Tuberculosis-Alcoholism Project in Berks County, Pa.

CLARE S. SMITH, M.S.W., A.C.S.W., and CHARLES R. HAYMAN, M.D., M.P.H.

AN INCREASING proportion of patients with active tuberculosis also have drinking problems. This hard-core group, difficult to reach with modern treatment techniques, consists of persons who deny illness or refuse treatment, and who, when hospitalized, leave before they are ready for community life. Although most of these persons are in the lower socioeconomic level, they represent all walks of life, have varying backgrounds and cultures, and have many kinds of difficulties. All these factors play a part in their attitudes toward their illness. Persons who work with these patients must understand that tuberculosis is not only a health problem but it has wide social implications.

Persons with a drinking problem also have diverse backgrounds. Alcoholism, too, is a condition that does not respond to prescribed treatment unless recognition is given to the place of interpersonal relations in recovery. Smith and associates have pointed out that "Alcoholism among tuberculous patients is not a new development; it is only with the advance made in the conquest of the disease that it now stands revealed as a major obstacle to the adequate control of tuberculosis" (*1*). Pragoff believes the final attempt to eliminate tuberculosis will probably be made among alcoholics (*2*).

Berks County Program

The Berks County tuberculosis-alcoholism project, planned as a 3-year study, was started in April 1963. Focused on patients with both tuberculosis and a drinking problem, the project's purpose was to demonstrate the contribution that social work can make in helping such patients to accept their illness, participate in the prescribed treatment, and be prepared to return to community life. The project was undertaken with full awareness that these patients do not usually seek the services of social agencies. It was planned that the social worker would function in areas where no casework service is offered, use every possible community resource available to the patient, and act as liaison between patient and resources.

Organizing the project involved more than recognition and use of existing community facilities. It also included good interagency and interprofessional relationships. Furthermore, adaptation to the economic, cultural, and social structure of the county was necessary, because what is frowned on as heavy drinking in one group is socially acceptable in another.

Treatment Facilities

Berks County has a State tuberculosis clinic, an alcoholism clinic, and a county tuberculosis sanatorium; none of which employs a social worker. The tuberculosis clinic, staffed by three physicians (two respiratory disease specialists and a radiologist) and six public health nurses, is open ½ day a week in the State health center. The alcoholism clinic is held in a hospital in the city of Reading 2 evenings a week; a physician sees the patients individually and a psychologist holds group sessions.

Miss Smith is director of the tuberculosis-alcoholism project in Berks County, Pa. Dr. Hayman, formerly medical director of Region VI, Pennsylvania Department of Health, is now associate director for preventive services, District of Columbia Department of Public Health.

The sanatorium has 70 beds for tuberculous patients. The alcoholism clinic does not routinely check its patients for tuberculosis, and few of its patients are known to have the dual conditions. Patients with tuberculosis and alcoholism are seen in either the tuberculosis clinic or the sanatorium. Therefore, the project social worker was assigned to work primarily in these two facilities and to make home visits when necessary.

The alcoholism clinic is interested primarily in alcoholism and refers tuberculous patients elsewhere for treatment. The tuberculosis clinic is interested in alcoholism only as it interferes with the treatment of tuberculosis. The sanatorium is neither a drying out station nor an alcoholism rehabilitation center. Its primary function is the treatment of tuberculosis. The project social worker therefore is the only person working directly with patients having both conditions.

Study Patients

For this study, a drinking problem is determined not only by the amount of liquor consumed, but by the drinker's use of it—his dependence on it and how it affects him. Patients with active tuberculosis and alcoholism as well as former patients who are still being treated in the tuberculosis clinic or by private physicians are included in the study.

Referrals are made by private physicians, agencies, relatives, friends, or the patient himself, but the clinicians in the tuberculosis and alcoholism clinics make the final decision as to who is to be included in the study.

The study began with 19 patients. At the end of 18 months there were 66 patients, 60 men and 6 women (15.3 percent of the total tuberculosis register for the county). Currently, there are 54 patients; 8 men have died, and 3 men and 1 woman have been discharged from the project.

The majority of the county's reported tuberculous patients are receiving treatment in the clinic or the county sanatorium; 76.7 percent of those on the tuberculosis register and 85.1 percent of those with the dual diagnosis (table 1). Of 24 study patients who are now being treated in the tuberculosis clinic or by private physicians, 14 were patients in the sanatorium within the past year. The low percentage of study patients being treated by private physicians, in contrast to the total number on the tuberculosis register, may be the result of differences in socioeconomic background. Also, physicians, especially those outside the city of Reading, possibly are not referring patients with the dual diagnosis because they are not aware of the project. This may also be a factor in the greater number of patients from Reading (table 2), the county seat and the largest city in the county (population 98,177).

