THE FAMILY AS A REHABILITATION RESOURCE

The Assessment and Application of Family Strengths and Weaknesses in the Rehabilitation of Male Arthritic Patients: Canadian Arthritis and Rheumatism Society (B.C. Division), Medical Centre, 1955-58.

by

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ABSTRACT

Physical disability resulting from arthritis is a widespread problem: when the sufferer is the **braadwinner** of a family, it is particularly serious, creating the need for special services not only for the disabled person, but also for his family. But the treatment potential of the patient also depends on how far his family is in turn a source of strength or weakness to him. This is a casework "dimension" that is far from fully explored.

This thesis considers the family as a treatment resource in the rehabilitation of a group of male arthritic breadwinners who have been in-patients at the Canadian Arthritis and Rheumatism Society (B.C. Division) Medical centre in Vancouver, B. C., for at least three months. While focusing on the patient in his family group, the study undertakes an intensive examination of the material found in case records and related correspondence from the Medical Centre's Social Service Department, a clinical social work setting. The outcome of the exploration was to emphasize two approaches: (a) the recognition of factors in family behaviour toward the patient which connote family strength, and (b) their application in casework to help meet the patient's needs.

Four comparative cases (two each of "strong" and "weak" examples) were selected to identify the variables affecting employment, treatment, and family interaction. The results of this analysis were then applied to the process of diagnosis and treatment to the total cases (seven) for which clinical and social information was available. The specific findings are (1) that the patient's family could influence positively the patient's rehabilitation potential; (2) that family strength could be recognized in a clinical setting treating the patient; (3) that certain additional kinds of diagnostic information are required prior to the patient's admission to the Medical Centre for treatment. A rating scale of family strength can be envisaged as an experimental counterpart of this complex adjustment process. Some practical implications for future service are discussed.

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CHAPTER I

REHABILITATION OF THE DISABLED BREADWINNER

Physical disability due to chronic illness results in the prolonged economic dependence of many a competent, productive Canadian. Apart from the discomfort suffered, if the victim is a family's breadwinner or the mother of young children, the resultant social problems of disability become more evident.

The Arthritic Diseases - A Nation-wide Problem[1]

The arthritic diseases, which take many forms, are chronic disorders of widespread incidence in Canada. Arthritis is the name applied to a group of rheumatic diseases which affect the joints and sometimes other body structures as well.[2] Among the most common forms are rheumatoid arthritis and Marie-Strumpell spondylitis.[3] These two, and other forms of arthritis, if they are neglected, and even with the application of presently-available modes of treatment (in one out of five cases), may lead to serious disability and deformity.

While statistics do not tell the whole story of the economic and social loss occasioned by arthritic disability, the following

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1 Facts About Arthritis and the Canadian Arthritis and Rheumatism Society, a pamphlet published by the C.A.R.S., 1959, is the source of material used in this section.

2 "Rheumatic diseases" is the broader classification which includes also the non-arthritic illnesses such as bursitis, sciatica, and lumbago which, although painful, do not affect the joints and are usually less serious than arthritis.

3 Marie-Strumpell spondylitis so named after French and German doctors associated with its identification.

estimates prepared (1957) by the Dominion Bureau of Statistics of the Department of National Health and Welfare, are eloquent: 50,000 Canadians are totally or severely disabled, and another 115,000 are partially disabled by arthritis. The annual cost to Canadian workers in lost wages is $75,000,000.00, representing for workers and business 9,000,000 working days. Of all those disabled by arthritis, 68 per cent are of working age, 18 to 64 years. Eighty per cent of those suffering from rheumatoid arthritis, the most serious form and one for which there is no specific cure, are between the ages of 20 and 50 years.

These estimates are of particular importance to this study, although the study is concerned with a specific group of breadwinners with rheumatoid arthritis and Marie-Strumpell spondylitis. The estimate implies that arthritis most commonly occurs in the prime of life when the arthritic is likely to be involved in providing for a family. This indicates that the problems of arthritics and their families appearing in the small group to be examined may recur elsewhere.

Further, those whose daily lives involve heavy physical toil or emotional strain tend to be particularly susceptible to the arthritic diseases. Arthritis, though it differs widely in duration, severity, and kind of treatment required, affects the joints of the body, causing stiffness inflammation, pain, and swelling, Rheumatoid arthritis affects particularly the body's peripheral joints, while Marie-Strumpell spondylitis affects mainly the spine. That the diseases preclude the strenuous activity necessary to the manual labourer who may also be a family breadwinner is evident.

Treatment of a chronic, disabling illness, which must be adapted to each individual case, implies also a prolonged period of care and heavy expense not indicated in the above estimates of wage loss.

The Canadian Arthritis and Rheumatism Society, B. C. Division, was formed in 1948 on the recommendation of a meeting of representatives of health departments, universities, and the medical profession, called by the Minister of National Health and Welfare in recognition of the above facts. Further description of this organization will be included in this chapter.

Rehabilitation and the Family of the Disabled Breadwinner

The goal of treatment of the disabled person is his rehabilitation. Rehabilitation is a concept capable of a wide range of definitions encompassing the return of the disabled person to gainful employment, or more extensively, "the cultivation, restoration, and conservation of human resources."[1] The latter definition seeks to include "the young, the adult, and the aged, in all their capacities and possibilities."[2] This is an ideal objective, and in its emphasis on the dynamic and nourishable quality of human capacities, it is akin to the philosophy professed by social work practitioners by which all their efforts on behalf

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1 & 2 Whitehouse, Frederick A., "Rehabilitation as a Concept in the Utilization of Human Resources," The Evolving Concept of Rehabilitation, Monograph I, July, 1955. The American Association of Social Workers, Washington, D.D., p. 22.

of the disabled person are guided.

In practice this concept of rehabilitation of the person with a problem of physical disability is expressed in the total regard by helping persons of his needs, his capacities to meet them, and the means required for their satisfaction.[1] Failure in practice to achieve the ideal of rehabilitation is, obviously, occasioned by the practical limitations of the helping person and of the resources available. Those resources which are available in the disabled person's own abilities, and in his environment, must be utilized to their fullest possible extent.

The disabled person's family, in this context, might be considered as one such resource or source of enabling assistance to meet his needs. This point of view does not ignore or discount the fact that these families are made up of persons each having his own individual needs. (the most important of which had probably been met by the breadwinner), or that they are as individuals limited in their abilities to meet them. Obviously, small children are necessarily dependent. The contention is, rather, that families are involved in the rehabilitation of the disabled person in complex ways which will be examined in ensuing chapters of this thesis.

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1 Human needs may be broadly identified as those needs which must be met for survival and personality growth of the human being. Charlotte Towle, in Common Human Needs, (the American Association of Social Workers, 1955) classifies needs as follows: the need of every person for physical well-being; for development of intellectual capacity; for relationships with others, particularly in early formative years; for respect and understanding of his spiritual significance.

The Purpose of This Study.

The purpose of this thesis is to explore, and, if possible, assess the ability of families to meet certain needs of their disabled breadwinners. The object is to indicate ways in which the family might be enabled as a resource to improve the disabled breadwinner's rehabilitation potential.

