanied by fever, tiredness, loss of strength, night sweats, loss of appetite and weight, cough and expectoration and sometimes hemoptysis.

The wide variety of symptoms accompaning tuberculosis may simulate other illnesses. Not infrequently it has been confused with colds, bronchitis, pneumonia, nervous breakdown, gastrointestinal disorders, malaria and laryngitis.

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[1] Francis Marion Pottenger, M.D.; Tuberculosis, St. Louis, The C. V. Mosley Co., 1948.

Another type of tuberculosis has a slow and insidious onset and the disease may be quite extensive before symptoms recognized by the patient appear. In these cases the diagnosis is usually made during routine examination. The patient usually lives and works for years before the disease is recognized and before the patient knows he is ill.

The presence of the tubercle bacilus in the sputum and a combination of some of the symptoms will direct the doctor's attention to the lungs and make the diagnosis of pulmonary tuberculosis fairly certain.

The first step in the diagnosis of tuberculosis is the tuberculin skin test. If this is positive, further investigation is necessary and usually an X-Ray of the chest is made.

In 1895, Wilhelm Conrad Roentgen discovered the X-rays which was to revolutionize diagnosis in many fields of medicine. It is unquestionably the greatest diagnostic aid we have in tuberculosis aside from sputum examination. However, a differential diagnosis of tuberculosis cannot be reached without a clinical history, physical examination, laboratory methods and X-ray examination of the lungs.

Lesions heal by preventing the multiplication of bacilli, destroying or encapsulating those in the tissues, and repairing the damage done to the organism. There are two chief reasons why lesions may fail to heal. One is that the lesion may be so located that local factors interfere; the other, the person's unresponsiveness with a defense adequate to meet the situation created by the infecting germ.

In the same measure as our interest in tuberculosis and our success in its treatment has our understanding broadened. It has become more and more evident that the domestic, social, economic and emotional problems of the

patient are of the utmost importance in cure. The treatment of tuberculosis has become a dual one. It has been found necessary not only to treat the disease but to treat the personality of the individual as well, so as to make it helpful rather than harmful. Even those methods of treatment which are directed almost exclusively toward the disease process depend upon the condition of the patient's mind. Another determining factor in the treatment of tuberculous patients is the psychology of the physician. M. F. Pottenger[1] describes this thus:

> "Unless he is interested in human beings and their problems, unless he is sympathetic with the disappointments, sacrifices and struggles that the patients are required to make, he cannot aid his patients to the fullest extent; for their greatest problem is often that of developing a proper psychologic attitude in the face of uncertainties of treatment and the disappointments attendant upon the necessity from a withdrawal for an uncertain time from the active duties of life. Many of the most serious difficulties are those of a domestic, economic and social nature, and unless these can be solved recovery will be retarded and may be prevented."

One of the questions that must immediately be decided when active tuberculosis is diagnosed is where and how shall the patient be treated. A few decades ago the treatment of pulmonary tuberculosis was relatively simple. The accepted routine consisted of rest in bed, fresh air, light, sunshine and plenty of food. Minimal cases did well with this routine but not the advanced cases. Today, in order to plan a more adequate treatment, the physician has to determine if the case is minimal, moderately advanced or far advanced, whether it is acute or chronic, unilateral or bilateral. There must be a choice between home treatment and sanatorial treatment. If sanatorial treatment is recommended, there must be a choice between routine management and surgical collapse. To carry on treatment of tuberculosis is not an easy task any more. It requires knowledge, skill

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[1]Ibid. Page 51

patience and tact on the part of the physician, and confidence, loyalty and determination to get well on the part of the patient.

Bed rest is still the fundamental treatment for pulmonary tuberculosis. All other forms of treatment are aids to this fundamental principle. This does not mean physical rest only. The adjustment of the patient to his disease and to his social, economic and domestic problems is a necessary part of his rest treatment.

There is no special diet for the treatment of tuberculosis, but an adequate well-balanced diet may be considered one of the important factors in the treatment of tuberculosis. The purpose then, is to furnish a dynamic diet in sufficient quantities so that the patient's defensive forces will be raised to the highest points possible.

Any measure which improves the patient's physiologic response, whether it be food, rest, exercise, open air, sunlight, a proper psychology, etc., meets the first goal in treatment, that is, aids the patient in developing a natural and specific defense. The second aim in the treatment of tuberculosis is to bring about favorable mechanical conditions for healing to take place. As the disease extends, the volume of the lungs diminishes. The pulmonary tissues go through great tension in order to fill the intrathoracic space, and this interferes with cavity closure and healing. Lessening the space by compression measures which put the lung at rest has become one of the most outstanding procedures in the treatment of tuberculosis.

Collapse therapy is not a cure for tuberculosis but a remedy for complicating mechanical conditions which interfere with recovery.

Pneumothorax is the most commonly used form of collapsed therapy. It consists in the introduction of air into the pleural cavity in order to restrict the movement of the diseased lung.

Sometimes adhesions prevent a proper collapse of the lung and then a pneumolysis, that is, the cutting of the adhesions is necessary.

If the disease is in the lower part of the lung and pneumothorax has not been successful, a phrenectomy is practiced. The aim is to paralyze the diaphragm by crushing or removing a long section of the phrenic nerve. When the diaphragm is paralyzed, it rises and so the pull of the collapsed lung is removed.

Pneumoperitoneum is sometimes established to increase the rise of the diaphragm. It consists of injecting air into the peritoneal cavity.

A more serious measure of collapse, because of its irreversibility, is thoracoplasty. It involves the removal of the ribs so as to allow the chest wall to fall in and hold the affected lung in collapse. The number of ribs as well as the length of each rib that is removed is according to the needs of each particular case. When more than one or two ribs are removed the operation is done in stages.

Furthermore some cases need a lobectomy or a pneumonectomy. They consist of the removal of a section of a lung and amputation of the lung, respectively.

Medicinal treatment that would cure tuberculosis has not been discovered yet. There is no specific drug for curing the disease, although streptomycin has given some encouragement. It stops the multiplication of bacilli, but does not destroy them. If the patient's own resistance is sufficient to destroy the bacilli in the tissues, cure results after treatment with streptomycin; if not, after a temporary checking the disease continues to develop.

Rehabilitation is another cornerstone in the treatment of the individual suffereing from tuberculosis. It should start from the day the

diagnosis is made and continue until the patient is again established as a self supporting individual in the community. This is the responsibility of the doctor, nurse, social worker, occupational therapist and all the other professional personnel whose goal is the re-establishment of the individual in a normal existence.

All the factors discussed above are of necessity to be considered in planning the treatment of tuberculous patients. This is the task of the doctor and the patient with the help of all other persons concerned with the problems, through joint consultation, planning and effort.

Prevention of tuberculosis has been the aim of a large number of surveys and campaigns throughout the world. Since 1882, when the causative agent of tuberculosis was discovered, the idea of prevention and control became one of the most important aspects in the fight against tuberculosis.

In outlining a program for the prevention of tuberculosis we need the co-operation and the combined effort of all official and voluntary organizations in the community. Special attention should be given to the education of the patient, his family and to the whole community, but always preventing the creation of the harmful state of phthisiophobia, that may be brought about by carelessly over-emphasizing the infectious aspect of tuberculosis.

The aims of the public health program are, first, to prevent that those not already infected become infected, and second, to prevent those with active clinical disease from dying and from spreading it to others, and finally, to bring about the maximum recovery.

Besides educational campaigns focused toward the outcasting of superstitions about misconceptions that interfere with the public health

program, it is absolutely necessary, if we are to succeed in the fight against tuberculosis, to have available all the facilities for an early diagnosis and an adequate treatment of all cases. B. C. G. vaccination of newborn babies is another measure that might become an important tool in fighting tuberculosis. This hope is expressed by Dr. Pottenger[1] when she says:

> "Vaccination has an immunological basis, It is logical. It is harmless. It is effective. It is now time that the B.C.G. be used in the protection of the exposed the same as mass tuberculin testing and mass X-raying are used in finding the infected."

Community organization and social action should be directed toward getting special aid in improving nutrition and housing and securing more hygienic living for the people and making available early diagnosis and treatment and sanatoriums, to offer institutional care for all the patients in need of it.

Resistance to diagnosis and treatment is one of the most difficult problems with which doctors, nurses, and social workers must deal. Some patients who refuse hospitalization and who refuse to observe reasonable precautions threaten the lives of others. Through education given by the nurse and casework treatment offered by the social worker many patients finally accept diagnosis and treatment. However, for the sake of the community the Philadelphia Health Department[2] has evolved a plan of court commitment for such cases in one of the tuberculosis hospitals maintained by the Health Department. During 1948, eighty-four patients were hospitalized under this plan. This is a problem in the treatment of a disease in which psychological and emotional factors play a very important role.

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[1]Ibid. Page 596

[2]Russel E. Teague, "Study of Tuberculosis Control in Philadelphia", Public Health Reports, March 3, 1950.

The Provincial Health Regulations in the Province of Quebec prohibit tuberculous patients with active disease from being food handlers. They are not allowed to be employed when having active disease where the air is or becomes loaded with injurious dust. No law exists, however, to enforce hospitalization when medical authorities consider it to be necessary and when such treatment is not voluntarily accepted by the patient.

Summing up, it can be said that since Koch's famous discovery of the etiology of tuberculosis, long strides have been made toward the wiping out of tuberculosis. As shown in tables (II) and (III),[1] the average rate of cases of infection and deaths from tuberculosis in the United States, Canada and the rest of the civilized world has been continuously declining. But, still there is a long distance to go before the fight against tuberculosis is over. In order to attain our goal of controlling the disease, the Health Department, the Sanatorium, social agencies, tuberculosis associations and all official and voluntary organizations in the community, should get together in a joint, planned effort to make of the whole program of prevention a unified, total process.

The next chapter will deal with the assumption that tuberculosis and its treatment impose a strain upon the emotional and psychic life of the individual.

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[1] See Appendix, Pages 70 & 71

CHAPTER III

STRESSES AND STRAINS IMPOSED BY TUBERCULOSIS AND ITS TREATMENT UPON THE LIFE OF THE INDIVIDUAL

There can be no doubt that the emotional reaction to tuberculosis is usually very severe. The development of this disease operates as a psychological crisis in the life of the individual, even those individuals deemed "well adjusted" or "well balanced".

From the very moment the diagnosis is given, the patient is submitted to a severe crisis of emotional stress. However, these patients differ from the majority of the psychiatric cases in that they have to face a difficult reality situation at a time when they are physically ill. The loss of earning capacity, the physical illness itself, the treatment it entails, and the constant fear and danger of relapse are some of the difficulties affecting the emotional, social and economic life of the tuberculous patient.

In this chapter the writer will discuss the reactions of the patients in the sample group to diagnosis, and the different stages of treatment: hospitalization, and the specialized therapy of collapse, including surgery. The effect of the patient's personality prior to his illness upon the behaviour of the tuberculous individual, will be discussed in the following chapter.

The diagnosis is the initial psychological shock the person receives. The reactions of the individuals in the sample group were intense and diverse. They reacted to it with their emotions and their intelligence, that is, with the whole of their personalities.

Inevitably, the diagnosis of tuberculosis implies that the patient will have to face a prolonged confinement. Reluctance to accept this is coupled with financial worries and anxieties concerning the family.

None of the patients in the sample group openly expressed the fear of death. Case number two, however, exhibited a very superficial cheerfulness which could be interpreted as a mechanism to cover her tenseness and her fears. She would discuss her disease laughingly and comment that "her tuberculosis was a special one because it was in her blood and in all parts of her body."

Due to these real factors a complete acceptance and adjustment to the disease and its treatment is quite rare. In the cases studied, the response to the diagnosis varied from cheerfulness to marked depression and were described by the patients as follows:

Five of the fifteen cases in the sample group stated they felt "unhappy", "miserable" and terribly depressed. Case number nine illustrates this type of reaction beautifully:

> Miss A. is a young attractive girl, 17 years old. When tuberculosis was discovered she felt miserable. She was working and was planning to get married soon.
>
> The diagnosis was given to her at the Royal Edward Laurentian Hospital where she was referred by her family doctor. Her mother who had suspected that it was tuberculosis had prepared her for the diagnosis. Nevertheless, the daughter felt it was a terrible shock and considered it the end of everything. She felt very unhappy and cried for days. Immediate hospitalization was recommended, but she had to wait for a bed. During that period she became moody and irritable. At times she would refuse rest, at other times she would simply lie in bed for days without talking or doing anything.
>
> After a month the cavity in her lung increased in size and the patient had to be admitted to the sanatorium as an emergency. She was hospitalized for 18 months and was then discharged, but had to continue pneumothorax at the Montreal Division.