Many of the study patients say they are lonely and go into bars just to be with other people. In smaller communities this need may be met in other ways. Another factor in the fewer patients from outside Reading may be the reluctance of rural patients and their families to admit drinking problems. Also, Jackson's studies show that most middle-class alcoholics are not recognized as such because of the hospital staff's concept of an alcoholic and because

Table 1. Location of tuberculosis-alcoholism patients by treatment centers, Berks County, Pa.

Location	Project patients		Total patients in tuberculosis register	
	Number	Percent	Number	Percent
Berks County tuberculosis sanatorium	22	40.7	74	17.2
Clinics	24	44.4	257	59.5
Veterans Administration hospitals	2	3.7	7	1.6
State tuberculosis hospitals	1	1.9	7	1.6
Mental hospitals	2	3.7	18	4.2
Private physicians	2	3.7	49	11.3
All others	1	1.9	14	3.2
Not known	0	0	6	1.4
Total	54	100.0	432	100.0

Table 2. Geographic location of patients in tuberculosis-alcoholism project, Berks County, Pa.

Location	Project patients		Total patients in tuberculosis register	
	Number	Percent	Number	Percent
Reading	43	79.6	252	58.3
Berks County (excluding Reading)	11	20.4	180	41.7

many tuberculous patients enter hospital life with no apparent drinking problem (*3*).

Reluctance to admit a drinking problem and the tendency of family and friends to conceal it may account for the small percentage of women referred to the project; 9.3 percent in contrast to 90.7 percent for men. In the total tuberculosis register, there are 35.2 percent women and 64.8 percent men. In the United States, male drinkers outnumber female drinkers 3 to 1, and male alcoholics outnumber female alcoholics 6 to 1 (*4*).

Eighty-three percent of the study patients are between the ages of 40 to 69, in contrast to 56.5 percent in the total register (table 3). In a Massachusetts study, it was noted that the patients were alcoholics for an average of 18 years before they contracted tuberculosis (*1*). This could account for the few patients under 40 years of age in our study.

Many of our patients under 60 years of age believe that they can no longer be productive members of society, many are not interested in employment, and others want jobs which do not require responsibility. Many patients have also stated that they do not want the responsibility of marriage, and the majority of those who are single, separated, or divorced said that they had never married or did not remain married for this reason. However, the total of 63 percent without marital ties is lower than the 92 percent in the San Fernando Veterans Administration study of skid row alcoholics (*5*), probably because our patients have diverse socioeconomic backgrounds. Only 24.1 percent of the project patients are married (table 4), and at least half of these have marital difficulties, have been separated at some time, or have had marriage counseling. Although some patients have been reluctant to accept marriage counseling when offered in this project, their wives have used this service.

Role of the Social Worker

New patients, seen first in the clinic and then recommended for the sanatorium, are assisted by the social worker. She discusses with them their illness, necessary preparations to be made before admission to the sanatorium, and what to expect in the sanatorium. She tries to help them overcome their unwillingness to accept hospitalization. Most of these patients are actively resistant to hospitalization because they

Table 3. Distribution by age groups of patients in tuberculosis-alcoholism project, Berks County, Pa.

Age group (years)	Project patients		Total patients in tuberculosis register	
	Number	Percent	Number	Percent
0–19	0	0	48	11.1
20–29	0	0	25	5.8
30–39	7	13.0	55	12.7
40–49	17	31.5	95	22.0
50–59	17	31.5	81	18.8
60–69	11	20.3	68	15.7
70 or over	2	3.7	52	12.0
Not known	0	0	8	1.9
Total	54	100.0	432	100.0

Table 4. Marital status of patients in tuberculosis-alcoholism project, Berks County, Pa.

Status	Project patients		Total patients in tuberculosis register	
	Number	Percent	Number	Percent
Single	15	27.8	132	30.6
Married	13	24.1	210	48.7
Widowed	7	12.9	39	9.0
Divorced	13	24.1	22	5.1
Separated	6	11.1	27	6.2
Not known	0	0	2	.4
Total	54	100.0	432	100.0

do not want to give up their easy access to alcohol, because in accepting hospitalization they are admitting diseases which they do not believe they have, and because they do not like restrictions of any kind. Time spent with a patient at this time can help him to understand the reasons for his resistance and to accept his need for hospitalization.

The patient is often not only burdened with the need for immediate hospitalization and his inability to fully grasp what he has just learned about his health, but he must also plan with and for his family and arrange for a leave from his work without knowing when or if he will be able to return to this kind of employment. The supportive, understanding assistance of the social worker can be most helpful in this crisis.