The Rehabilitation Process and the Role of the Social Worker.

The process of rehabilitating a disabled breadwinner, considering the rehabilitation goal to be the maximum use of his residual strengths, may be divided into two parts as the process is observed in practice. The first involves assessment of the person's problem of disability, and of his residual strengths to overcome it, and is termed "diagnosis." The second involves the process of resolving the problem by appropriate means and enabling the person to utilize his residual strengths. The term "treatment" is applied to this part of the total process. The purpose of diagnosis might be said to be the determination of rehabilitation potential; of treatment, the rehabilitation of the person.

The role of the social worker in the rehabilitation process implies social diagnosis and treatment of the disabled person in his total environment and this includes his family setting. A social diagnosis as distinguished from a medical diagnosis or functional assessment (although it must utilize both) is the product of an on-going process of helping the person through a therapeutic relationship and environmental change to meet his

needs.[1] It is based not only upon information obtained from the person through such a relationship in an agency where he appears for help at a given time--a "cross-section" of his present behaviour pattern and apparent success in problem-solving --but also upon his behaviour in the past. This further implies a "vertical" examination to give a more realistic assessment of his capacities to meet his needs before as well as after the onset of illness. By this means the degree of "disability" his illness has caused may be determined.

"Disability" is considered in this social context as a problem, albeit a complex one, which the treatment phase of the process of rehabilitation is designed to overcome. The degree of social disability varies for each person and must be assessed not only by determining his functional impairment and medical prognosis, but also through examination of the life tasks he has undertaken. For example, the degree of social disability experienced by an untrained manual labourer who has assumed the role of breadwinner for a wife and family of dependent children may be greater than for a well-educated and more adaptable person without incumbents.

The effect of disability on employment is an aspect of the disability problem of great importance, both in determining

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1 Helen Harris Perlman, Social Casework, The University of Chicago Press, 1957; Chapter XI.

individual rehabilitation potential and in conditioning the rehabilitation process. It is a subject which deserves much broader consideration than can be accorded it within the scope of this thesis. Just as there are evident degrees of disability, there may be expressed a range of employability suitable to residual capacities of disabled persons. This range of employability, to be provided for, requires a variety of available jobs. Dr. J. A. P. Millet, Chief of Psychiatric Service of the American Rehabilitation Committee, makes reference to this in the following remarks:

> "The final criterion of success in the program (of rehabilitation) is the acceptance of the patient in satisfying and remunerative employment, in which he proves himself capable of giving service satisfactory to the employer. Obviously, there are many individuals whose disability is so great that they cannot ever be integrated with the general working force in competitive industry. For these less fortunate ones special centres of activity are badly needed, suited to their maximal capacity for creative output. The establishment of centres in Great Britain where such groups have found profitable employment and social satisfactions which would otherwise have been denied them provides us with a challenge to our own resources, both professional and social."1

Referring again to the example stated above of the labourer and the well-educated person without incumbents, comparatively speaking, the rehabilitation potential, if the rehabilitation goal is re-employment, may be less-favourable for the labourer, though the functional disabilities of the two persons are approximately the same. Social aspects of disability are therefore important to

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1 Millet, John A. P., "Understanding the Emotional Aspects of Disability", an address, Institute on Rehabilitation, Report of Proceedings, Bryn Mawr College, Bryn Mawr, Penn., 1956, p. 52.

rehabilitation, and the value of a social diagnosis to determine the rehabilitation potential of each disabled person is evident.

The Canadian Arthritis and Rheumatism Society, B. C. Division Medical Centre: Setting of the Present Study.

Human needs and their satisfactions are seen to be complex and interrelated and a broad range of services is required to meet them. The modern development of rehabilitation "teams" working in rehabilitation "centres" to help the disabled person, might be considered practical recognition that his need for a healthy physical body is the most important of all. The teams, composed of specialized treatment personnel--doctors, nurses, physiotherapists, occupational therapists, and social workers--act to provide such a range of services.

These services may include, to give a sampling, diagnostic services, vocational counselling, medical, surgical, psychiatric, and dental care, hospitalization, training, occupational tools, job placement, and "follow-up" of the patient after his discharge. Many of these services may be available outside such a centre either by bringing them to the patient or by referral of the patient to the appropriate sources.

The Canadian Arthritis and Rheumatism Society, B. C. Division Medical Centre, in Vancouver, is one such centre for the diagnosis and treatment of persons suffering from the Rheumatic diseases. This is the setting in which the disabled persons described in this thesis have received intensive treatment as in-patients during the three years 1955 to 1958. The information obtained is drawn from that recorded by social workers in the Centre's Social Service Department.

The development of C.A.R.S., a national, non-profit organization incorporated under federal law, has been described elsewhere.[1] The B. C. Division of C.A.R.S. was the first established of eight which now serve every province in Canada except Prince Edward Island and Newfoundland. The Vancouver Medical Centre, which shares some facilities, including the accommodation, of the G.F. Strong Rehabilitation Centre, is an integral part of services which include 26 branches throughout B.C. Through travelling medical consultants, direct medical treatment, physiotherapy, occupational therapy, and social service, the Division serves approximately 3,500 patients annually, and provides special drugs to patients of low income.[2]

Each patient considered for treatment in the Centre receives a medical, functional, and ideally, a social assessment before his admission. Facilities in the Centre limit the number of in-patients to 10 persons at any one time, although others living in the Centre's vicinity are served on an out-patient basis, and a very few who cannot manage self-care are admitted to the nursing wing of the G.F. Strong Rehabilitation Centre. The average period of treatment is about three months, and the cost of this (for room, board, and treatment during the period 1955 to 1958 was about $9.50 to $10.50

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1 Rohn, George, Rehabilitation of Arthritis Patients, Master of Social Work Thesis, University of British Columbia, 1953; pp 14-18

2 Facts About Arthritis and the Canadian Arthritis and Rheumatism Society, C.A.R.S., 1959.

per day) is borne for each patient by the provincial government, or by C.A.R.S. or both.[1] In rare cases the patient has paid for his own care or has contributed. Of the 80 patients admitted during the three years, only five could pay for their own care, and another 15 patients contributed to theirs. The other 75 per cent could make no contributions. This indicates the modest means of most of the patients admitted, and implies the great cost to them of chronic illness, any personal savings having been previously absorbed for treatment services.

The process of selecting patients for admission implies a provisional assessment of the patient's rehabilitation potential. The complexity of this essentially diagnostic process has been indicated by a former Centre medical director in a letter to a B. C. general practitioner who referred a severely-disabled patient. (The patient was eventually admitted to the nursing wing by special arrangement). The statements pertaining to his functional assessment are quoted as follows:

> "It is extremely difficult to predict whether a patient is capable of improvement under the intensive rehabilitation program available at the C.A.R.S. Medical Centre. However, because of the nature of the physical set-up, there are certain criteria which the patient must fulfill. No bedside nursing service is available and, in fact, the Centre is much like a super boarding home. The patients must be able to dress themselves, attend to their usual tasks of

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1 The B.C. Government's former Social Welfare Branch of the Department of Health and Welfare, now a separate department, The Department of Social Welfare, sponsors rehabilitation "trainees" at the G.F. Strong Rehabilitation Centre on a quota of 12 persons at any one time.