Two of the patients studied stated they could not believe they were ill. It came as a shock and they needed time to accept it. Denial was used as a defense because of their inability to accept the fact of their illness. Case number 13 shows this reaction:

This is a single woman, 42 years old, who had been in charge of her family since she was very young. At the time the diagnosis was given she was housekeeping for her father and her two unmarried brothers. She refused to give up her duties or to realize that she was ill. As her lung condition was becoming worse and she would not consider hospitalization, she was referred to a psychiatrist. After a while the patient agreed to let another person care for her family and she is now hospitalized at St. Agathe.

Another type of reaction was shown by two cases who received the diagnosis almost gladly. Case number 1 is a good example. When informed that she had tuberculosis, she said: "I am glad, now I can rest."

Three patients took the diagnosis quietly without any expression of feeling. They were apparently resigned with their fate and did not complain. Case number 8 shows this kind of reaction.

This is the case of a single man, 31 years old. He was 18 when tuberculosis developed. Hospitalization was considered urgent. The patient accepted it quietly and did not show any feeling whatsoever.

Before his breakdown he had shown some symptoms of abnormal behaviour, such as exposing himself and peeping into bedrooms at night. On one occasion he was caught by the police and punished. The patient considered tuberculosis was a punishment for his behaviour and accepted it without complaint.

After four years in hospital he was discharged for violating the rules of the institution. Now he is at home, living with his mother and sister. He takes very good care of himself and never misses a treatment at the Royal Edward Laurentian Hospital. His abnormal sexual behaviour has continued, but when he was referred for psychiatric treatment for this, he refused to discuss his sexual problems with the doctor.

One patient refused to comment on how she felt when the tuberculosis was diagnosed. She explained that this had happened many years ago and she did not want to remember the past.

Two cases said the shock of the diagnosis left them confused and terribly worried. This reaction is illustrated by case number 2.

This is a young and attractive woman, who was 23 years old when the disease was diagnosed. She had been married for a year and had just had a baby. She was so confused that she

now says she cannot remember what really happened, that "the only thing I had in my mind was that I had tuberculosis and that I had to leave my husband and my baby."

Wittkower[1] in one of the most exhaustive studies made about tuberculous patients in English sanatoria, points out the severe initial shock which follows reception of the diagnosis. He says it is usually accompanied by dismay and horror. After this follows certain patterns of emotional reaction including resignation, indifference, depression, anxiety, defiance, cheerfulness, resentment or apathy.

Dr. Jules V. Coleman[2] also describes the reactions of different patients to the diagnosis of tuberculosis. He says:

> "The dreaded word tuberculosis may produce a psychologic blackout in which the patient is incapable of understanding or even hearing anything that follows. Various reactions are then noticed. Sometimes there is a dull apathy that persists for weeks or months. A more active response with more expression of feelings, weeping or agitation may be safer than a walking out reaction. Blustering denial of the serious significance of the illness is often more serious and difficult to handle, and incalculable physical destruction and breakdown of personality may ensue before fuller awareness is reached. Still other patients respond to explanations with anger and rejection which may be a way of fighting off feelings of guilt."

The reactions to the diagnosis of four of the patients in the sample group were influenced by their preconceived ideas about tuberculosis, which has at times been associated with "dirt", "bugs", "worms" and "holes in the lungs."

Case number 1 is a very good illustration of this association of tuberculosis with "dirt" and "bugs":

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[1]Wittkower, op. cit.

[2]Jules V. Coleman, Hurst and Honbein, "Psychiatric Contribution to care of Tuberculous Patients," Journal of American Medical Association, Vol. 135, pp 699, 1947.

> The patient is a nice looking girl, 19 years old. Her first contract with tuberculosis was at the age of ten, when she had to keep bed rest for three months. When she went back to school she felt that she no longer had a place among the girls in her grade, and this feeling of difference was greatly increased when on her return the nurse found she had head lice and so told the girl in front of the class. The other students started calling her names related to tuberculosis, "bugs" and "dirt."
>
> Four years later, when she was in school, she suddenly had the feeling that her head and her face were all full of bugs. She knew she did not have lice, but she had the itchiness and the sensation of lice in her scalp. She became very nervous and anxious and stopped eating and resting. Consequently, she had her second breakdown with tuberculosis and was hospitalized. While in the hospital her symptoms became accentuated and she was referred for psychiatric treatment. For a long time the patient associated tuberculosis with "dirt" and "bugs".

Other groups of patients associated tuberculosis with long years of forced idleness and with the possibility that they might never return to full working capacity.

Misconceptions acquired from parents about the disease are of great importance in the ultimate acceptance of tuberculosis and its treatment. As Holland Hudson[1] explains, "each one of us began life as a child and each of us is influenced throughout our lives by the parents, brothers and sisters with whom we grew up."

Case number 6 showed this clearly:

> This is a young girl whose father has for years suffered from tuberculosis, but has always denied the disease. Three of the seven children in the family developed tuberculosis and he persists in taunting them "You are consumptive." This patient received the diagnosis with great anxiety followed by a severe depression.

Case number 8 showed how tuberculosis was considered a stigma, something to be ashamed of. In discussing the possible source of infection, Mrs. S. explained that she could not understand how her son developed

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[1]Holland Hudson, "The Role of the Family in the Control of Tuberculosis", American Review of Tuberculosis, Vol 57, pp. 519-527.

tuberculosis. She said: "My husband came from a very nice family and my family was very good too. There has never been tuberculosis in either of them."

Four other patients confessed to having been absolutely ignorant of what tuberculosis and its treatment was, when it was first diagnosed.

The rest of the patients had some knowledge of the disease through contacts with friends and relatives who suffered from it. In some of these cases identification with a relative who had died after many years of suffering was the cause of very disturbing symptoms. Case number 13 refused to accept her illness until psychiatric treatment was offered. The patient's previous contact with the disease was through her mother whom she had nursed until the latter was admitted to the sanatorium. One month after admission the mother had died.

E. G. Seltzer[1] describes these attitudes of patients and their families to the disease as follows:

> "In spite of long years of public health education there are still many who are totally ignorant of the facts concerning this disease, or who are influenced by superstition. Many attitudes toward the disease and many of the patients' own feelings about it spring from attitudes that are prevalent in our culture. Large groups in the community still consider tuberculosis of which to be ashamed, a taboo. It belongs to the group of illnesses which still carry stigma, such as mental and venereal diseases. Tuberculosis seems to be linked with ideas of weakness, it suggests to some poor heredity, to others lack of cleanliness. To many it represents a failure to live up to the generally admired standard of health and strength, and this, in our culture is unforgiveable."

In the treatment of tuberculosis a fundamental conflict exists between the need of the community to protect itself from the danger of infection, and the personal need of the patient for a great deal of

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[1]E.G. Seltzer, "Personal Problems in Treatment of Tuberculosis," American Review of Tuberculosis, Vol. 49, 1944, p. 561.

attention, acceptance and understanding and the warmest possible support from relatives and friends. The patient often resents the slightest sign of rejection and usually considers the precautions taken as sings of fear of the disease, or else of rejection of himself. The following case illustrates this conflict:

> Case number 5 is the case of a young, well educated woman. As soon as tuberculosis was detected, the patient felt rejected. Before the onset of tuberculosis she had worked to help her husband through college. She held the same job for over two years and had received several promotions. However, when the disease was discovered she was "discharged at once". Her husband, who together with the wife was living with her parents, left the house and is now living with his own parents. He visits his wife occasionally. The patient feels she "gets on her father's nerves" and that her mother resents the responsibility of taking care of her. The mother's attitude is that the patient "takes out her frustration on me, but I can take it."

Another good example of this feeling of rejection is shown in case number 12.

> The patient is a young married woman, who had three children. While she was pregnant of her youngest child, her husband deserted her. After the child's birth the patient developed tuberculosis. Three months later her baby died, and as she was unable to take care of the other two children, they were placed in another home. The patient then felt terribly lonely and finally went to live with a married sister. The patient was not contributing financially and soon felt that her presence in the home was a cause of discord between her sister and her sister's husband. After a short time her sister also developed tuberculosis, and things became so difficult for the patient that she left the home and went to live with a married man. Her sister called her ungrateful and stated that the patient was "mentally lost." She did not care about her children or about her health. Soon she began to feel terribly ill and came back to her sister's home despite her feeling that she was not wanted there. She asked for admission to the hospital and finally was admitted. She is now receiving psychiatric treatment in the sanatorium.

The second traumatic psychological experience comes when a patient learns that he has to be hospitalized. In every case in the sample group the medical recommendations included institutional care. Some of the

cases had to wait for beds. Others were hospitalized at once. In these cases the patients felt they were hospitalized in order to prevent the spread of the disease to their families and the community. Two cases were hospitalized as emergencies. In only three cases did the patients feel that the hospitalization was recommended primarily for their own benefit.

Hospitalization means removal of the patient from the home for a long period of time. In twelve of the cases this recommendation was given at the same time as the diagnosis. Two patients refused to accept it. Hospitalization was readily accepted by ten patients. The other three cases were advised to rest at home, but eventually they too were hospitalized.

Of the seven patients who left the hospital against medical advice, four were readmitted later. Of these four, two patients were subsequently discharged upon medical consent. The other two were dismissed from the hospital for disciplinary reasons.

Eight of the patients in the sample group were discharged as improved and with medical consent. Of these, four had a relapse and had to be readmitted. Two of these left against medical advice; the other two stayed in the hospital until discharged for the second time.

Summarizing, of the fifteen cases studied we found that eleven left the hospital against medical advice sometime during the course of the disease.

The general opinion of the group of patients who were readmitted was that it was harder for them to accept hospitalization the second time that it had been the first time. The following case illustrates this point:

> Case number 2 is a young married woman with a boy four years old. Tuberculosis was diagnosed after the birth of her child. Soon after his birth the baby was admitted to the B.C.G. Clinic and the patient was hospitalized at the Royal Edward Laurentian Hospital, Laurentian Division. After two months in the hospital she left against medical advice. For four years she remained at home

attending the Royal Edward Laurentian Hospital, Montreal Division, and doing fairly well. However, recently her sputum again turned positive. The doctor's advice was for her to go back to the hospital for six months. The patient explained that she felt desperate and immediately refused to follow the doctor's suggestion. She cried bitterly for four days. The patient saw her doctor at the clinic recently; and while discussing her hospitalization, she told him: "If you give me a written statement saying that it would be only six months and that afterwards I will be all right again, I will go to the Sanatorium."

Of the cases who left the hospital against medical advice six stated that they were restless and anxious and that they believed they would be much better at home. Three cases believed the hospital was not doing anything for them. They complained about the meals and the medical care. Two other patients were discharged for violating the institution's regulations.

Hospitalization also means giving up the privacy and comfort which some of the patients enjoy in their homes. Case number 10, a woman 43 years old, a very unstable and narcissistic person, resented being in a ward with other patients. It was very difficult for her to eat her meals when she was sorrounded by so many patients who were coughing and spitting. She was also very disturbed by the patients who were dying and who seemed to her to be just "skin and bones" after many years of suffering. This patient left the hospital against medical advice and is very hostile towards nurses, doctors and hospitals.

The positive and negative effect of the fellow patients in a hospital is another very important factor in the final adjustment of the patient to this new way of living. For instance, case number 15 refused surgery because she saw a man die after an operation similar to the one recommended her by her doctor. When she was told that she needed the operation, she became very upset and cried bitterly. She stated that during the first weeks of her hospitalization she became very confused and upset from listening to

the other patients' conversations. She explained, "all you hear is about tuberculosis and treatment. Some of the information is correct, but most of the time they give wrong concepts about the disease."

Tuberculosis is a long-range adversary which inevitably brings difficulties and worries. The realtionship between husband and wife, parents and children, employer and employee, etc., are usually affected by tuberculosis and its treatment.

Of the fifteen patients studied, ten had to leave their jobs as a result of the diagnosis and treatment of the disease. After their discharge from the hospital the general urge was to look for different employments. Some of the patients did not want to return to their former jobs because they felt that everybody knew they had had tuberculosis and their former fellow employees would always be looking at them as tuberculous patients. Others believed that their employer would not take them back. They showed great fear of further rejection, as the following instance indicates:

> Case number 7 is now authorized to do four hours of sedentary work. She is a young, attractive woman who feels she should work in order to help financially as her husband's income is inadequate to meet the family needs. She will not consider going back to her former job, as she is sure her employer would not take her back because she had tuberculosis. She would rather do harder work elsewhere than return to her previous work.