Even the lone man, the alcoholic without a job, has decisions to make and things to do before he can move physically and emotionally to the sanatorium. Often he has to notify the department of public welfare of his change of address. Frequently a special grant must be requested for pajamas and other necessities. This is usually the person who is most resistant to hospitalization, who may admit drinking but denies a problem, and who insists that he does not have tuberculosis until he is so ill that he has difficulty in caring for himself. One of our patients, known to have active tuberculosis, changed addresses, evaded efforts of the public health nurse to locate him, and, when found and hospitalized, died within 24 hours.

In this project the social worker is a bridge between the community and the hospital because she is in the unique position of being able to follow the patient from the community to the hospital and from the hospital back to the community. Generally, a community social worker and a hospital social worker assist a patient, and, although one service may be a continuation of the other, rarely does the same person follow the patient through both transitions.

Each new patient in the sanatorium is seen by the social worker within a week after admission. Those who have talked with her before their admission often anticipate this first interview in the hospital. They are eager to discuss their experiences and to express their anxieties. Most patients whose first contact with a social worker is in the sanatorium hear about this service from other patients. They also are given an opportunity to express their fears about their health and their admission to the sanatorium. Those who have families may express concern for them. A few deny having any problems. During their hospitalization, the social worker tries to help these patients understand the nature of their illness and what they must do to overcome it, as well as the effect of anxiety, fear, and other emotions on both tuberculosis and alcoholism.

This kind of service probably does not differ from the service offered to any patient admitted to a hospital. However, several factors differentiate the services which the social worker provides to the project patients. For many of these patients it seems easier to admit a drinking problem than tuberculosis, but some deny both or blame outside forces beyond their control for their condition. Although none of the patients in the Massachusetts study denied alcoholism, 25 percent denied tuberculosis and 25 percent saw no relation between the two (*1*).

Most patients go through a period when their strong feelings of resentment are expressed in hostility toward the clinicians, the hospital staff, or something, such as the food, in the hospital.

The alcoholic, who has even less tolerance for frustration than the average patient, can be so hostile that the staff, especially those inexperienced in working with such a patient, finds it difficult to understand this hostility and to work with him. In such a situation, the social worker can help to interpret this behavior. The alcoholic tends to live from day to day, and he quickly becomes impatient if plans do not become immediately effective. This is also difficult for the staff to understand and accept. He begs for medication and in 2 or 3 days he tells the physician that he is not going to take it any more because it is not doing him any good. He insists on some privilege and then, while it is in the process of being worked out, he tells the nurse to "just forget it." This intolerance for delay is often a precipitating factor in a patient's going away without leave just before his discharge with medical approval becomes effective. The social worker must keep this impatience in mind in any attempt at long-range planning.

These patients create difficulties in ward

discipline because they are the ones who most frequently leave without permission to go to the nearest bar, who smuggle liquor on the ward, and who drink excessively when given a pass. They later have strong guilt feelings which are manifest as hostility or deep remorse and depression. In one study where patient government was attempted to control these difficulties, the patients were "adamantly opposed to informing" (*5*). Berks County sanatorium does not have any form of patient government.

Learning to live with other persons in a hospital is not easy for those with drinking problems, especially the lone persons, because few have good interpersonal relations. The patient who gains a better understanding of himself and his reactions through consultation with the social worker is more likely to learn to accept those with whom he lives so closely.

Many of the patients are known to have had dependent personalities since childhood. Life in the sanatorium with its protected environment, with most basic needs supplied, hours controlled, bed rest, and personal services can be so comfortable that they do not want to leave. The social worker, while helping them to face the reality of possible long-term hospitalization, also helps them to see this as an episode in their lives leading to ultimate return to the community.

Return to the community may be considered a threat by these patients, who constantly express their feelings of inadequacy, who shun responsibility, and who see failure as the inevitable end to whatever they undertake. They may talk of leaving the sanatorium and may request frequent passes for, in this way, they can have the freedom of the community and still be able to return to the shelter of the hospital. However, when faced with discharge from this protected environment they resist it, passively but persistently. Sometimes physical symptoms may reappear. Sometimes the patient asks that the discharge date be delayed until he receives his next check because he will have to pay room rent in advance. Sometimes when he gets the check, he spends the entire amount and again insists that he cannot go out as he has no money for essentials.

Whenever possible, the social worker helps the patient who is being discharged to bridge the gap between hospital life and community life. The improvement achieved in his health during hospitalization can be broken down in a few weeks after discharge when a patient who is not prepared for leaving the hospital and not ready to keep appointments and assume responsibility returns to sleeping under a bridge and living on handouts. When a patient needs public assistance, the social worker notifies that agency as soon as definite plans are made for his discharge. The patient, included in the planning while he is still in the hospital, has a feeling of security in knowing that he will have somewhere to go as well as some money when he leaves.