> daily living, and go to the dining-room by themselves--either in a wheelchair or walking. Since there are no nursing attendants, and no orderly service, patients must be able to look after themselves.
>
> " The intensive type of physiotherapy and occupational therapy makes it essential that their disease be at least in clinical remission. The length of time required is great, most patients requiring at least three months and some longer before any great improvement can be expected."

Thus there are certain limitations in the number of patients admitted and the amount of their functional disability which are imposed by the existing facilities of the Centre. The medical director went on in this letter to recommend that the patient be assessed medically by the C.A.R.S. travelling consultant, when next he visited the patient's area of residence.

> "Under these circumstances and considering the physical disability of (the patient) I do not think it wise at the present moment to disrupt his family life to bring him down to Vancouver for assessment before admission to the Centre."

Social assessment of the patient who lives in an area other than Vancouver and environs which C.A.R.S. caseworkers reach must be done by the provincial Social Welfare Department workers. The Department's investment in accurate assessment of rehabilitation potential, and the patient's family concern in his rehabilitation process is indicated by the medical director as follows:

> "Because of the relatively great cost, and the length of time as well as the limited supply of beds available, some assurance is required that the patient will benefit from the treatment, and therefore the Social Welfare (Branch) requires a rather detailed medical report from this office, before they will consider any patient (for contribution to the cost of his care)...
>
> " It is sincerely hoped that we can do something for (the patient), but on two or three occasions in the past year or

> two we have admitted patients to the Centre without having them first assessed, and this has resulted in a great deal of heartbreak for both patient and the staff. This patient would appear to be well settled and happy in his home surroundings, and I would not like to disturb this unless we feel that it would be worthwhile."

Further correspondence concerning this patient, a 50 year-old logger who had been unable to work and support his wife and daughter for some years, and was now supported by his wife, was directed by the head of the C.A.R.S. Social Service Department to the provincial Social Welfare Branch. The letter requested S.W.B. opinion on the patient's rehabilitation prospects, and defined the term "rehabilitation" for this purpose as follows:

> "...By rehabilitation I do not mean a complete recovery and job-placement. There are varying degrees of rehabilitation, and even if a man, like (the patient), could be helped physically to be less of a burden to himself and family, such a step might be worthwhile."

The C.A.R.S. medical consultant had also directed a letter to the patient's private doctor, stressing the need for "a report from the social worker in your district as to environmental and social status of the patient and his family, and a short medical report as to his condition and prognosis." The designated worker visited the patient's home, and determined that the wife's income exceeded the maximum allowable for S.W.B. sponsorship. The patient, loath to spend his small savings, already depleted by the cost of treating his illness, told the worker that, since he had no hope of returning to work, he would rather not "gamble" his residual savings on treatment at the Centre.

Eventually, after some months, during which time reports from the local C.A.R.S. physiotherapist were submitted to the Medical

Centre that the patient's physical condition was deteriorating, he was admitted to the Centre under C.A.R.S. sponsorship. He received medical attention, physical and occupational therapy, and casework; was discharged three months later able to walk 100 feet unaided, and much further with crutches. Although he could not become reemployed, he managed later to help paint his house. The caseworker summed-up the case stating: "The (rehabilitation) goal has been more than achieved."

Each team member concerned in this man's rehabilitation and his family, had contributed to his recovery. To determine the nature and assess the relative importance of any one service to the achievement of rehabilitation potential is very difficult. This is, however, necessary to the primary aim of this thesis: to determine what influence, if any, family factors have in the patient's rehabilitation.

The Method of Study

Cases were selected from the 80 patients (half of them males, half females) who attended C.A.R.S. as residential patients during the three years, 1955 to 1958. Those selected were married male breadwinners admitted from and discharged to their homes, both urban and rural in B. C. They were the fathers of dependent children living in their homes. All families were, therefore, families of "procreation" for purposes of this study, and the wider family connections were not considered in selecting the sample group.

A further selection was made of those whose arthritic condition was of a kind for which there was no specific "cure", and for which

the medical prognosis was uncertain.

Chosen finally for detailed examination of their files--including case records, medical reports, and related correspondence --were seven patients. These were rheumatoid arthritics and Marie-Strumpell spondylitics with peripheral joint involvement, five of whom had become gainfully-employed following their discharge from the Centre.

It was considered that in order to achieve rehabilitation--to reach his maximum potential--the disabled person's needs for income, personal care (if indicated by his condition), and for emotional support and encouragement to use his residual strengths, had to be met. The demonstrated abilities of the patient-family groups to meet these needs plus the means they employed to do so was the focus of the analysis. These activities and attitudes were collectively considered "family factors".

Obviously, other objectively-and subjectively-determined variables such as age, severity of the disease, vocational training previously attained, and availability of employment in his residential area had to be considered in addition to family factors as determinants of rehabilitation potential. It was assumed that each patient had received appropriate treatment of a uniform standard at the Medical Centre.

From such an analysis it was hoped that those factors which characterized the behaviour of a "strong" family (one able to meet the patient's special needs) might be applied to the assessment of other patient-family groups with the purpose to indicate means

whereby a patient's family might be enabled as a treatment resource.

Certain limitations should be noted here in the use of case records for analytical purposes. Such limitations relate, firstly, to the variety and amount of material recorded in a clinical setting when the patient is not seen in his family group, and secondly, to the need to rely on correspondence with provincial workers, who might not be familiar with the rehabilitation process, for family information. In only four out of ten cases examined in the total group were the patient's families interviewed by a caseworker, either from C.A.R.S. or from the provincial Social Welfare Branch.

Most of the information obtained on patient and family attitudes comes from subjectively-recorded impressions by the caseworker of the patient's interviews with him, and allowance must be made for this.

CHAPTER II

RECOGNIZING FAMILY FACTORS IN REHABILITATION

The problem of disability of a family's breadwinner presents many aspects to the helping person. Environmental implications of disability as they affect the man's re-employment potential have been considered briefly in the preceding chapter, and will be examined further in the course of this chapter.

The caseworker, planning treatment services with each patient from the "base" of a clinical setting such as the C.A.R.S. Medical Centre, has the benefit of a comprehensive assessment provided by the team as a whole of the patient's present physical and emotional capacities. This must be supplemented by information relating to the patient's total environment to know what, in fact, he is "up against" in attempting to resume his task of providing economically for himself and his family. In the patient's home environment his family may be considered both as a possible (and complex) influence in his rehabilitation, and as a possible resource to meet his needs.

Always present in planning treatment is the threat of the chronic illness; of the unpredictability of its course, which may upset a retraining or re-employment plan temporarility or permanently. The emotional impact of this uncertainty on the patient's ability to use his residual strengths is of vital concern to the helping person in understanding the patient's needs.