In the sample group relationships between husbands and wives were also affected by the disease. In six cases the relationship became very strained and in two cases legal separation followed the diagnosis of tuberculosis in one of the parties to the marriage. Case number two expressed the opinion that the sanatorium is good for unmarried patients, but that married women should be with their husbands. She believed that her husband was wonderful, but during the short time she spent in the sanatorium, she

heard of so many husbands who were going around with other women while their wives were in the hospital, that she could not bear to stay in the hospital. She was afraid her husband would do the same thing.

Case number 3 further illustrates the difficulties in marital relations accentuated by the disease:

> This is the case of a male patient, 28 years old. He married when he was very young and went to live with his wife's parents. He never felt he was the head of the family. Four years after his marriage he developed tuberculosis, and when hospitalization was recommended, he accepted it immediately. While in the hospital, he fell in love with another patient. This brought on difficulties with his wife, but when the patient was discharged for breaking the rules of the institution, he went back to her because he had nowhere else to go. The difficulties continued and each one accused the other of going out with a different partner. The wife was working and the patient had to stay in bed all day, depending on her for all his needs. He became very anxious and finally they were both referred for psychiatric treatment in the hope of improving their relationship.

Two of the patients in the sample group were adolescents when they were admitted to the hospital. While in the hospital, they became more independent and felt ambivalent toward their parents and towards the problems of sex and occupations. In one case the patient refused to go back to her mother. She is now living with a sister and has made arrangements to study in order to become independent as soon as possible. The other case went back to her home, but she would not permit anyone to interfere with her activities. The patient's mother states that she cannot handle her anylonger and has decided to let her do as she pleases, as this is the only way to keep peace in the home.

Case number 10 is an excellent example of the effect of tuberculosis upon the relationship between mother and child:

> Seven months before the patient's breakdown with tuberculosis, her son, who was seven years old, returned home from the hospital where he had been hospitalized for many months with infantile paralysis. The patient continued her son's treatment at home

> and soon became very restless and nervous, and tuberculosis developed. The patient was then hospitalized for 18 months, and when she returned home, the child would not obey her and she declared herself unable to handle him. He snapped at her and became very rude and harsh towards her. When the patient complained about her health he would comment "that is all I hear in this house: I am tired, I am sick" and then he would walk out leaving her crying. The patient was very upset by her son's behaviour and commented that the only thing a person needs to be happy is not to have children. She wants him to go to camp and told him "You are going to camp; I have to rest from you for at least one month."

We will now turn to another aspect of treatment which may be considered another traumatic psychological experience in the lives of the tuberculous patients. Besides the emotional shock caused at first by the diagnosis of the disease, and secondly, by the separation of the patient from his family and friends, the patient must have a third disturbing experience in accepting the specialized treatment for the collapse of the diseased lung.

Of the fifteen cases in the sample group, eight patients were having pneumothorax and two were having pneumoperitoneum. Two other patients were on strict bed rest. One had a phrenectomy and five had thoracoplasty. Three patients had had both pneumothorax and thoracoplasty.

The reaction of the patients to pneumothorax was dependent on their previous knowledge of this therapeutic procedure. Case number 7 was terrified when the doctor recommended pneumothorax. A very good friend of her mother's had died as a result of a certain complication produced by the pneumothorax. Her family was therefore opposed to the patient's having it and, consequently, she refused treatment for a long time. It was not until she saw what pneumothorax was doing for other patients that she accepted it. She commented "now I am very glad I did accept it."

Case number 3 was very impressed by the comments of other patients in the hospital regarding pneumothorax. He was afraid of the needle and of the complications. In spite of doctors and nurses' interpretations, he

consistently refused to accept it. Finally he accepted it when he was readmitted to the Sanatorium after having left it against medical advice.

Case number 9 shows another reaction towards treatment. This patient has become very dependent on the pneumothorax and fears the moment when this treatment will be discontinued. She fears she might have a relapse if her lung is permitted to expand.

Five patients had thoracoplasty. The feelings of all of them toward the operation were similar. They felt overwhelmed and terrified at the resulting deformity. Fear of death as a sequel of the operation was not expressed by any of these patients.

Patients need a good and honest explanation and interpretation of the operation and of the expected results, and must be given an opportunity to express all their fears and doubts, if they are to be able to understand and accept the operation. The following case illustrates this beautifully:

> Case number 10 is the case of a woman who had a thoracoplasty in three stages. She felt extremely hostile against the doctors, nurses and everything associated with the hospital. She made a detailed report of all the operations she had undergone and told how she was "neglected" in the hospital. She cries every time she mentions all the sufferings she has gone through. She stated that she accepted the first operation because she thought it was going to cure her. Then two more operations followed. She showed the writer the scars saying, "look how they have cut me, look at the mess they have made of me." She complained that they should have told her that there was to be more than one operation. She felt the doctors should be honest and tell the truth to the patients.
>
> She resents her physical appearance as a result of the operations and feels that everybody laughs at her. She also feels that she was used as a "guinea pig" in the hospital for experiments, and to give the internes practice. The patient feels acutely unhappy and said she wished she were dead rather than suffering as she is now suffering.

A patient must be helped out to accept the need for surgery and to understand why operation is necessary. Then he must make the decision

himself after an honest interpretation of what is going to happen. He must be aware that surgery is not going to cure tuberculosis, but will aid in his recovery. Only through this process may the operation by successful.

In this chapter the writer has described and illustrated by means of case materials the strains and stresses that tuberculosis and its treatment impose upon the emotional life of the individual. This aspect of tuberculosis has now been generally accepted by the medical authorities. Nevertheless, we have to consider the question of why some patients show more ability to withstand these strains and stresses than others. In the next chapter the writer will try to answer this question by analyzing the effect the pre-tuberculous personality has upon the behaviour of the fifteen patients selected for this study, after they had contracted the disease.

CHAPTER IV

THE EFFECT OF THE PATIENT'S PREVIOUS PERSONALITY UPON HIS BEHAVIOUR AND UPON HIS REACTION TO TUBERCULOSIS

Since psychiatrists became interested in the emotional problems of the tuberculous patients, many studies have been carried out by psychiatrists and phthisiologists in relation to the personality of the tuberculous patient, before and after the onset of tuberculosis. Consequently, a controversy has developed between two schools of thought. Some medical men are of the opinion that tuberculosis produces a definite pattern of thought and conduct and that there is a well defined personality structure which is typical of the tuberculous patient. They also believe that there is an abnormal mental state peculiar to the disease. The other group mantains that tuberculosis differs slightly from any other chronic, organic illness in its effect upon the mind. They believe that the tuberculous patient has not a typical character or a personality, but that he is an individual whose emotional reactions are mainly determined by his previous personality. They think that the patient's response to tuberculosis is essentially his general response to life and its difficulties.

This second assumption, i.e., that it is the previous personality that determines the patient's reaction to tuberculosis and its treatment, will be explored through the analysis of the cases forming the sample group of this study.

By personality the writer means the behaviour and attitudes of the patient as influenced by the social and emotional environment at home and by his experiences at school and in his work.

In order to learn something about the patients' previous personalities, the writer looked for the following data in each of the cases studied:

1- Which was the first contact the patient had with tuberculosis which might have affected his attitude toward the disease?

2- What was the nature of the family relationship before and after the patient's breakdown with tuberculosis?

3- What was the character of the relationship between the patient and other tuberculous patients in the family group?

4- What was the nature of the patient's relationship and experiences in school and in his work?

The data were gathered from the medical records kept by the doctors and nurses from the Royal Edward Laurentian Hospital; from the psychiatric evaluation done by the psychiatrists from the Allan Memorial Institute of Psychiatry, the Royal Victoria Hospital Psychiatric Clinic and from the Royal Edward Laurentian Hospital Psychiatric Clinic. Excellent material was also gathered from the social service records in the cases where they were available, and from the interviews with the patients and their relatives.

Some of the records disclosed good information regarding the patient's background, including the relationship existing between the patient and his family group before and after the tuberculous breakdown, and regarding the character of the individual and his behaviour before the development of tuberculosis. In other cases most of these materials were missing and the writer had to combine pieces of information from the different sources of material in order to acquire some knowledge of the patient's personality in the past. The material so collected had many limitations. The writer is conscious of the fact that this is a very difficult subject to deal with. All the information is likely to be affected by the biases and prejudices of

the professional people who recorded it. Moreover, the information requested was related to characteristics and behaviour of the patients many years back and some of the informants did not have a clear recollection thereof or had distorted ideas of what really happened. Another of the greatest difficulties the writer met in trying to explore the assumption under consideration in the sample group was that in fourteen out of the fifteen cases, the patients were referred for psychiatric treatment many years after the onset of tuberculosis. Despite these shortcomings, the materials available offered important clues for an understanding of the patients' personalities as now stand.

The writer used seven cases from the psychiatric clinic of the Royal Edward Laurentian Hospital. This is a new clinic and these patients were recently referred to the psychiatrist. In most of them a psychiatric evaluation of the present situation was the only psychiatric information available for they had been seen by the psychiatrist only once.

The other eight patients in the sample group were cases referred by the Royal Edward Laurentian Hospital to the Allan Memorial Institute or to the Royal Victoria Hospital Psychiatric Clinic before the organization of their own psychiatric clinic. In most of these cases the record included psychiatric evaluations which were written after the patient was discharged from the institution.

A clear-cut psychiatric diagnosis was available in ten out of the fifteen patients. One patient was never seen by the psychiatrist and in the other four a general description of the characteristics and the present behaviour of the patient was given instead of the diagnosis. The psychiatric diagnosis in the sample group are as follows:

TABLE 3

Distribution of the Sample Group According to the Psychiatric Diagnosis

Psychiatric Diagnosis	Number of Patients
Total	15
Anxiety with Depressive Features	5
Anxiety with Hysterical Features	2
Chronic Anxiety State	1
Obsessive Compulsion	1
Hysterical Reaction in a Very Immature Personality or Early Schizophrenia	1
Not seen by a Psychiatrist	1
No clear-cut diagnosis	4

In the sample group studied the writer found out that in the majority of the cases the patients were experiencing emotional and mental distress before or at the time of their breakdown with tuberculosis.

Breuer[1] explains the influence of the emotional and psychological factors in the etiology of tuberculosis as follows:

> "Maladjustments in the work life, the social life and the emotional life, easily produce upsets which undermine the resistence-maintaining way of living. Therefore it, is not surprising that psychic disturbances, such as long continued mental conflicts, excessive fatigue, or emotional situation from which there is no escape, result in tuberculosis."

It is the writer's assumption that these problems do not only affect the etiology of tuberculosis, but also affect the course of the illness and the individual's reaction to the disease and its treatment.

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[1]M. J. Breuer, "The Psychic Element in the Etiology of Tuberculosis," American Review of Tuberculosis. Vol. 31, 1935, Page 233

The first contact the patient had with tuberculosis, and his past experiences with other members of the family who had suffered from the disease, are factors influencing the patient's reaction to the disease and its treatment. It is very significant to know if the patient is the source of infection or if he has been infected by another member of the family. Of the fifteen cases in this group, seven were infected by other members of the family. In other five cases the patients were the source of infection of other members of the family group.

In both situations there are significant implications with damaging potentialities to the personality of the patient. They might also influence the relationship within the family group and the reactions of the individual to the disease and its treatment.

Miss T.[1] is the case of a single woman, 43 years old. She is the eldest in a family of eight, and has for many years assumed the mother's role in the family. She also nursed her mother who had been suffering from tuberculosis for a long time. The mother died one month after having been admitted to the sanatorium. The patient was terribly disturbed and she felt responsible for her mother's hospitalization and consequently, for her death. Shortly after her mother's death it was discovered that Miss T. had tuberculosis too, and hospitalization was recommended. The patient would not admit she had tuberculosis and would not accept the required treatment. It was not until she was feeling very ill, that she agreed going to the hospital, but she left shortly after her admission, against medical advice. While at home, she continued assuming the mother's role, cocking the meals and housekeeping for her father and two unmarried brothers. She could not bear the thought of leaving the three men without a housekeeper.

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[1]Case No. 13, See Appendix, Page 113

It can be assumed that the patient refused hospitalization and treatment because she was not willing to give up the mother's role which she had always played and which she believed it her duty to continue playing after her mother's death. The fact that her mother died one month after her hospitalization, may have produced a deep fear of death that is underlying the patient's behaviour. In the above case, Miss T. was a contact for her tuberculous mother.

In case number six[1], Miss B. made herself responsible for the infection of her youngest brother, who as a mongolian idiot and who died from tuberculosis at the age of ten while Miss B. was in the sanatorium. This patient's adjustment to tuberculosis and its treatment has been affected by her past experiences and family relationship.