The State employment service offers aptitude testing and job counseling before discharge from the hospital. Here again the social worker can interpret the patient to the agency and prepare the patient for the agency. The social security disability pension, available to some patients, provides for compensation to continue while the patient goes to work on a trial basis. If the patient has other problems, the social worker helps him to contact the appropriate community resource. The resource may be a family service agency, the alcoholism clinic, the alcoholism resident treatment center, or Alcoholics Anonymous. The project social worker is available to the patient in the community just as she was in the hospital.

Helping these patients to assume a self-supporting role in the community is difficult because they are so poorly motivated. Fairly typical is a 43-year-old man who has always lived with relatives and who, after being discharged from his third hospitalization, had no other plan than to return to them and live on his small disability pension. He would not discuss rehabilitation or job training.

Before his last hospitalization, this patient's relatives had asked him to do some chores in the house and to take some responsibility for its upkeep. Each time he felt that he was under pressure, he would go out to drink. Finally, after drinking constantly for a month, he suffered a physical breakdown and was hospitalized. His history revealed a boy who left school at the age of 16 because of disciplinary action and who was seriously injured in an automobile accident at 17. He had had several jobs,

all of which, according to his statements, had many bad aspects and no good ones. He has not worked since his first hospitalization, has no special interests, no hobbies, and no close friends. He drinks to escape from unpleasant situations, and he is positive that he will never be able to work again because of his tuberculosis and his own conviction that he has a severe case of silicosis. He refuses treatment for his illness, and he refuses followup care in the tuberculosis clinic. This patient was recommended for psychological testing and psychiatric evaluation, but neither he nor his family would cooperate.

Not all of the patients who are offered casework service use it. However, the social worker continues to make it available, and often, when least expected, a patient requests it. This generally happens when the patient feels that he is in a crisis. Patients who have difficulty in establishing interpersonal relationships and who believe that failure is inevitable can through the social work situations experience a satisfactory interpersonal relationship, one that accepts them as they are, does not change when they fail to measure up to expectation, believes that they can accomplish something and helps them as they try, does not turn away if they fail, and offers to help them try again. As Ottenberg has stated (*6*): "Establishing and maintaining a genuine relationship with the patient is of first importance. For these patients the relationship itself seems to be therapeutic."

Conclusions

Results of the first 18 months of the Berks County tuberculosis-alcoholism project indicate that the patients have responded well to the casework service. Although some of the sanatorium's project patients as well as nonproject patients have left without permission or against medical advice during the past year, the sanatorium reported that none of these patients left because of a drinking problem. Most of the project patients in the tuberculosis clinic attend regularly and are following the clinicians' recommendations, although in the past some had been irregular in attendance and uncooperative.

Among the project patients who live in the community, 28 percent are either not drinking or have moderated their drinking so that it is no longer a problem. This is encouraging in view of the fact that other studies of discharged alcoholic patients indicate that they tend to return to their former habits of drinking excessively and avoiding health authorities (*2*, *7*).

Changed attitudes and behavior patterns are more difficult to measure. These can be determined only after many months of work by the social worker. However, a change is becoming evident in the number of tuberculosis-alcoholism patients who are assuming more interest in and responsibility for improving their living conditions and in taking employment.

The project is still new and it remains for the future to show how much social work can accomplish in helping the patient with both tuberculosis and alcoholism to accept treatment, to work toward his recovery, to return to responsible community living, and to prevent recurrence of his illnesses.

REFERENCES

(*1*) Smith, J. C., and Demone, H. W., Jr.: Measurement of the tuberculosis alcoholism problem in Massachusetts and steps to combat it. Amer Rev Resp Dis 84: 263–267, August 1961.

(*2*) Pragoff, H.: Adjustment of tuberculosis patients 1 year after hospital discharge. Public Health Rep 77: 671–679, August 1962.

(*3*) Jackson, J. K.: A social science view. *In* The alcoholic tuberculous patient and the community. Institute proceedings. Glenn Dale Hospital, Glenn Dale, Md., May 4–5, 1959, pp. 38–53.

(*4*) McCarthy, R. G.: Facts about alcohol. Science Research Associates, Inc., Chicago, 1951, p. 30.

(*5*) Wilbur, B. S., Salkin, D., and Birnbaum, H.: A critical evaluation of the therapeutic community approach to the tuberculous alcoholic. *In* Toward intensive treatment for the tuberculous alcoholic patient. Workshop proceedings. Firland Sanatorium, Seattle, Wash., April 12–13, 1962, pp. 27–30.

(*6*) Ottenberg, D. J.: The physician's role in the treatment of tuberculosis—alcoholism. *In* Toward intensive treatment for the tuberculous alcoholic. Workshop proceedings. Firland Sanatorium, Seattle, Wash., April 12–13, 1962, p. 12.

(*7*) Jackson, J. K., and Holmes, T. H.: Alcoholism and tuberculosis. Human Organization 16: 42–43, winter 1958.