Evidently, some environmental influences on re-employment potential may be objectively observed and described. This is true of some factors affecting the patient's physical well-being, such

as income provision or personal care when he cannot help himself. Other influences must be recognized by the observer through impressions gained of the way the patient relates to others in his environment in the process of meeting his needs; of the way he relates to the members of his family, and to helping persons, and the way family members relate to him. What, for example, is the patient's attitude to the loss of his breadwinner role, and what are the attitudes of family members to his necessary dependence? How might these attitudes affect his rehabilitation?

Evidence that family relationships may be of significance in the patient's rehabilitation appears in a previous study conducted at the C.A.R.S. Medical Centre.[1] From examination of socio-economic factors, such as marital status, affecting the rehabilitation of a group of adult male rheumatoid arthritics--breadwinners and others--treated as residential patients during the years 1952 to 1955, the author noted that those who were married and living in "stable" family groups were best able to adapt to the limits imposed by illness, and to make best use of the rehabilitation service.[2]

The purpose of this chapter is to examine the ways in which each breadwinner-patient's family adapted to his disability; in

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1 MacInnis, Margaret R., Socio-economic Factors in the Rehabilitation Potential of Arthritic Patients. Master of Social Work thesis, University of British Columbia, 1958.

2 Ibid. p. 69.

particular, family modes of adapting to the interruption or curtailment of his gainful employment, and the economic dependency this implied, as these might have influenced his chances of rehabilitation. ("Rehabilitation" for the purpose of this analysis includes re-employment suitable to the physical capacities of the patient, and from which he derives some emotional satisfaction). In other words, to determine how the patient's family--those persons with whom he lived and for whom he had provided before and after the onset of illness--met their own and the disabled person's special needs.

With the above-mentioned purpose, examination of the on-going rehabilitation process as seen and recorded by caseworkers from the various sources available was undertaken to answer the following questions:

1. Could some patient-family groups be recognized as stronger or better-able than others to reach the patient's rehabilitation objective? By what means could they be so recognized?

2. In the strong families, what are the things one builds on in casework?

3. If some patient-family groups were stronger than others, what could be done to help strengthen the weak patient-family groups to improve the patient's chances of rehabilitation?

4. Are these influences in the family ever significant enough to be major or even deciding factors in the patient's rehabilitation?

Selection of Cases for Study.

In order to answer the questions above-stated, it was necessary to identify variables which appeared to affect the patient's employment and to determine the place occupied by the patient's family in attaining the rehabilitation objective. The sources of information utilized were the case recordings, correspondence, and medical reports on each of a group of male breadwinner-patients who were medically-diagnosed rheumatoid arthritics or Marie Strumpell spondylitics, and who received similar treatment for their condition. The information available on all (39) male patients who were admitted to the C.A.R.S. Medical Centre from various points in British Columbia during the three years, 1955 to 1958, was examined. A time period of at least one year between the patient's discharge from the Centre and examination of the record was allowed for the patient's re-establishment in employment if he was able to accomplish this.

From these 39 cases were chosen those men who were married and had wives and dependent children living with them for whom they were, or had been, until their illness prevented this, the sole breadwinner. The patient might previously have had out-patient treatment at the Medical Centre or at a C.A.R.S. branch, but this was his first admission.

The patient's family group was defined for purposes of selection uniformity as being the patient's wife and child or children living in the same home and on the same income or incomes.

Ages of the total group of 39 male patients admitted to the C.A.R.S. Medical Centre, 1955 to 1958, ranged from 6 to 66 years. The final sample of seven were patients whose ages ranged from 34 to 55 years, all being, therefore, of normally-employable ages. These distributions are shown in the following table:

Table 1 Numerical Distribution of Male Patients at the C.A.R.S. Medical Centre, 1955 to 1958, According to Age.

Age	Patients	
	Admitted to Centre	Selected for Study
1 - 19	2	0
20 - 29	8	0
30 - 39	3	2
40 - 49	7	4
50 - 59	13	1
60 - 69	6	0
Total	39	7

The patient-family group in each of these seven cases could by this delimitation be examined as a significant factor in the patient's rehabilitation. This significance could be assumed because the patient had expressed recognition in interviews with the Social Welfare Branch, or C.A.R.S. caseworker, or other person

connected with his treatment at the Centre, that his family was concerned with and influenced by his plans for the future. In what ways and by what means these patient-family groups influenced the patient's rehabilitation is illustrated in the four cases which follow. These families apparently demonstrated differing degrees of strength in meeting the special needs of their arthritic bread-winners.

Variables Influencing Rehabilitation

These records were searched for information which could conceivably have a bearing on employability. Such information concerned age of the patient, duration of illness, number of dependents, education and vocational training he possessed, attitude of the patient to treatment which he understood would improve his employability, attitude of the family to the patient's dependency, and resources mobilized to improve the patient's physical and vocational skills. By this process it was determined that the material could be classified from the point of view of the persons originally recording it as follows:

(a) Those factors or variables affecting employability of the patient which could be assessed and described objectively, such as age, duration of illness in years, etc.

(b) Those factors or variables affecting employability of the patient which had to be assessed and described subjectively, and which reflected the aim of the observer (usually the caseworker) and his concept of means whereby this goal might be reached. This involved a caseworker's and other team members' assessment of

"attitudinal" or emotional aspects through interviewing and observing the patient in the Medical Centre or in his home, or both.

A complete outline for analysis of each case is as follows:

(a) Those variables affecting employability of the patient which can be assessed and described objectively:

(1) the course and severity of the disease in relation to the patient's physical ability to perform work;

(2) availability in the immediate area in which the patient and his family live of employment suitable to his age, degree of disability, and training, when the patient is in relative remission of the disease;

(3) the patient's work pattern in the past as shown by length of periods of employment and unemployment as related to periods of arthritic exacerbations (and not to another form of disability such as mental illness, alcoholism, etc.);

(4) resources mobilized to cover living costs and costs of medical care during the patient's periods of dependency and treatment from the following sources:

(a) the patient's personal savings and property;

(b) family employment and personal help to the patient;

(c) community resources such as social assistance, and C.A.R.S. treatment services.

(b) Those variables affecting employability of the patient which must be assessed and described subjectively:

(1) attitude of the patient to work and family respons-

ibility before and after the onset of his illness; to dependency on others for income and personal care;

(2) attitudes of the patient's family to the dependency of their breadwinner and to plans to restore his independence.

Thus the family's effect on employability is conceived to occur through activities and attitudes relating to the patient's physical and emotional needs. These activities and attitudes are expressed through (1) the provision of income and personal services to the patient during his periods of dependence, and (2) acceptance of the patient's dependency needs and support of plans for his independence. The latter implies an examination of those attitudes which lend support to his resumption of employment.

Analysis of Selected Comparative Cases: Disabled Breadwinners.

The four comparative cases which are analysed according to the previous outline shall be named "Mr. Wehrner","Mr. Thompson", "Mr. Rigby", and"Mr. Lewis". Each had become employed following discharge from the Centre. The first to be examined is the case of Mr. Wehrner.