> Miss B. is single, 24 years old. Immediately after her hospitalization, the patient became very lonesome; she cried, had shaking spells, headaches, felt very nervous and dizzy. A year later her behaviour became more difficult. The event that precipitated this behaviour was the death of her youngest brother, of whom she had taken care before her hospitalization. She stopped eating, wanted to go home, found it impossible to rest in bed and feared she would start screaming. She felt a great longing for her brother and could not eat or sleep, was very nervous, restless, and everything bothered her. She resented the other patients and had dreams of being "cut open" and burried alive. Finally the patient was discharged from the sanatorium and was referred for psychiatric treatment.

Apparently, Miss B. felt she was responsible for her brother's death, for it appears that he contacted the disease from her. This and the feelings she might have had towards her brother, of whom she had to take care after her return from work, may be a possible explanation for her anxiety and her disquieting behaviour at the hospital.

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[1] See Appendix, Page 89

The family constellation and the kind of homes from which the patients came are significant factors in understanding the behaviour of the tuberculous patients.

Of the group of fifteen cases studied, only one patient had what may be classified as an adequate home and emotionally stable parents. The other fourteen patients had very unstable parents and inadequate homes.

Case number 14[1] showed clearly the effect of emotionally unstable parents upon the patient's personality and upon his reaction to tuberculosis and its treatment. Mrs. R. was admitted to the Allan Memorial Institute before tuberculosis was diagnosed. There tuberculosis was discovered and the patient was then referred to the Royal Edward Laurentian Hospital:

> On her admission to the Allan Memorial Institute Mrs. R's. primary difficulty consisted in anxiety and tension present since the age of 13 in varying degrees of intensity, expressing itself primarily in the form of severe headaches, and tightness in the back of her head. The onset of her symptoms coincided with the mother's deserting the family and going off with another man. Mrs. R. was the eldest in the family of five children and had to assume the mother's role in the home. The father was a severe alcoholic who "took it out on the patient", more especially since he felt that Mrs. R. looked like her mother.
>
> Mrs. R. was admitted to the sanatorium, but one month later she left the hospital against medical advice. She was greatly depressed and felt very unhappy in the hospital..
>
> The psychological examination showed that Mrs. R. had a bright, normal intelligence with some perfectionist drives. She also showed some hysterical features and considerable hostility directed toward male persons. In addition she showed ambivalence toward the mother and authority figures, hostility toward the husband and a longing for happiness.
>
> The patient's main worry while in the hospital was the welfare of her three children, who had to be placed before her hospitalization. She felt the children had been deserted by her the same way her mother had deserted her family when Mrs. R. was 13 years old.

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[1] See Appendix, Page 114

Case number 6[1] is another good example of the influence that the members of the family group have upon the personality of the patient:

> Miss B's. parents are both living. They are not legally married, but have been living together for about eighteen years. The father's legal wife is still living. Mr. B. is a severe alcoholic and has not worked since 1948. He "picks on" his children and is always telling them "you are consumptive."
>
> Miss B's. mother is described by the patient as very nice, but somewhat domineering. As far back as the patient can remember the mother has been working as a domestic and as a charwoman. The patient and her elder brother were brought up by the godmother until the age of six, when she had to go back to her parent's home. Miss B. stated it was very difficult for her to go back, for she had always considered her godmother as her own mother.
>
> Miss B. is the second eldest child in a group of seven siblings. Her eldest brother is also a tuberculous patient. Another brother, aged 20, had rheumatoid arthritis and since then he has become extremely quick tempered and on some occasions he almost loses his mind. Miss B. has been severely beaten by him several times. Her youngest brother, a mongolian idiot, died of tuberculosis at the age of 10, at the time when the patient herself was hospitalized.
>
> Prior to the patient's breakdown with tuberculosis, she was feeling tired and weak and sick to her stomach. As she could not work, her father called her lazy and turned her out from the home. For four months she lived with a neighbor, until her mother insisted on the patient's return home. A few months later she developed tuberculosis.

The frustrations and emotional deprivations experienced by Miss B. in her early years and the nature of the relationship with a very unstable family had influenced the abnormal reaction of the patient to tuberculosis and its treatment. When the patient was hospitalized, she became emotionally disturbed and had to be discharged and referred to the Allan Memorial Institute. After her discharge from the Allan Memorial Institute, Miss B. returned home and one month later had a relapse in her physical condition. Consequently, the patient was re-admitted to the sanatorium. It appeared that this patient was very ambivalent toward her family. Her home situation and family relationship were so difficult, that Miss B. was eager to stay

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[1]See Appendix, Page 89

away from home. Yet, once in the hospital, she felt so guilty because of her feelings toward her family, that she became emotionally disturbed and constituted a behaviour problem in the hospital.

The patient's attitudes and conflicts in his work or at school are a good index to determine the character of the patient's personality prior to his breakdown with tuberculosis.

It was the writer's observation in the sample group that most of the patients who had difficulties in adapting themselves to the school routine or to their jobs, had serious difficulties in accepting their new life at the sanatorium.

Case No. 1[1] showed the similarity of the patient's behaviour while she was in school to her behaviour at the hospital:

> Miss L. developed the first psychiatric symptoms at the age of 14, when she was in eighth grade. She felt a terrible itchiness on her face and scalp and had to scratch and rub herself as if she had "bugs". She became very selfconscious of her itchiness and felt that everyone was looking at her. She withdrew from all social contacts and soon afterward left school. She left her home town and came to Montreal to work. There her difficulties increased and she developed and obsessive compulsion of washing her hands until they were blistered. She also washed her hair two and three times a day. She shifted from one job to another, until tuberculosis was discovered. Her reaction to the diagnosis of the disease was "I am glad, now I can rest." While she was at the hospital, her emotional symptoms became more accentuated and she was so unhappy, that she left the hospital against medical advice.

Case number 6[2] also illustrates this type of disturbed person:

> Prior to her breakdown, Miss B. was working as a saleslady in one of the big department stores in Montreal. She did not make friends easily and did not get along well with her fellow employees. Immediately after work she had to come home to look after the family. She was very impatient and irritable in her work.

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[1] See Appendix, Page 74

[2] See Appendix, Page 89

> Her behaviour in the hospital followed more or less the same pattern. Miss B. became very sensitive to the remarks or teasing of the other patients. Her difficulties grew more acute after her hospitalization. She did not get along well with her fellow patients and said they were not the kind of people she liked to associate with. She was resentful, withdrawn and unwilling to discuss her difficulties with anyone.

Some of the patients in the sample group exhibited evidence of having been using tuberculosis for a definite purpose. As Alfred O. Ludwing[1] says:

> "Conscious or unconscious he (the tuberculous patient) may be using his tuberculosis for a purpose, for escape, for selfpunishment or even for purpose of retaliation toward the family or others. It may serve him as the long sought excuse to sink into helpless dependency."

To continue with Miss B., it appears that she is now using the disease as a means of staying away from her difficult home situation. Miss B. has had a deprived social economic and emotional life. She appeared to have taken a great deal of responsibility at home prior to her illness, and now she uses the opportunity to reverse her responsibility toward her family and toward the hospital. This attitude she has expressed by constant demands of gifts from the family, and attention and coddling from the medical staff. Miss B. was discharged from the Royal Edward Laurentian Hospital to wait for admission to the Allan Memorial Institute, where she was admitted a few weeks later. After her discharge from the Allan Memorial Institute, the patient had a relapse in her physical condition and was readmitted to the Royal Edward Laurentian Hospital.

Dr. Herome Hartz[2] describes this behaviour by saying that in a surprisingly large number of patients it will eventually be seen that feeling ill with tuberculosis was a way of attempting to escape from an unbearable

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[1]Alfred O. Ludwig, "Emotional Factors in Tuberculosis", Mental Hygiene, June 1947, p. 888

[2]Jerome Hartz, "Tuberculosis and Personality Conflicts" Psychosomatic Medicine, Vol. I, 1944, Page 351

emotional situation. He emphasizes the fact that unless this is understood, it may stand in the way of the patient's wanting to get well. It may unconciously hinder him from cooperating in the treatment. In severe instances, it may even lead to sabotage his own recovery.

Mrs. C.[1] is another instance in the sample group of the possibility of the patient's using her illness as a leeway to escape from overprotective parents. Mrs. C. explained that she had always wanted to live away from her parents, but never had the courage to do it. She accepted hospitalization readily and, in spite of her parent's objections, she was hospitalized. Mrs. C. was adjusting herself very nicely to the sanatorium, but suddenly she developed obsessive compulsive symptoms and it was impossible for her to remain in the hospital. Mrs. C. was crying all the time and washed her hands until they were blistered. She expressed the fear that she would not be able to get herself clean. Going to the bathroom was a ritual that could not be interrupted and it usually lasted about 45 minutes.

Mrs. C. returned to her home against medical advice, and there her symptoms grew more acute. She was then referred for psychiatric treatment. Now the patient is working the whole day and although she is still living with her parents, her symptoms have abated.

Lawson G. Lowrey[2] describes the psychodynamics operating behind obsessive compulsive behaviour when he explains that the compulsive need for cleanliness may be interpreted as a symbolic attempt to clean the unconscious guilt associated with masturbation, incestual feelings or with any other anxiety-producing situation. He says that the fears and rituals

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[1] Case No. 5, See Appendix, Page 86

[2] Lawson G. Lowrey, Psychiatry for Social Workers, (2nd edition), Columbia University Press, N. Y., 1950, p.

are strong protections against the irruption of disturbing unconscious material into consciousness, and usually the earliest attachment to parents is involved in this kind of behaviour.

In the analysis of the sample group the writer found that other conditions, mainly psychological, existed, which, in her opinion, might be interpreted as further indications of a long history of emotional instability and insecurity of the patients in the sample group. Some of these conditions developed with the onset of the tuberculosis. In other cases they were present long before the disease developed, but they became accentuated when tuberculosis developed. These conditions are anorexia, suicidal tendencies, alcoholism and amenorrhea.

Tuberculosis is one of the most frequent causes of amenorrhea. This condition was present in three of the cases in the sample group and it is the writer's impression that it added to the nervous disturbance of the patients as expressed by the weakness, dizziness, indigestion, insomnia, etc., experienced by the patients.

Suicidal attempts were registered in two cases in the sample group. In the case of Mrs. D.[1] their erratic behaviour existed years before her breakdown with tuberculosis. After Mrs. D. developed tuberculosis, she became so deppressed that she tried to commit suicide in an attempt to put an end to all her worries and difficulties.

Case number 7[2] tried to commit suicide first when thoracoplasty was recommended, and again shortly after the operation was performed. Two other patients threatened to commit suicide.

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[1]Case number 12, see appendix, page 110

[2]See appendix, page 93

Mrs. S.[1] is a young married woman who used to drink heavily when she was upset and probably used liquour as an escape from domestic difficulties. In this case the husband and the father were also alcoholics.

Anorexia, a condition associated with tuberculosis, is also associated with the individual's drives against himself. This condition was present in three of the cases in the sample group. Dr. Karl Menninger,[2] mentions tuberculosis as one of the illnesses in which psychic factors contribute toward the individual's self destruction. He says:

> "Tuberculosis is after all a graceful way to destroy oneself slowly, tragically, often with relative comfort, good food, rest, peace and the sympathetic tears of all."

The influence of the family relationship on the tuberculous patient and on his attitude toward the disease and its treatment was also shown in the analysis of the sample group. It is the writer's belief that families enlightened in regard to tuberculosis can make important contributions in the fight against the disease. In some of the cases it was felt that, from the emotional point of view, other members of the family needed more care than the patient. They, too, must learn to accept the disease and must be urged to treat the patient as objectively and as normally as possible.

The analysis of the fifteen patients selected for this study suggests that, according to the psychiatric diagnosis and the patient's behaviour, most of these patients were neurotic individuals. Only in the case of Miss L.[3] had the psychiatrist made a tentative diagnosis of early schizophrenia.

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[1] Case number 7, see appendix, page 93

[2] Karl Menninger, Man Against Himself, N. Y. Harcourt, 1938, p. 395

[3] Case Number 1, see appendix, page 74

Weiss and English[1] point out the high incidence of neurosis in persons suffering from tuberculosis. They set forth the possibility of a neurotic personality preceding the tuberculous breakdown. Neurotic habits related to eating and anxiety states, which prevent adequate rest or sleep, may precipitate the development of tuberculosis.

The findings and conclusions of the whole study will be discussed in the next chapter.

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[1]Edward Weiss and O.S. English, Psychosomatic Medicine, 1943 pp. 408-409.

CHAPTER V

SUMMARY AND CONCLUSIONS

This study was concerned with fifteen tuberculous patients referred for psychiatric treatment. The group included members of both sexes and both married and single persons who were referred for psychiatric services during the year from March 1, 1950 to February 28, 1951. No definite age was decided upon and the sample group included persons from 19 to 43 years, who had been discharged from the Royal Edward Laurentian Hospital, Laurentian Division, but who were still attending the Montreal Division for treatment.

The sample group is an heterogeneous group in its cultural background, such as religious affiliation, language spoken, occupation and economic status.

Most of the patients in the sample group had received treatment for tuberculosis for many years prior to their referrals for psychiatric treatment. It is the writer's assumption that one of the reasons for this situation was the limitations arising from lack of psychiatric services. Another reason may be that, in spite of the fact that for as far back as 30 years ago psychiatrists and phthisiologists recognized the importance of emotional factors in the development and course of the tuberculous process, little attention was paid to such factors until the last decade. Up to this time, the patient was treated not as an individual, but as a diseased pair of lungs. The acceptance of the unity of mind and body in the treatment of tuberculosis was greatly emphasized by Dr. William Osler. He stated that what happened to the tuberculous individual depended more upon what went on in their heads than on what went on in their chests.

Tuberculosis represented a psychological crisis in the lives of the fifteen patients studied. These patients differed from the majority of the psychiatric patients in that they have a difficult pathological reality

situation to deal with, in addition to their other problems. This study has shown that the lack of earning capacity, the changes in the family relationships, the necessary treatment of the disease and the fear and danger of relapse are objective factors affecting the emotional reactions of the patient to tuberculosis.

In her attempt to evaluate the effect that tuberculosis, a chronic and infectious disease, had upon the individuals in the sample group, the writer deemed it practical to study the reactions of the patients to the diagnosis of tuberculosis. It was found that the reactions to the diagnosis of the disease were intense and diverse. The patients reacted to the disease with their emotions, their intelligence, and, in short, with their total personalities. Depression and anxiety were the most frequent pattern of reaction evident in the patients studied. Yet, the fear of death was not expressed by any one of them in their description of the emotional reaction to the diagnosis of the disease. On the other hand, superficial cheerfulness, denial, and forgetfulness were widely used mechanisms among the patients studied.

This study has disclosed that it is important that the initial reaction of the patient to the diagnosis of tuberculosis be carefully considered by the professionals working in the field. In the majority of the cases the disturbed initial reaction tended to become fixed. It is the writer's impression that this explains most of the irregular discharges of the patients from the hospital. It also caused great difficulties in the further course of treatment.

It has been found out through this study that the individual's reaction and acceptance of the disease and its treatment is greatly influenced by the misconceptions and erroneous ideas entertained about it by the patient himself, his family group and the community.

It is discouraging that, notwithstanding all the education difused on and the publicity given to tuberculosis since Koch's discovery of the tubercle bacillus in 1882, there still are many anxieties and fears associated with it, as well as a great deal of ignorance and superstitions about it.

From the analysis of the sample group the writer gathered that a great proportion of the patients had erroneous ideas about the disease. They had the idea that tuberculosis is a sign of weakness or lack of cleanliness. Some of the patients associated tuberculosis with "dirt", "bugs" or holes in the lungs. They considered tuberculosis as a stigma, something to be ashamed of.

The stresses and strains imposed by the treatment of tuberculosis is another factor that affects the emotional lives of the patients and interferes with the final acceptance of tuberculosis and its treatment.

In every one of the cases in the sample group hospitalization was considered a fundamental aspect in the treatment of the patients.

This study disclosed that in the majority of the cases in the sample group, where there existed an unpleasant and difficult home situation, hospitalization was readily, and in some cases eagerly, accepted. Nevertheless, once the patients were in the hospital, they became restless and developed many and diverse psychiatric symptoms that made it impossible for them to remain there.

It is also shown through this study that for most of the patients in the sample group hospitalization meant separation from the family and friends at a moment when they expected greater moral support, affection and attention from them. Since they faced a terrible conflict, they needed this support, yet at the same time they were considered a menace to public health, and consequently, they had to be segregated. Some of the

patients regarded hospitalization as evidence of the family's rejection and wish to get rid of them, because of their fear of infection.

The study of the sample group demonstrated that a small proportion of the group regarded institutional care as a measure suggested for their own benefit and not because they were a threat to the security and health of the family and the community. E. G. Seltzer[1] explained that there is no stronger argument in helping out the patient to accept hospitalization than to make him feel that the recommendation being made is the best plan for him.

Once they were in the hospital, the patients had to readjust themselves to a prescribed routine in an authoritative atmosphere where they were expected to observe strictly the rules and regulations of the institution. At the same time they had to adjust themselves to new people, strangers, with whom they have only one thing in common, namely, their tuberculosis. These are all problems that affected the emotional lives of the patients and interfered with the final acceptance of the disease and its treatment.

Bed rest, which is still considered the cornerstone in the treatment of tuberculosis, places the patient in an extremely passive and dependent situation. It is the writer's observation that hyperactive and restless patients could not accept this passivity, for it only added to their original anxiety. Homesickness, worries, and fears were the underlying factors behind the behavior of these restless patients. These are the patients usually labeled as uncooperative and who refuse to live within the limitations of their conditon.

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[1]Seltzer, op. cit.

In relation to the specialized collapse therapy, particularly surgery, it was found that it usually left the patient overwhelmed, depressed and terribly anxious.

The patient's reaction to these therapeutic measures have been influenced by their experiences in the past and by the distorted knowledge acquired about it.

In cases of surgery it was found out that a clear explanation of the operation and the reasons why it was recommended should be given to the patient after the emotional shock had abated. This study has shown that the patients are usually emotionally blocked when they first hear about the need for the operation. Therefore, it is necessary to give them an opportunity, later on, to express their fears and doubts. It was found out that the greatest worry and fear among the patients operated for thoracoplasty was that of deformity or disfiguration of the body image.

Through the analysis of the reactions of the patients to the diagnosis and to the different stages in the treatment of tuberculosis, it was found out that both tuberculosis and its treatment impose serious strains and stresses upon the emotional lives of the patients, making it very difficult for them to accept completely the disease and its treatment.

The assumption that the ability of the patient to withstand the stresses and strains imposed by tuberculosis and its treatment depends largely upon the individual's personality in the past, was explored in the sample group focusing on the following aspects:

1. The character of the relationship between the patient and his family, before and after the onset of tuberculosis.

2. The character of the relationship between the patient and other tuberculous patients in the family.

3. The patient's attitudes and experiences in his work or at school.

It was disclosed that in the majority of the cases in the sample group there prevailed great social, economic and emotional deprivations before the development of tuberculosis, or at the time of the onset of the disease. It is also demonstrated that in the group of patients studied, emotionally insecure and unstable parents and homes were largely responsible for the behaviour of the patients after their breakdown with tuberculosis, and for the reactions of the patients to the disease and its treatment.

This study also showed that the reactions of the patients in the sample group to tuberculosis and its treatment may be explained in terms of the patients' experience with relatives and friends who had suffered from the disease. The most disturbing effects occured in those cases with a family history where the patients identified themselves with the member of the family who died of tuberculosis after long years of painful treatment and sufferings.

Another observation made during the study of these fifteen tuberculous patients was the similarity in the behaviour and in the attitudes of the patients when hospitalized, with their attitudes and behaviour at school or in their work before their breakdown with tuberculosis. In some cases a number of these difficulties became accentuated when the patient had to face the difficult reality situation imposed by tuberculosis and its treatment.

Summarizing, it can be inferred from the analysis of the fifteen cases selected for this study, that the great majority of the group appeared to be emotionally unstable and insecure individuals long before their breakdown with tuberculosis.

It may be concluded that the structure of the personality of the patients prior to the onset of tuberculosis can be considered as one of the most important factors influencing the patient's mental reaction to tuberculosis and its treatment. It was found out that in many of the cases the pattern of response to the difficulties imposed by tuberculosis and its treatment was very similar to the individual's response to other difficulties prior to the breakdown with tuberculosis.

This conclusion has been beautifully described by Henry Sewall[1] as follows:

> "An individual with a given personality make-up will react to tuberculosis either normally or abnormally, according to his emotional stability or instability as determined by his personality make-up before the onset of the disease. Normal adjustment to tuberculosis may be expected in the patient with an emotional stable personality make-up. Abnormal mental states may be expected in the tuberculous patient who is already emotionally unstable before the onset of the disease."

In closing the writer desires to emphasize the fact that this was only an exploratory study. It is the writer's intention to arouse interest and concern about the emotional problems of the tuberculous patients and to stimulate other students to study them further. Tuberculosis offers fascinating opportunities for studies in the field of medicine, psychiatry and social work.

The emotional factors in the rehabilitation of the tuberculous patient and his attitude toward the future are some of the aspects which require further study. Specific age, marital and family groups of patients could be used to throw more light in the emotional problems of the tuberculous patients referred for psychiatric treatment. Examples of such groups are:

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[1]Henry Sewall, "Environments of Tuberculosis", American Review of Tuberculosis, January 1932, p. 9

1. Group of married men in the sanatorium, whose income constituted the sole means of subsistence for the family.

2. Emotional problems of tuberculous mothers in the sanatorium.

3. The problems of the adolescents in the sanatorium.

These are subjects which offer rich fields of interest for further research.

A P P E N D I X

"A" APPENDIX TABLES

TABLE I

TUBERCULOUS CASES REGISTERED, NUMBER OF DEATH AND DEATH RATES PER 100,000 POPULATION FROM TUBERCULOSIS IN PUERTO RICO, DURING THE YEARS 1945-1950[a][b]

Year[c]	Cases Registered	Total Death	Death Rates per 100,000 Population
1946 - 1947	30,649	4,317	207.6
1947 - 1948	33,833	4,160	196.9
1948 - 1949	40,834	3,857	179.7
1949 - 1950	46,014	3,201	146.8

[a] Annual Reports of the Bureau of Tuberculosis, Department of Health of Puerto Rico.

[b] Rates per 100,000 population based upon the total population of 1,869,255 according to the census of 1940.

[c] The vital statistics year refers to the July 1 - June 30 period.

TABLE II

NUMBER OF DEATHS AND DEATH RATES FOR

TUBERCULOSIS (ALL FORMS) FOR THE YEARS 1945 - 1947.

CANADA(a)(b)

Forms of Tuberculosis	Death Rate	Total	Male	Female
TOTAL	43.4	5,453	3,000	2,453
Respiratory System	84.7	4,621	2,562	2,059
Meninges	7.6	417	218	199
Intestines	1.9	102	41	61
Vertebral Column	1.0	56	30	26
Bones and Joints	0.7	40	25	15
Skin	0.05	3	2	1
Lymphatic System	0.3	19	8	11
Genito - Urinary	1.2	68	48	20
Other organs	0.3	17	12	5
Disseminated	2.0	110	54	56

(a) Rates per 100,00 population based upon the total population of 12,283,000 according to the census of 1941.

(b) The Canada year Book, 1950. Dominion Bureau of Statistics, Ottawa, p. 215.

TABLE III

NUMBER OF DEATHS AND DEATH RATES FOR TUBERCULOSIS

OF THE RESPIRATORY SYSTEM AND OTHER FORMS FOR THE YEARS

1945 - 1947 FOR CANADA[a] AND THE UNITED STATES[b]

(Exclusive of deaths among Armed Forces)
(Rates per 100,000 Population)

	CANADA						UNITED STATES					
	Number of Deaths			Rate per 100,000 pop.			Number of Deaths			Rate per 100,000 pop.		
Years	1945	1946	1947	1945	1946	1947	1945	1946	1947	1945	1946	1947
Total	5546	5821	5449	45.8	47.4	43.4	52916	50911	48064	40.1	36.4	33.5
Resp.System	4565	4818	4616	37.7	39.2	36.8	48879	46939	44462	37.0	33.6	31.0
Others	981	1003	833	8.1	8.2	6.6	4037	3972	3602	3.1	2.8	2.5

(a) The Canada Year Book 1950, Dominion Bureau of Statistics, Ottawa, p 215.

(b) The Extracts of the Public Health Reports, August 6, 1948, pp. 1029-1045 and April 7, 1950, pp. 468-493; and Vol. 62 April 4, 1947, pp. 504.