This 48-year-old man, father of a teen-aged son, came to Canada from eastern Europe with his family of origin at 18 years, settling in a prairie city. There were other members of his particular religious sect, noted for its cultural solidarity, in the same city.

(a) Those variables affecting employability of the patient which can be assessed and described objectively.

When he came to the Medical Centre, Mr. Wehrner, a rheumatoid

arthritic for 13 years, was suffering pain and stiffness in most joints of his body, but there was little evidence of any physical limitation. Though he had been living for the past 12 years in a rural area, and had, until admittance to the Centre, been working part-time on his farm, he had managed to attend a C.A.R.S. branch for weekly physiotherapy treatments. He was considered by the rehabilitation team to be fit for "light employment" on discharge from the Medical Centre.[1] His treatment period had extended to four months.

Planning for his re-employment involved also consideration of jobs which were available and suitable to the patient's age, degree of disability, and training. Mr. Wehrner stated that he had completed the equivalent of public school education in his former country, and was without other vocational training. Though he had in the past engaged in a variety of jobs, including mining and mill work, he could be considered vocationally eligible only for manual labour. While at the Centre he made the decision to move to an urban community where lighter, unskilled jobs were available. He bought a house in the city, moved his family, and following discharge from the Centre, obtained a janitorial job.

The patient's work pattern was relatively stable. He had

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1 The term "light employment", frequently used by medical practitioners, in the writer's experience, implies only that the patient is to some degree functionally disabled. Further exposition in each case of specific disabilities and types of employment available, or which might be available to the patient, is at least required to determine "actual" re-employment potential. The term may be said to imply the patient's need for employment of which he is functionally capable. See also the comment of Dr. J. A.P. Millet quoted on page seven of this thesis.

worked since leaving school--some 34 years ago, 30 of these years having been spent in Canada. He came to B.C. during the Depression period of the 1930's, and while employed in mill work, bought a house in a good city residential area. In the course of this employment, in 1942, he was injured, receiving compensation for a period of incapacity under the Workmen's Compensation Act. He blamed his accident for his arthritis.

When he was able to return to employment, his doctor having advised lighter work, he bought and sold in sequence a dairy farm and a fruit farm. In spite of investments in the fruit farm, little revenue was realized although the small holding was debt-free, and readily salable when he decided to move to the city.

Resources available to the patient to cover his living costs and costs of medical care were derived from his savings and his wife's employment. Savings had been minimized by an investment in his farm, plus family maintenance costs and medical expenses, and the lack of revenue from the farm had forced the wife to do day work. The patient remarked to the C.A.R.S. caseworker, "I have paid more money to doctors than I have for my board." The family did not apply for social assistance.

(b) <u>Those variables affecting employability of the patient which must be assessed and described subjectively.</u>

Examination of the patient's attitude to re-employment and family responsibility by the C.A.R.S. caseworker revealed this patient to be authoritative and decisive, with extreme fear of dependency on his wife and family which implied for him loss of status. Also noted was a tendency to project on authority the

blame for any difficulties he encountered in the course of treatment--a further indication of his refusal to accept his physical limitations. He discussed his needs and problems realistically, however, and while using treatment resources came to the decision to move his family to the city and to find lighter employment.

"I used to wear the pants in the family, but I can't any longer, and my wife does not," he said in the initial stage of his treatment. "Before my illness we had a happy home. I want to get that back. This illness has made me cranky and tense."

The patient's family attitudes to his dependency and plans for his re-employment were assessed by the C.A.R.S. caseworker at the Medical Centre. The family was not seen. The caseworker noted in the record of interviews with the patient that "there appeared to be a good relationship between husband and wife, "the patient having complete assurance that the family would accept and act on any decision he made.

Established in lighter employment, the patient revisited the Centre as an out-patient, reporting happily, "Now I am a man again." He could, he said, "talk back now" to his employer.

Significance of the Wehrner Family in Re-employment: An Estimate.

This patient's family was a positive factor in his re-employment. The family was (a) a purveyor of resources of income and home maintenance, and (b) a source of support for his psychological independence. His wife apparently accepted and complemented the authoritarian nature of the breadwinner-husband-father role as the patient visualized it. One might also speculate in this case that,

should the wife have been unable to work, the family might have called upon the wider kinship and religious group for support. This family gave an impression of "strength."

The second case to be examined is that of Mr. Thompson.

This 41-year-old man, a Canadian of British origin, and the father of three teen-aged children, came to the Medical Centre with Marie-Strumpell spondylitis and peripheral joint involvement. The disease had first occurred seven years prior to this course of intensive treatment, following a minor mishap while the patient was employed as a postman.

(a) Those variables affecting employability of the patient which can be assessed and described objectively.

The course and severity of his disease was such that, although the prognosis for Marie-Strumpell spondylitis is generally considered more favourable than it is for rheumatoid arthritis, Mr. Thompson had not been working for over two years. He could accomplish all personal care and was not, therefore, dependent for these needs, but he found walking very difficult. At time of discharge from the Centre, though there was continuing activity of his illness, he had responded satisfactorily to physiotherapy, and medical treatment, and was considered by the team to be fit for "light employment". This contraindicated his return to farming in which occupation he had been engaged.

Age and degree of disability, then, presented relatively favourable indications for re-employment, although the disease was still active and might at any time become so severe as to ruin his

plans. This patient had to his credit in obtaining lighter work the completion of senior matriculation and some typing and book-keeping, this advantage being lessened in value by the fact that he had never, for any significant length of time, applied his knowledge. He had completed school during the Depression years of the 1930's when jobs were difficult to obtain. He had then found it necessary to follow in his labourer father's footsteps and he had worked for some years as a labourer with his father's employers.

The ensuing variety of semi-skilled jobs he obtained by changing his place of residence, finding it necessary on these occasions to rely on his family to operate a heavily-mortgaged farm which he had in the meantime acquired. While he was at the Centre the patient's family was still living in the rural area where no "white collar" jobs were available. It was apparent that either dependence upon the family and outside sources (public assistance) for income was necessary, or a move to an area where a more suitable type of employment was available, if he was to maintain his independence.

Mr. Thompson's work pattern prior to the onset of arthritis as well as after the onset had shown some instability, not all accounted for by his present illness. In his approximately 21 years of employment, including self-employment in farming, he had held seven jobs, but he had made a continuous effort to remain independent. These jobs included unskilled labour as indicated, which he left following an attack of pleurisy, and both semi-skilled and clerical employment with a government service during

wartime. He had left this, because of what he described as "eye trouble", to obtain outside work, and chose farming.

Without experience in farming, though he worked hard, he quickly became involved in debt for equipment and found it necessary to take a job as a heavy-equipment operator in northern British Columbia to supplement farm earnings and meet the payments. His physical condition deteriorated, and he obtained lighter work as a construction camp cook. At this time he suffered a severe peripheral joint involvement of arthritis which up until that time had been confined to his spine. His next job as a garage mechanic was interrupted by another exacerbation of his disease, and he was hospitalized. From that time until his discharge from the Centre, he had not worked.