TABLE IV(a)

DISTRIBUTION OF 15 PATIENTS AS TO AGE, SEX, MARITAL STATUS AND EFFECT OF THE TUBERCULOUS BREAKDOWN ON THE OCCUPATIONAL STATUS

Age Group	Total	FEMALE							
		Married				Single			
		No. of Patients Left Jobs	No. of Patients Left School	Kept Part Time Work	Kept Working	No. of Patients Left Jobs	No. of Patients Left School	Kept Part Time Work	Kept Working
TOTAL	12	7				5			
15-19	1					1			
20-24	3	1				2			
25-29	3	3							
30-34	1					1			
35-39	1	1							
40-44	3	2				1			
45-49									

TABLE IV(b)

DISTRIBUTION OF 15 PATIENTS AS TO AGE, SEX, MARITAL STATUS AND EFFECT OF THE TUBERCULOUS BREAKDOWN ON THE OCCUPATIONAL STATUS

Age Group	Total	MALE							
		Married				Single			
		No. of Patients Left Jobs	No. of Patients Left School	Kept Part Time Work	Kept Working	No. of Patients Left Jobs	No. of Patients Left School	Kept Part Time Work	Kept Working
TOTAL	3	1			1	1			
15-19									
20-24	1				1				
25-29	1	1							
30-34	1					1			
35-39									
40-44									
45-49									

"B" CASE MATERIAL

Case Number 1

SOCIAL AND PSYCHOLOGICAL BACKGROUND

Source of Information

Interview with Miss L.

Miss L. is the youngest child in a family of seven siblings. She described her father as a man who had a violent temper and who never "bothered" with the children. The patient's mother did not care about her either, but "after Miss L. was taken sick, at the age of ten, she would give her daughter anything she wanted. Miss L. commented that "she spoiled me".

As a child she was afraid of darkness and had always been very nervous.

Psychiatric Report

When the patient was ten years old, she developed tuberculosis and was ordered by the doctor to rest in bed for three months. Consequently, she had to leave school. On her return to school, three months later, she withdrew from contact with other children, for she felt "different." Shortly after her return to school, the school nurse discovered that the patient had head lice and told her so in front of the class. The other children started teasing her and calling her names associated with tuberculosis and "bugs". This incident was an awful emotional shock to Miss L., who became increasingly withdrawn and unhappy.

When she was 14, and in the eighth grade, she suddenly developed a terrible itchiness around her face and in

the scalp. She could not go to shcool, for she had to keep on scratching and rubbing herself all the time, which turned her very selfconscious. Then she left her parents and her home town and came to Montreal to live with her eldest sister. She worked as a waitress, as a domestic and as a saleslady. Her symptoms continued; she became very anxious and suffered from terrific headaches. She could not enjoy entertainments; she stopped eating and could not rest. A year after she came to Montreal, tuberculosis was discovered. Her reaction to the diagnosis was "I am glad, now I can rest."

Case number 1

BEHAVIOUR AFTER THE ONSET OF TUBERCULOSIS

Sources of Information

Medical Record and Inteview with the Patient

Miss L. is a young attractive girl, 19 years old. She had been receiving treatment for tuberculosis since 1947. Her psychogenic symptoms became accentuated after her hospitalization. She could not attend social activities, for she felt everyone was looking at her because her head was dirty or full of "bugs". She knew she did not have "bugs" for she had seen many doctors and they had reassured and told her there was nothing wrong with her. She could not even go to the hospital's dining room. She cried bitterly and became so restless and unhappy that she left the hospital against medical advice. She went again to live with her married sister, but soon her brother-in-law refused to have her at home, and Miss L. was readmitted to the sanatorium. After her return to the hospital, her demeanor grew very difficult. She used to leave the hospital without permission and go to the village to have some drinks. On those occasions she felt happy, for her emotional symptoms subsided. She did not care about her lungs' condition. She explained the writer that it was not until she read about psychiatry, that she decided to do her best to improve her physical condition, so that she might be referred for psychiatric treatment.

Miss L. was referred to the Allan Memorial Institute after her discharge from the sanatorium.

The psychiatric report described her as a thin, but well nourished girl. She spoke readily and was pleasant and cooperative, but vague, dettached, distant and off-hand. She was withdrawn and her emotions were shallow and restricted. She was mildly depressed and became rather tense and anxious when she talked about her symptoms.

She gave the impression of being very immature and dependent. The final diagnosis was "a severe hysterical reaction in a very immature personality, or early schizophrenia."

Case Number 2

SOCIAL AND PSYCHOLOGICAL BACKGROUND

Source of Information

Interview with the patient.

Mrs. G. is an attractive married woman about 28 years old. She is the only child in the family, and since childhood, she had been very active and independent. She described her relationship with her parents as very good. She has been head strung since childhood and becomes tense very quickly on the slightest provocation. Then she would forthwith appear gay and active.

Any emotional stress would cause Mrs. G. indigestion and severe headaches.

Mrs. G. was married at 23. She spent in the hospital most of the first year after her marriage. She developed pleurisy and shortly afterwards, she had a baby. It was after childbirth that tuberculosis was discovered in Mrs. G.

Case Number 2

BEHAVIOUR AFTER THE ONSET OF TUBERCULOSIS

Source of Information

Medical Record

Mrs. G. was very confused and upset by the diagnosis of tuberculosis. Hospitalization was recommended and she accepted it, because she believed she would be cured after a short period of institutional care. Her baby was admitted to the B.C.G. clinic at the same time the patient was admitted to the sanatorium.

As soon as she was hospitalized, she began to worry about her husband and baby. She could not rest and all the time she was moving from one side of the bed to the other. She could not accept the necessary dependency needed in the treatment, and soon became so nervous and anxious that she left the hospital against medical advice two months after her admission. She continued her treatment in the Royal Edward Laurentian Hospital, Montreal Division, where she was advised to take 16 hours of rest every day. At the beginning she followed the doctor's orders and was doing very well at home, but soon she resumed her activities and forgot all about her rest. Her last X-ray showed a new cavity in her left lung, and hospitalization was again prescribed.

Mrs. G. refused to accept hospitalization and became very upset. She cried for four days, but afterwards she appeared gay and cheerful.

Mrs. G. has not been able to make definite plans for her hospitalization yet. She thinks the hospital is all right for unmarried girls, but that the place for married women must be with their husbands.

Severe attacks of indigestion followed this emotional stress and Mrs. G. was referred for psychiatric treatment. The diagnosis was "chronic anxiety state."

Case Number 3

SOCIAL AND PSYCHOLOGICAL BACKGROUND

Source of Information

Mr. H. is a young, thin and pale, married man about 26 years old.

He is the youngest in a family of three boys. Both parents are dead. The death of his mother, three years ago, to whom he was very attached, was a severe shock for him. He was his mother's favorite; she would give him anything he wanted.

Interview with the patient

After his mother's death, the patient had been feeling that he neglected his mother after he was married. He married at 19 against his mother's consent. He went to live with his wife's parents and was never happy there. Difficulties with his wife began when he started going out drinking with his friends. Sometimes he would come home very late at night and did not eat and relax. His wife could not withstand drinking, and when he came home drunk, she would attack him with anything at hand.

His disease was discovered in a routine examination in the factory where he was working. He blamed himself for catching the disease, because he refused to eat or rest adequately while he was drinking.

Case Number 3

BEHAVIOUR AFTER THE ONSET OF TUBERCULOSIS

Source of Information

Medical Record

Mr. H. has been suffering from tuberculosis since 1949. Shortly after the diagnosis, the patient was hospitalized. The first weeks in the sanatorium were all right for the patient, but soon he got "fed up with it." As soon as he came into the hospital he started listening to other patients' stories about the disease and its treatment. He became very frightened and refused treatment in spite of all the interpretations given by the doctors and nurses.

He had the feeling that the hospital was just like a prison. He grew very depressed and one day left the hospital against medical advice. After being away from the hospital for a few months, he became so sick that he asked for readmission. This time he accepted treatment readily. Nevertheless, after a short stay in the hospital, he grew anxious and restless again and one night he left the hospital and got drunk. Next morning he was discharged from the sanatorium for breaking the institution's regulations.

At this point, the relationships with his wife were very difficult. Mrs. H. knew that her husband was in love with another patient in the hospital, who was discharged before Mr. H. was. After his discharge, Mr. H. went back to his wife because he had no other place to go.

Mr. H. resents that he has to depend on her for all his needs. He has been authorized to work for four hours, but has been unable to land a fitting job. His wife is kept working all day, while he stays home, resting.

The patient and his wife were referred to the psychiatric clinic in an attempt to improving their relationship.

The psychiatrist described Mr. H. as a tense and restless individual who wears off his tension by drinking and driving fast.

Case Number 4

SOCIAL AND PSYCHOLOGICAL BACKGROUND

Source of Information

Miss J. is a young woman 30 years old. She has been suffering from tuberculosis since 1941.

Her previous contact with the disease was from her father, who was a tuberculous patient and never took care of himself. He would not stay in bed and was constantly quarreling with the patient's mother. There was considerable friction in the home, as Miss J's father blamed his illness and financial difficulties on the wife's change of religion.

Medical Record

Miss J's father was very sullen and never tried to prevent the infection of the other members of the family. He continually refused treatment and hospitalization. Yet, when his two daughters developed tuberculosis, he was very unhappy and blamed himself for it.

Miss J. was admitted to the sanatorium; soon afterward her father died. While in the hospital, the patient's main worries were the family's financial situation and her youngest sister's illness.

Social Service Record

Miss J. was never seen by a psychiatrist, for she sustained there was nothing wrong with her.

Case Number 4

BEHAVIOUR AFTER THE ONSET OF TUBERCULOSIS

Source of Information

Interview with the patient

Miss J. was referred for psychiatric treatment because she grew very nervous and was losing weight. She refused to see a psychiatrist because she believed there was nothing wrong with her. She was willing to see the psychiatrist once, only to please the doctor and the nurse from the Royal Edward Laurentian Hospital, who referred her to the psychiatric clinic and have been very kind to her, but she would not commit herself to continue the prescribed treatment.

Now the patient is working as a saleslady and feels quite happy. She believes her main difficulty is the economic situation of the family. Her sister was discharged from the hospital and is also working to help the family.

Case Number 5

SOCIAL AND PSYCHOLOGICAL BACKGROUND

Source of Information

Psychiatric Report

Mrs. C. is a young, married woman about 28. The patient is the only child in the family and she has been overprotected by her parents all her life. Her parents have always been terribly worried about her health and the patient is very disturbed by their anxiety.

Mrs. C. has been described by the psychiatrist as and inhibited, rigid personality with perfectionist drives.

Interview with the patient

She finished two years of college education and for the last two years before her breakdown with tuberculosis, she had worked as a stenographer and won several promotions.

The patient married a college student and continued working to help her husband through college. They were living with her parents and shortly after their marriage, marital difficulties began. On several occasions, Mrs. C. became hysterical after arguing with her husband.

When tuberculosis was discovered she was immediately discharged from her job. Her husband then went to live with his own parents, and only visited her occasionally.

As the patient was unable to rest at home, hospitalization was suggested, which Mrs. C. readily accepted.

Case Number 5

BEHAVIOUR AFTER THE ONSET OF TUBERCULOSIS

Source of Information

Mrs. C. had been suffering from minimal pulmonary tuberculosis since 1949. She accepted hospitalization, for she looked at it as an opportunity to get away from her parents. She explained that she had always wanted to live away from her parents, but did not have the courage to do it.

Mrs. C's parents were shocked and emotionally disturbed when hospitalization was suggested to their daughter. The mother could not believe that her daughter would be well taken care of at the sanatorium where there were so many different classes of people. The father refused to accept the diagnosis.

Medical Record

These negative attitudes and feelings affected Mrs. C, who felt very confused and depressed.

Finally, she was admitted to the sanatorium, and during the first weeks she adjusted very nicely to the new environment. But suddenly she developed a series of compulsive symptoms that made it impossible for her to stay in the hospital. Mrs. C. was constantly crying and at times got to washing her hands until they were blistered. She expressed her fear of being unable to get herself clean.

Mrs. C. was utterly afraid of getting impregnated with almost everything she came into contact with. Going

to the bathroom was a ritual that could not be interrupted, and usually lasted about forty-five minutes. During this time her parents had to sit still in the living room with all windows and doors closed. Any noise disturbed her. She was always changing her clothes and her bed sheets.

Her condition grew so difficult, that the patient had to be referred to a psychiatrist. The diagnosis was obsessive compulsion neurosis.

Psychiatric Report

Psychotherapy did not do much good. The psychiatrist suggested some job that would keep the patient busy and away from her parents during the day.

Apparently, her condition improved considerably.

Case Number 6

SOCIAL AND PSYCHOLOGICAL BACKGROUND

Source of Information

Miss B. is a single, 24 year-old woman who had a mild strabismus.

The patient had a long history or neurotic manifestations. When she was 12 years old, in response to her father's drinking and violence, she used to cry and run out of the house in a great fear, to get help.

She has been very selfconscious of her visual defect since very young, and at the age of 17 she was operated on in order to correct this defect.

Psychiatric Report

One month after the operation, the firm for whom she was working refused to take her back because she was always sick. At that time she was feeling tired, weak and sich to her stomach. As she could not work, her father called her lazy and turned her out of the home. For four months she lived with a neighbour, at which time her mother insisted on her return home. A few months later she developed tuberculosis.

Interview with the patient

Miss B's parents are both living. They are not legally married, but have been living together for eighteen years. The father's legal wife is still living. Miss B's father is a severe alcoholic and has not worked since 1948, when he hurt his right hand in an accident. He picks up on his children and is telling them "you are consumptive".

Miss B's mother is described as very nice, but domineering. She, the mother, has been working since the patient can remember, as a domestic and charwoman, in order to help bringing up her seven children. As She had to work so hard, the patient and her elder brother were brought up by her godmother and she remembers how hard it was for her to come back to her parents' home. She considered her godmother as her own mother.

Miss B. is the second child in the line of seven siblings. Her elder brother is also a tuberculous patient. Another brother, aged 20, had rheumatoid arthritis when he was a child and since then he has become extremely quick tempered and on occasions he almost loses his mind. Her youngest brother was a mongolian idiot. The patient cared for him very much.

Previous to her breakdown with tuberculosis, the patient was very nervous, tired and worn out. She attributed this to the fact that she was working and at the same time had to carry a great responsibility at home, taking care of the family. She became increasingly irritable and impatient.

At work she was not happy either. She did not make friends and had difficulties in getting along with her fellow employees.

When tuberculosis developed and hospitalization was recommended, Miss B. accepted it eagerly.

Case Number 6

BEHAVIOUR AFTER THE ONSET OF TUBERCULOSIS

Source of Information

Medical Record

Miss B. was referred for psychiatric treatment from the Royal Edward Laurentian Hospital due to her behaviour at the sanatorium.

Immediately after her hospitalization, the patient became very lonesome, cried, had shaking spells, felt nervous and developed severe headaches.

A year later her behaviour became very difficult. The event that precipitated this behaviour was the death of her youngest brother from tuberculosis. He was a mongolian idiot and she had taken care of him before her hospitalization. As a result of his death, Miss B. stopped eating and wanted to go home. She found it impossible to rest in bed and feared she would start screaming. She felt a great longing for her brother. She did not eat or sleep, felt very nervous, restless, and everything bothered her. She resented the other patients and had dreams of being "cut open" and buried alive. Finally the patient was discharged from the sanatorium and was referred to the Allan Memorial Institute for psychiatric treatment.

Psychiatric Report

The patient was admitted to the Allan Memorial Institute where her condition was diagnosed as "anxiety state with depression."

Miss B. was discharged from the Allan Memorial Institute after two months treatment. One month after this discharge she had a relapse in her physical condition and had to be readmitted to the sanatorium.

Case Number 7

SOCIAL AND PSYCHOLOGICAL BACKGROUND

Source of Information

Mrs. S. is a young, attractive, married woman of about 29. Her husband described her in the following terms: "she has never been able to face trouble and goes right to pieces when things are bothering her. When she is upset she drinks heavily."

Medical Record

Mrs. S. was very nervous as a child, never slept well and has always been a fussy eater. She is the eldest in a family of three children. The patient was two years old when her sister was born. She said they got along nicely but on occasions she, the patient, was very jealous of her sister.

Interview with the patient

Mrs. S. described her father as an alcoholic who has been always mean to her mother. Her mother, she said, is very nice, but domineering.

She married very young even when she did not love her husband very much. A year after their marriage a baby was born, and two months later, Mr. S. went overseas where he stayed for four years. While her husband was away, she fell in love with another man and when her husband returned she resented it and began to drink heavily.

Before her husband return she developed tuberculosis and since then she has had twelve readmission to the hospital. Each time she left the hospital against medical advice.

Case Number 7

BEHAVIOUR AFTER THE ONSET OF TUBERCULOSIS

Source of Information

Medical Record

Mrs. S. is a very thin, restless, young married woman. She has been suffering from tuberculosis since 1945. Since then she has had twelve readmissions to the hospital and each time she left against medical advice.

Right thoracoplasty was recommended by her doctor and Mrs. S. became very depressed. She developed severe headaches, crying spells and dizziness and shortly afterwards, she attempted suicide. Mrs. S. was admitted to the Royal Victoria Hospital, where she received electric shock treatment. Her depression lifted, she was discharged from the Royal Victoria Hospital and was admitted to a tuberculosis hospital, where thoracoplasty was done. Five ribs were removed. One month after the operation, she had to be discharged from the sanatorium against medical advice, because of a new depressive state. After this discharge, the patient tried to commit suicide again by taking an overdose of sleeping pills. She was referred for psychiatric treatment and since then is attending the psychiatric clinic of the Royal Victoria Hospital.

Psychiatric Report

The psychiatric evaluation stated that it appeared that this patient had been unstable for a long time prior to her breakdown with tuberculosis. Her relationship

with both parents seemed to be a sphere of conflict for she would become very tense and anxious while discussing them.

The psychological examination showed that Mrs. S. is a narcissistic, immature person with low frustration tolerance. She showed considerable hostility, the primary figure being the mother.

The final diagnosis was "chronic anxiety state with depressive features."

Case Number 8

SOCIAL AND PSYCHOLOGICAL BACKGROUND

Source of Information

Mr. E. is a young unmarried man of about 31. He is the youngest in a family of four children. His mother is extremely religious and strict.

Before Mr. E's birth, his mother had lost three babies shortly after their birth. When the patient was born, Mrs. E was afraid that the same thing will happen to the new baby, so, she has always overprotected him. The patient's father died when he was 8 years old and the mother worked very hard to raise the family properly. Mrs. E. stated that the patient has always been the favorite of all the members of the family.

Prior to his breakdown with tuberculosis, Mr. E. had some difficulties with the police because of his antisocial sexual behaviour. His mother could not tell the writer when his behaviour started. She can not understand why her son behaves in that way since her husband came from a very nice family and she tried very hard to bring him up "decently". When the patient was a little boy, she would never undress him in the presence of anyone. The same thing she did with the girls. Not even her husband was permitted to see the patient's sisters undressed.

Interview with the patient's mother

The first time she knew about Mr. E's deviant sexual behaviour was when he was 16 years old. The patient was surprised by the police one night peeping into a bedroom. He was severely punished by the police and by his mother.

The punishment did not stop him and shortly he resumed his antisocial behaviour. Recently he was arrested when he was surprised kissing a girl six years old. He told the police he did not hurt the child and that he was kissing her because he is very fond of children.

Mr. E is still attending the tuberculosis clinic at the Royal Edward Laurentian Hospital. He never misses a treatment and usually takes very good case of himself. He is not working in spite of having been authorized by his doctor to do a full time work.

He was referred to the psychiatric clinic of the Royal Edward Laurentian Hospital. The psychiatrist's opinion was that Mr. E is an exhibitionist. He resents having his sexual life discussed and he does not want to talk about it. He refused psychiatric treatment after the first interview with the psychiatrist.

Case Number 8

BEHAVIOUR AFTER THE ONSET OF TUBERCULOSIS

Source of Information

Medical Record

Mr. E. has been suffering from tuberculosis since 1939. The first time he was admitted to the hospital, he remained there for four years, until he was discharged.

After his discharge he came back to his mother's home and continued his antisocial behaviour described previously. Two years later he had a relapse in his physical condition and was readmitted to the sanatorium. One year later he was discharged against medical advice for breaking the rules of the institution. He was admitted to another hospital and after a few weeks he left the hospital again. He went to the village near the hospital and there he exposed himself and attacked a woman. He was arrested by the police and the accusation was "indecency". After a few days in jail he was transferred to Bourdeaux penitentiary to serve a year penalty.

Interview with patient's mother

During this year he sometimes became so violent that it was believed he was out of his mind. Mr. E's mother commented "I think that the tuberculosis has gone to his mind."

After he was released from jail, the patient came back to live with his mother and his sister. Actually the family relationships are very tense and he often snaps at his mother and resents everything she says or does.

He locks himself in his room and would not discuss his problems or plans with anyone.

Afterwards he masturbated himself and exposed his genital organs in an alley and in the presence of a neighbor's wife. When Mrs. E called his attention, he explained he had been "watering" in the lane, when the neighbour's wife came out of the house.

The patient left school at the age of 15 against his mother's consent and went to work in a night club as a waiter. At that time he was planning to join a band, for he plays several musical instruments, but he had a haemoptysis and was admitted to the sanatorium as an emergency.

Case Number 9

SOCIAL AND PSYCHOLOGICAL BACKGROUND

Source of Information

Miss A. is the eldest in a family of two girls. Since her sister was born, her father took care of her and apparently she has been always more attached to her father than to her mother. When she was nine years old, her father went overseas. Miss A. missed him so much that she became seriously ill. Since then her mother declared herself unable to cope with her daughter. Miss A's father stayed away from home for six years and finally her parents were legally separated. Shortly afterwards, her father returned to Canada and came to visit the family. This constituted and emotional shok for Miss A., who always wanted her father to come back home. The relationship between her parents is described by the patient by saying that "they quarreled like cats and dogs". Soon after his return the girl developed tuberculosis, when she was about sixteen years old.

Interview with patient's mother

The relationship between Miss A. and her mother has been very difficult. They could not talk to each other for usually they ended up in a terrible quarrel. Mrs. A. thinks the patient is very hostile against her and by way of evidence she told the writer about an occasion when she tried to stop Miss A. from going out with a man, her daughter became very angry and told her "I hate you so much that I could kill you."

Psychiatric Report

Miss A. has expressed the fear of her father seducing her. She has had heterosexual experiences since the age of twelve, when she was casually seduced. Since then, she has had innumerable affairs with men. She gets no pleasure from sexual intercourse, but enjoys the preliminary petting. She said that when a man kisses her, she cannot say no.

It seems that Miss A. must put herself in a position where she will be hurt. She is activated by deep feelings of guilt, not because of incestuous feelings toward her father, but arising from an unconscious primitive rivalry with the mother and a wish of destroying her.

Case Number 9

BEHAVIOUR AFTER THE ONSET OF TUBERCULOSIS

Source of Information

Miss A. has been suffering from pulmonary tuberculosis since 1947. She was hospitalized for two years, at which time she was discharged to continue her treatment at the Royal Edward Laurentian Hospital, Montreal Division. She was referred for psychiatric treatment to the Allan Memorial Institute in 1950.

Medical Record

The patient complains of tiredness and of being very unhappy. She has severe crying spells and lately snaps at people. Apparently she can not keep a job for long.

Her relationship with her mother are very difficult, and she always does what she pleases. Sometimes she feels very depressed and sometimes she appears hilarious. While at the sanatorium, she became pregnant and she had to be brought to Montreal where a therapeutic abortion was done. As Miss A. was a Roman Catholic, she was very worried about this.

Psychiatric Report

There is a marked emotional upset in this case, due to a broken home situation. The parents were legally separated many years before the patient developed tuberculosis. The main psychiatric features in the case were nervousness and depression.

Case Number 10

SOCIAL AND PSYCHOLOGICAL BACKGROUND

Source of Information

Mrs. M was born in 1911 in Montreal, from Polish parents. After her birth, her family returned to Poland. The patient explained her mother was very unhappy, for her father was always away from home and used to drink heavily.

Mrs. M was the eldest in a family of three children. She was very attached to her brother and described her sister as "mean, just like her father". Now the two sisters are living in Montreal and they do not visit each other.

Interview with the patient

When Mrs. M was 13 years old, her mother died. After her mother's death, the father left the children with the paternal grandfather and came back to Canada. Shortly afterward he remarried. The patient commented she never knew what family life really was until she married and had her own family.

She married in Poland and came back to Canada during the depression years, at which time she experienced many hardships. She worries about almost everything and has the feeling that no other person has more troubles than herself.

Medical Record

A few years before her breakdown with tuberculosis, her only child had infantile paralysis and had to be hospitalized for many months. When he went back home from the hospital, Mrs. M had to continue her son's treatment at home. She felt the responsibility was so big that she soon became very nervous, tense and irritable. She could not eat or sleep, and seven months after the boy's return home, she developed tuberculosis.

Case Number 10

BEHAVIOUR AFTER THE ONSET OF TUBERCULOSIS

Source of Information

Interview with the Patient

Mrs. M. has been suffering from pulmonary tuberculosis since 1945. She was hospitalized for eighteen months and went through a three-staged thoracoplasty, at which time seven ribs were removed. Mrs. M. feels despondent at times because her personal appearance is not as it used to be before the operation. She does not want her neighbours to know that she has tuberculosis and resents the visits of the nurses.

Mrs. M. feels that she has more trouble than anyone and that nobody can help her. She cries very easily and she is certain of bad news everytime the visiting nurse comes to see her. Mrs. M. explained the writer that she has always been very nervous, sleeps poorly and worries continuously about everything.