Resources available to the patient to cover his living costs and costs of medical care were derived from the efforts of his family on the farm and from social assistance. Personal savings were nil, and debts amounted to $3,000.00 at the time of the patient's entering the Centre. In spite of his efforts, his own farm equipment was repossessed and the family became tenants on their farm. As the patient was unable to work, his wife and teen-aged children, particularly the eldest daughter, aged 17, struggled to continue operating with little resultant revenue, their reward being only a place to live.

The wife had for several years worked away from home, and when about one year before the patient's arrival at the Centre, her health broke down, temporary social assistance was given the family. This also provided medical care for the patient who was periodically

hospitalized during the two years prior to treatment, for from three to six months at a time.

The patient was referred through his own doctor for a functional assessment to the C.A.R.S. travelling medical consultant. Intensive treatment for three months at the Medical Centre was financed by the provincial Social Welfare Branch. By this time the disease had run a seven-year course and the patient had been totally unemployed and dependent for the past two years.

Following his discharge from the Centre the patient completed successfully a bookkeeping course which had been arranged during his stay there. He then moved with his family to another district where clerical employment was available, obtained a suitable job and built his own house.

(b) Those variables affecting employment of the patient which must be assessed and described subjectively.

In the course of an unspecified number of interviews with the patient prior to intake, the Social Welfare Branch worker in that area entered the patient's home to assess his eligibility for social assistance. Using information obtained on this basis, the attitude of the patient to re-employment and family responsibility was determined. The S.W.B. worker, in a report to C.A.R.S., described the patient as being "not an aggressive person, but he has shown considerable determination and persistence in trying to remain independent." The worker believed that with improvement in his physical functioning he would soon become self-supporting; that he had "some feeling" about his wife working.

There was no other information available concerning the patient's expectations of treatment at the Medical Centre or of what it could accomplish for him, possibly due to the social worker's lack of information about the treatment plan, the general prognosis of the type of arthritis from which he suffered, and the employment opportunities available to a disabled person in that area.

The C.A.R.S. caseworker in the Centre met a tense, anxious man "seething with suppressed anger", according to the record, who, while he could not express his hostility directly, acknowledged a strong feeling of personal inadequancy. This was related to his wife's employment while he was dependent. He would not discuss his family relationships in detail, but remarked that he was depriving his eldest daughter of professional training to which he himself had only inspired. (He had wanted to train as a teacher following his high school, but found this financially impossible). This family need was a main focus of his anxiety to become again employed. There was also some defensive criticism of his wife as being "highly nervous", and at times "very difficult". He did not relate this verbally to the heavy demands upon her, but this he implied. His attitude to his family's dependence on social assistance rather than on his wife's employment was not expressed.

The attitude of the patient's family to the dependency of their breadwinner and to plans to restore his independence received little attention from the Social Welfare Branch worker who interviewed the family. One could certainly assume that the strain of providing for the family had aggravated the wife's physical and

emotional insecurity and that she would be unable to tolerate much of her arthritic husband's hostility which attitude of the patient to his wife had been readily evident to the caseworker. One might speculate further that the patient had focused much feeling on his eldest daughter whose ambition to become a nurse he was anxious to help realize. (The C.A.R.S. caseworker offered to investigate means of financing this training).

Financial help in the form of social assistance had come to this family when it was absolutely necessary, when the wife could no longer assume jointly with the children the breadwinner role.

Significance of the Thompson Family in Re-employment: An Estimate.

This family was a positive factor, although outside help was required, in the patient's re-employment because it was (a) a purveyor of resources of income and home maintenance, and (b) a source of motivation to the patient's recovery, partially as a means to live out the desire he had expressed in his own life for "something better." This family also gave an impression of "strength". With the wife's recovery one might project this situation and consider the family as a resource to provide for the patient during possible future periods of dependency.

The third case to be examined is that of Mr. Rigby, a 34-year-old father of three pre-school-aged children who was admitted to the Medical Centre with Marie-Strumpell spondylitis and peripheral joint involvement.

(a) Those variables affecting employability of the patient which can be assessed and described objectively.

Since the onset of the disease seven years before admission to the Medical Centre, its course and severity had been such that Mr. Rigby had held a series of some eight jobs, finally becoming a janitor and bus driver. He had continued to work until a few weeks before admission to the Centre, when the pain in his back necessitated hospitalization.

The patient had found his present employment after many attempts, including farming and sales, the latter involving a move to an urban area. The Rigbys had moved from the city to their present rural neighbourhood because, the patient stated, he and his wife had become "fed up" with city life. He felt that he could combine the janitor work and bus-driving very well, and wanted to return to that employment following his treatment at the Centre. He was given leave-of-absence by his employer with the understanding that he would be able to resume the same employment upon discharge.

Mr. Rigby was not interested in retraining, he told the C.A.R.S. caseworker, although a referral to the Vancouver Youth Counselling Service to which he consented estimated him to be a man of above-average intellectual capacity, and quite capable. He had a meagre grade-school education, and his area of residence offered no variety in more highly-trained jobs.

Mr. Rigby's work pattern displayed some instability, possibly due to residual effects of injuries which had preceded the onset of his present illness. At 10 years of age while lifting a log he

had experienced a severe back strain, and again at 15 while skidding logs for fire wood he injured his back and knees. Another injury, to which he ascribed the onset of his illness, had occurred seven years before.

With savings gained through employment, he bought a farm starting, he said, from "scratch". He had to give up this project because of back pain and there followed, as mentioned above, a series of jobs including work on a poultry farm and several jobs as salesmen. These were temporary due to the insolvency of two companies he worked for, and he moved back to the rural area. His children were born during this time.

Resources used by the patient to cover living costs and costs of medical care were derived from his own work, although for a time prior to his admission to the Medical Centre it had been necessary because of his pain and exhaustion on completing his bus run for his wife to fill in as janitor. The patient received infrequent treatment from a C.A.R.S. physiotherapist; infrequent because of his isolation and distance from a C.A.R.S. branch.

(b) <u>Those variables affecting employability of the patient which must be assessed and described subjectively</u>.

The attitude of the patient to work and family responsibility was determined from several sources of information. The C.A.R.S. caseworker found the patient to be a quiet, insecure, unhappy man with marked feelings of inadequancy as a breadwinner and as a man. That this had been apparent also to the C.A.R.S. travelling medical consultant who saw him while he was living at home was indicated in a medical assessment report. The doctor commented, "Because of

the emotional turmoil in this man's environment, it is considered that he would benefit by social casework during this period (in the Medical Centre)". The report of the Youth Counselling Service described the patient as being of near-superior intelligence, but "very unhappy in his home and marital relationship."

The patient's attitude to treatment, however, was good. He showed physical improvement and was judged capable on discharge of returning to full employment.

The patient was uncommunicative with the C.A.R.S. caseworker concerning his family relationships, but did express apprehension about the Youth Counselling Service test. Although he saw the value of the test and consented to take it, he feared that "they would find out how ignorant I am."

The attitude of the patient's wife to her husband's illness and the insecurity of her position was clearly expressed to the C.A.R.S. Social Service, firstly, in a report of a C.A.R.S. staff member, not a caseworker, who visited the home, and again through a crisis which developed while the patient was in the Centre.

During the home visit it was evident, contrary to the Social Welfare Branch worker's assessment report which had been requested by C.A.R.S. that there was "a good relationship" between the patient and his wife, actually a relationship destructive of his chances for re-establishment existed. The wife, bitterly resenting the additional manual work her husband's illness had occasioned, remarked that she planned to supplement her own training and return to work while "George stays home to do the cooking and mind the baby."

At the Centre the patient received a letter from his wife informing him that she had applied for and had been granted employment by his own employer. She reminded him that as more than one member of the same family could not be hired, according to organization policy, he would not be returning to his job.

The patient was greatly perturbed, and noting his reaction, the doctor commented in a letter to the patient's employer that "if the situation develops as threatened, the patient could continue to deteriorate."

Through this intervention of the C.A.R.S. staff, initiated with the approval of the patient, his job was saved and the couple were allowed both to continue in their jobs. No information was available concerning arrangements for daycare of their children, and it is assumed that these were made privately by the couple.

Significance of the Rigby Family in Re-employment: An Estimate.

While the patient's wife could work to supplement the family income, her competition with the patient and her insecurity were negative factors in determining his chances of re-employment, and, in the judgment of the doctor, the situation could have been conducive to the patient's physical deterioration. This family gave an over-all impression of "weakness."

The fourth, and last, of the cases to be examined is that of Mr. Lewis, at 55 years, the eldest of the four patients, and the father of two teen-aged children. He was of the four the patient who had experienced the most recent onset of his disease, which was rheumatoid arthritis.

(a) Those variables affecting employability of the patient which can be assessed and described objectively.

The course of the disease, while relatively brief, having first appeared one year before his acceptance for treatment at the Medical Centre, was very severe, involving his knees and ankles. The condition was difficult medically to control because the patient could not tolerate certain drugs which were often most successful in controlling the disease. He developed in sequence gastric ulcers which had previously bothered him, and psoriasis, necessitating the interruption for hospitalization of his treatment period at the Centre. He spent a total of six months between the hospital and the Centre.

An urban resident, who had been self-employed for 15 years in the construction business as a skilled tradesman, Mr. Lewis faced the need to discontinue this business in favour of lighter work, which, in spite of his age, could conceivably be found in an urban area. He had been raised on a prairie farm and received only a public school education. However, he had continued to educate himself when possible, had studied bookkeeping and soon after the onset of his illness had taken a course in real estate selling which he did not manage to complete.

A Youth Counselling Service assessment, administered while he was at the Centre, found him well able to manage a clerical job, but noted that his age and physical handicap were discouraging factors in seeking re-employment.

A major physical improvement was noted following his discharge

from the Centre with the administration of a new medicine. Mr. Lewis recovered, and again became employed. The fact that he lived in an urban area and had been well established there was greatly in his favour.

The stability of his work pattern as a factor in his re-employment potential was evidenced in his steady employment since his early 'teens. There had been some irregularity of employment during the Depression of the 1930's which could be accounted for by the fact of job shortages at that time. The patient's shift of employment shortly after the onset of his disease, was related to hospitalization for surgery to treat his gastric ulcer. Another severe exacerbation had occurred when his wife had been hospitalized for surgery.

Resources used by the patient to cover living costs and costs of medical care were supplied by outside sources in the form of social assistance. The patient had exhausted his savings and had a heavy mortgage on his home, which was located in a good residential section of the city. His wife took clerical employment but became mentally ill at the beginning and was hospitalized during the year for prolonged periods. The two children worked during their holidays, and the family received social assistance while the patient was in the Centre, plus continuing attention from the urban Social Welfare Branch worker.

(b) <u>Those variables affecting employability of the patient which must be assessed and described subjectively.</u>

The attitude of the patient to work was evidenced in his tenacity to remain employed, and his feeling of responsibility for

his family was indicated by his expressed relief when they were granted social assistance. The caseworker noted his extreme anxiety about loss of income, expressed initially by apathy, depression, and disinterest in treatment. He responded physically as well as emotionally after provision was made for the family.

The patient was considered a mature and decisive person by the caseworker, as his employment record would indicate, but the demands upon him had become excessively great.

The attitude of the patient's family to the dependency of their breadwinner, and to plans to restore his independence could be assessed through an interview the caseworker had with the wife. Mrs. Lewis was seen by the caseworker during the assessment period prior to the patient's admission to the Centre and while he was still in hospital for treatment of an exacerbation of his illness. She was at that time disoriented and extremely anxious, blaming herself for her husband's illness because of her (necessary) dependence on him when he was ill. She suffered a severe mental breakdown shortly after this, and was hospitalized to receive psychiatric treatment.

The two children who were described by C.A.R.S. staff members who had seen them as being responsible and understanding of their parents' difficulties were provided with summer camp employment during their vacation from school.

The caseworker concluded on the record of this case: "It seems that this is a situation where a man has tried to continue on and support his family while his illness has placed many strains on the family to the point where they are all quite upset at the

present time."

Significance of the Lewis Family in Re-employment: An Estimate.

This patient's family was a negative factor in the man's re-employment because of their total dependence on him. However, this case illustrates the value of well-timed services to re-enforce the existing strengths of what might be termed a "weak" family.

A summary of the preceding material, indicating the variables which apparently influenced each patient's re-employment potential is presented in Schedule "A" (page 41-A).

Criteria of Family Strength

Analysis of these four cases has shown that among those variables influencing the patient's rehabilitation, his family group is a significant, and, as in the case of Mr. Rigby, can be a decisive factor. This influence may be exerted through (1) family employment and provision of personal care; (2) patient-family attitudes to the patient's dependence and plans for his independence.

Physical resources had been met in three of the cases by the wife's employment. (Mr. Lewis, the fourth patient, received no support from his wife who gave evidence in her mental breakdown of her own unmet dependency needs). This was a "last resort" in each case and the husband had shown in his work history his determination to remain independent even while aggravating his physical condition.

The attitude of each patient to his wife's employment was similar. Each gave expression to his unhappiness over this role-

reversal and his resultant feeling of inadequacy.[1] That the patients were also in these expressions projecting their frustration and fear of chronic and progressive illness, and realized in their wives' employment the extent of their disabilities, was an important factor. This did not, however, discount the fact that with discontinuity of the breadwinner role they were feeling an accompanying loss of status.

The family attitude to the patient's illness proved a decisive factor in each case. Examination of available information on family attitude before, during and after the patient's treatment in the Medical Centre shows that when the patient's wife and children were able to accept realistically the patient's need because of his illness to be dependent, a better work adjustment was made. Both patients, one who was still in a relatively solvent financial position, and another without funds but with a good basis for retraining, moved their respective families to an area where they could find more suitable employment.