Psychiatric Report

She resents her son H, who is now 14 years old, because he is a very spoiled child and does not carry out her orders. He also makes a lot of noise and brings dust and mud into the house. Mrs. M. has experienced increassing difficulty in bringing up her only child, who she apparently has somewhat overprotected. He is spoiled and disobedient.

Mrs. M. has been increasingly irritable in the last five years and has had difficulty with her sleeping. She

has been in constant conflict with her husband, and her only child has become very difficult because of the disagreement between the parents. The final diagnosis is anxiety state with depressive features.

Case Number 11

SOCIAL AND PSYCHOLOGICAL BACKGROUND

Source of Information

Mr. F. is a young married man about 26 years old. He is the third in a family of five children, of whom four were girls.

When Mr. F. was six years old, his parents referred him to a Child Guidance Clinic. The child was very disobedient, aggressive and used to dream and phantasy very much. The parents explained at that time that when Mr. F was four years old, while playing with one of his sisters, he fell from a two-story window and

Social service record

hurt his head. Since then he was never the same anymore.

After he finished the fourth grade, he refused to continue attending school. He was 12 years old then and has ever since working in all kinds of jobs.

He served in the Army for two years and after his discharge he was forced to be married. The girl who has a partially withered arm was already pregnant when she married Mr. F.

The patient has never experienced a real family life. His mother died many years ago and his father died in 1936, in a mental hospital. Since his father's death, the patient has become terribly afraid of becoming insane.

After his son's birth, Mr. F has become very irritable and impatient. He continually flies off the handle,

quarrels with his wife, and when spanking the child he feared he would lose control. When the baby cries "he just go to pieces."

One year after the child's birth Mr. F developed tuberculosis.

Case Number 11

BEHAVIOUR AFTER THE ONSET OF TUBERCULOSIS

Source of Information

Medical record

Mr. F. has been suffering from tuberculosis since 1949. He was admitted to the sanatorium and a year later he was discharged from the hospital as improved.

After his discharge he has been undergoing a very difficult economic situation, and had to apply to different social agencies for financial assistance. The family is living in a small room in a tenant house.

The difficulty concerning his son continued and the patient referred himself to the Royal Victoria Hospital Psychiatric clinic for psychiatric treatment.

Psychiatric report

The psychiatric report described the patient as a very inmature person, of limited mental ability, and who in many ways continue to react on a childish level.

Case Number 12

SOCIAL AND PSYCHOLOGICAL BACKGROUND

Source of Information

Mrs. D. is a very pale looking female, 25 years old.

There is not enough information about Mrs. D.'s background in the medical record. The patient was referred by the Royal Edward Laurentian Hospital to its psychiatric clinic and was seen by the psychiatrist once. Mrs. D. was readmitted to the Sanatorium and the psychiatrist has continued her case there.

An interview with the patient or her relatives could not be arranged.

Psychiatric Report

From a brief report by the psychiatrist and from the scattered information in the medical record it was gathered that Mrs. D. was an unstable individual.

Mrs. D. has had a difficult marriage since its beginning in 1944 and was abandoned by her husband two years ago when she was pregnant of her third and youngest child.

After the child's birth, Mrs. D. developed tuberculosis and was referred to the Royal Edward Laurentian Hospital, in 1949.

According to the medical record, Mrs. D. has tried to commit suicide several times during the last five years_

that she left the home and went to live with a married man. Commenting upon this, Mrs. D.'s sister said "nobody at home could reason with her" and considered her ungrateful. She also stated that Mrs. D. did not seem interested in her children any more. The sister said since Mrs. D. went to live with this man she is "absolutely mentally lost", and she, the sister, did not consider Mrs. D.'s health condition as serious as before.

Mrs. D. came back to her sister's home despite her feelings that she was not wanted there. She was feeling very sick and soon afterwards tried to commit suicide again. She was taken to a mental hospital where she was given psychiatric treatment and was discharged after three weeks.

She was very unhappy, nervous and was losing weight. Mrs. D. finally asked for readmission to the sanatorium and was admitted. Apparently she feels happy in the T.B. hospital where she is under psychiatric treatment, too.

Case Number 12

BEHAVIOUR AFTER THE ONSET OF TUBERCULOSIS

Source of Information

Mrs. D. is a very pale looking female. The onset of tuberculosis was traced to the time of her third child's birth. Three months later, her baby died at the "B.C.G. Clinic". She became very tired and nervous. Mrs. D. complained about difficulty in breathing and a choking sensation. These symptoms developed after the placement of her two oldest boys in a home outside of Montreal. She is always worried about them. Following the placement of her children, she attempted suicide and was finally referred to the Psychiatric Clinic of the Royal Edward Laurentian Hospital.

Psychiatric Record and Medical Record

After Mrs. D developed tuberculosis, she went to live with her married sister. Her husband does not help her financially and consequently she had to depend upon her sister and her brother-in-law for all her needs.

Soon she started feeling she was not wanted in the home and realized that her presence there was a cause of discord between her sister and her brother-in-law. She became very upset and nervous, for she did not have a place to go.

When her sister developed tuberculosis too, the situation became so difficult and she felt so guilty

Case Number 13

SOCIAL AND PSYCHOLOGICAL BACKGROUND

Source of Information

Miss T is a single woman, 43 years old. She is the eldest in a family of eight. Since she was very young, she assumed the responsibility of helping her mother in bringing up the family. When the patient's mother developed tuberculosis, Miss T nursed her for many years. When Miss T's mother was hopelessly ill, she was admitted to the hospital, and one month later she died. The patient felt very depressed and responsible for her mother's hospitalization and death.

Medical Record

Soon after her mother's death, Miss T developed tuberculosis. Hospitalization was recommended, but soon after her admission, she left the hospital against medical advice. She denied the disease, could not believe she was ill, and consequently, rejected the prescribed treatment. She continued keeping the house and cooking meals for her father and her unmarried brothers.

She was referred for psychiatric treatment to attempt helping out the patient in her accepting the disease and its treatment.

Psychiatric Report

Miss T always looked and cared for the younger members of the family. She could not bear the thought of leaving the three men without a housekeeper.

Case Number 13

BEHAVIOUR AFTER THE ONSET OF TUBERCULOSIS

Source of Information

Medical Record

Miss T. has been suffering from tuberculosis since 1944. She refused treatment and continued doing the housekeeping for her father and her unmarried brothers.

After her referral to the psychiatrist, the patient realized she was seriously ill and immediately looked for someone to replace her in the home.

Now the patient is at the sanatorium and is receiving psychiatric help at the same time, so that she may benefit from the institutional care.

Case Number 14

SOCIAL AND PSYCHOLOGICAL BACKGROUND

Source of Information

Interview with the patient

Mrs. R is the only patient in the sample group who was referred to a psychiatrist before tuberculosis was discovered. This is a married woman of about 33. She has had three children, the oldest is 9 and the youngest is 3. Mrs. R. was born in Quebec City. Her family moved to Montreal when she was one year old. During her childhood she was a tomboy, bit her nails, and had a terrible fear of snakes and bugs. She left school when she was in eighth grade, to look after the family.

Psychiatric Report

On her admission to the Allan Memorial Institute, the patient's main difficulty consisted in anxiety and tension present since the age of 13 in varying degrees of intensity, expressing itself primarily in the form of severe headaches and tightness in the back of her head. The onset of these symptoms coincided with her mother deserting the family and going off with another man. The patient who was the eldest in a family of five children, had to assume all the responsibility in the home. The father was a severe alcoholic. He "took it out on the patient", since he felt Mrs. R looked like her mother, and she assumed the mother's role in the home.

Mrs. R has had numerous treatments for her headaches, but none has proven helpful.

Mrs. R. married at 23. Her husband is a telegraph operator and is away from home most of the time. Mrs. R. says he is very stubborn and an alcoholic.

The patient has three children and is terrified at further pregnancies. A few months before her referral to the Allan Memorial Institute, she had a self-induced abortion.

The psychological examination showed that Mrs. R has a bright normal intelligence with some perfectionist drives. She also showed some hysterical features and considerable hostility directed toward male persons. She also showed ambivalence toward her mother and authoritative figures, hostility toward the husband and a longing for happiness.

The final diagnosis was "chronic anxiety state with hysterical features."

Case Number 14

BEHAVIOUR AFTER THE ONSET OF TUBERCULOSIS

Source of Information

Medical Record

Mrs. E. was admitted to the sanatorium one month after her referral from the Allan Memorial Institute. A month after her admission she was so depressed that she left the hospital against medical advice. While she was in the hospital, she became very worried about her three children. She could not rest and finally returned to her home. Now she is attending the Royal Edward Laurentian Hospital Clinic.

Case Number 15

SOCIAL AND PSYCHOLOGICAL BACKGROUND

Source of Information

Mrs. H. was born in Russia 42 years ago. She is the youngest in the family and stated she was not wanted by her parents. There is a difference of about ten years between the patient and her next sister.

Her mother died when Mrs. H. was a girl about seven years old. She cannot remember very well about it, although she realized it was very difficult, for she was very attached to her mother.

After her mother's death, her father was never at home. He finally came to Canada and left her with an aunt. Her sister and her eldest brother were married and came to Canada, too. She described her life here as very hard. She had to work hard and never enjoyed a real home.

Mrs. H. met her husband in Poland and they were married there. Then they came to Canada. It was during the depression years, whom it was very difficult for her to adjust herself to the new country and to the difficult economic situation. She had two children, was so worried about their health, and had to work so hard during those difficult years, that she developed tuberculosis. She has been known to the Royal Edward Laurentian Hospital since 1934.

Mrs. H. would not talk about how she felt during those difficult years. She commented she had forgotten everything about it.

Case Number 15

BEHAVIOUR AFTER THE ONSET OF TUBERCULOSIS

Source of Information

Interview with the patient

Mrs. H is a small, thin woman, 42 years old. She has been suffering from tuberculosis since 1934. She has always been terribly concerned about her health and is terrified when one of the members of the family is taken ill.

She is restless and suffers from insomnia and anorexia. She also complains about generalized pains over her entire body and a burning sensation in the vagina.

Medical Record

She has become very selfconscious of her Russian origin especially during the last year and she believes the Dominion Immigration authorities are arranging to deport her.

Mrs. H is prone to feel that people dislike her and laugh at her. These feelings have increased in the last months because of disagreement with her brother over the ownership of a house. Mrs. H feels very guilty about this, for her brother have always been very kind to her.

Psychiatric Report

Now Mrs. H believes she has cancer in the chest. She complains of a tight feeling in the chest and palpitations and loss of memory.

The psychiatrist's impression is that the patient is suffering from anxiety state with depressive features.

"C" DOCUMENTARY SCHEDULE

Schedule used to collect material from the Medical and Social records, for background information before the interview with the patient.

1) Name

2) Age

3) Address

4) Referral

a) Tuberculosis

1- Date

b) Psychiatric treatment

1- Date

5) Occupation

6) Marital Status

7) Diagnosis

a) Tuberculosis

b) Psychiatric

8) Family History

9) Personal History

10) Onset and symptoms of tuberculosis.

11) Onset and symptoms of the psychiatric disorder.

Information desired from the patients in the sample group and from the following members of their families: father, mother, wife or husband, and siblings.

A. Family History

1) Patient's name

2) Birthplace

3) Birthdate

4) Status

c) What was the patient's attitude toward the diagnosis?

d) What were the patient's feelings toward the disease before and after the onset of tuberculosis?

e) What were the patient's attitude toward treatment?

1- Sanatorial care

2- Other specialized treatment.

3- Surgery

f) How does he think disease has affected his life situation?

1- Adequacy for work?

2- Social activities?

D. Social Factors

1) Is the family known to social agencies?

a) If so, Why?

2) Living conditions

a) Number of rooms

b) Number of persons living in the house

c) General Appearance

d) Neighborhood

3) Economic Conditions.

a) Income

b) Source of income.

c) Salary

d) Insurance

e) Other sources

4) Taboos and superstitions in regard to the disease.

5) Language

6) Education

7) Occupation

Number of years in the same job.

8) Religion

B. Medical Factors

Tuberculosis	Psychiatric
1) Diagnosis	1) Diagnosis
a) Date	a) Date
2) Recommendations	2) Recommendations
a) Was he admitted to a Hospital?	a) Was he admitted to a Hospital?
b) How long did he stay?	b) How long did he stay?
c) Why was he discharged?	c) Why was he discharged?
Date	Date
d) Is he attending a clinic of tuberculosis?	d) Is he attending a clinic of tuberculosis?
3) Contacts	

C. Emotional Factors

1) Family relationship before and after the breakdown with tuberculosis.

a) Wife-husband

b) Parents-children

c) Siblings

2) Man's role and authority

3) How was tuberculosis detected?

a) Was the patient a contact?

b) Was he the source of infection of other members of the family?

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