Mr. Lewis was totally dependent on outside sources, though his wife had attempted employment, and Mr. Rigby's wife was apparently too threatened by her husband's illness to be appreciative of his need for support and encouragement. Without outside

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1 The term "role" a sociological concept, is here regarded as the social identity of a person in a defined life situation, in this case his family situation. It refers "to the way in which an individual perceives himself and is perceived in relation to the expectations of society". (Dr. Herman D. Stein, "Socio-cultural Concepts in Casework Practice", Smith College Studies in Social Work, February, 1959. Smith College School for Social Work, Northampton, Mass.).

SCHEDULE A Summary of Variables Affecting the Rehabilitation of Four Patients [1]

A Objective Variables.

Patient	Functional Goal [2]	Availability of Employment	Work Pattern	Resources			
				Income [3]			Personal Care
				(a)	(b)	(c)	
Wehrner	"Light" Employment	No	Steady	x	x		Self
Thompson	"Light" Employment	No	Some instability		x	x	Self
Rigby	Employment (unspecified)	Yes	Some instability	x	x		Self
Lewis	"Light" Employment	Yes	Steady			x	Hospitalized.

B Subjective Variables

Patient	Attitude of Patient	General Attitude of Family	Rehabilitation Goal [2] Reached in Family
Wehrner	In each case the patient expressed anxiety over loss of his breadwinner role and expressed determination to become re-employed	Positive - encouraging	Yes
Thompson		Positive - encouraging	Yes
Rigby		Negative - discouraging	Partially
Lewis		Negative - discouraging	Partially

1 Sources of Information: C.A.R.S. case records and files for all four; home visits in the Thompson and Rigby cases; clinical interview with a Lewis family member.

2 Functional goal so expressed as "light" employment by medical practitioners indicates the patient's need for employment of which he is functionally capable. (See pages 7 and 24). Rehabilitation goal includes also the patient's return to employment and his emotional security in so doing.

3 (a) patient's personal savings and property.
(b) family employment.
(c) community resources i.e. social assistance).

intervention it is doubtful whether these patients might have become re-employed.

The conclusions may be summarized as follows:

The breadwinner role in a family group is generally regarded in North American cultures as the prerogative and obligation of the male who derives status from adequate role performance. When this role is discontinued, emotional disturbances may result, not only from the insecurity attendant upon loss of income. This may be evidenced in the behaviour of each family member and in inter-family relationships. To these stresses, caseworkers must be sensitive in order to help the patient sort out and clarify the roles with which he experiences stress so that the attendant conflicts may be resolved.

The problems of role reversal has been examined by a noted psychiatrist, Dr. Nathan Ackerman in a recently published study, The Psychodynamics of Family Life. Dr. Ackerman writes as follows: "Family roles must be sex-appropriate, well-defined, and capable of fulfilling the essential needs of its members in a reciprocal role interaction. Where conflict and frustration of personal needs emerge the family must have psychological resources for reaching a correct perception of the problem."[1]

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1 Ackerman, Nathan W., The Psychodynamics of Family Life, Basic Books Inc., New York; 1958. Page 328.

Evidence of the effect of reversal of roles may be seen in the behaviour of members of the four families examined in this chapter. When the family income is obtained through employment of the wife outside the family group there are emotional repercussions which can negate rehabilitation efforts.

To the disabled man whose wife works, disability means practically that he must meet his own personal needs and those of young children as best he can in the absence of other resources. Each patient had carried on in his breadwinner role as long as possible, giving up this role to his wife, though this was a necessary step, with reluctance. While in some cases expressing recognition of the strain on his spouse caused by his dependence, and appreciation of the fact that she was meeting income need, there was evidence of the hostility toward her for the usurpation of his status which this implied. His ability to refrain from expressing this hostility in disparaging his wife through recognizing the situation and doing what he could to constructively alleviate it, could be counted an asset in the family's success to meet his needs.

The wives of these disabled persons displayed a variety of reactions to the role-reversal. For all of them this meant greatly-increased physical and mental stress, but there was much evidence in one case (Rigby) that the reversal gratified a latent desire to compete under favourable circumstances with the husband. This had apparently further reinforced the husband's feeling of inadequacy, apart from the fact that the special circumstances involved nearly resulted in the loss of the job he had held. The wife was also apparently in conflict about this, for she refused

to accept the fact of the patient's disability while forcing him further into an emotionally-dependent role.

Inter-family relationships had, with patterns of family function, evidently been severely disturbed by the breadwinner's dependence, although the information from which this was drawn did not give a clear picture of the pre-illness pattern. As one patient remarked, "Before my illness we had a happy home. I want to get that back. This illness has made me cranky and tense."

Further recognition of the impact of illness on the family group has been observed by Dr. J.A.P. Millet who writes as follows:

"The shattering of the usual pattern of equilibrium by the disability...implies not only the altered equilibrium within the body and mind of the disabled person, but a corresponding dis-equilibrium in the environment of which he is a dynamic part. Changes occur in the domestic scene: parents, wives, sweethearts, or children can no longer react in the same way....The group has suffered a social amputation of one of its component members."[1] Particularly relevant to the future of the disabled arthritic in his family is the following quotation, also from Dr. Millet:

"The more uncertain the outcome, the less the possibility of restoring the original patters of equilibrium, the more lively

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1 Millet, John A.P., Op. Cit.; p. 54.

are these disturbances apt to become, and the greater the obstacles that will be placed on the road to rehabilitation."[1]

Therefore, to achieve rehabilitation, provision of income resources and personal help from within the family should be accompanied by recognition of the patient's need to be dependent, and at the same time, of his need to utilize residual strengths. A strong family, in addition to providing assistance to the patient, demonstrates these attitudes of recognition and understanding in their behaviour toward him. Family strength might be said to rest upon the clarity and complementary nature of breadwinner and housewife roles and the family members' recognition of external realities.

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1 Ibid. p. 55.

CHAPTER III

THE CONCEPT OF FAMILY STRENGTH: CASEWORK APPLICATIONS

The recognition of family strengths and weaknesses has been amply demonstrated in the preceding chapter. A related, but practically different, aspect of the same subject is the application of this knowledge in continuing casework.[1] How can the patient with weak family supports be aided? How are the family resources, when they exist, utilizable; how can they be best built upon? To explore this issue of the diagnostic and treatment values which the concept of family strength may have for the practising caseworker, serving the disabled breadwinner in a clinical setting, these questions will be followed out in all seven cases of the selected sample, including the four previously presented.

In three of these cases, identified as Families "A", "B", and "C", other variables than those previously outlined as involving the family were of greater relative importance in determining the employment potential of the patient. As is indicated in Schedule B,[2] two of these patients, each with a high degree of physical impairment, were functionally-rated incapable of employment. These cases will, however, be examined for (1) family strength, or the

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1 Social casework is one of the methods of social work which has been defined as "a process used by certain human welfare agencies to help individuals to cope more effectively with their problems." (Perlman, Helen Harris, Social Casework, The University of Chicago Press, Chicago, 1957. P.4).

2 Page 46-A.

SCHEDULE "B" Summary of Objective Variables Affecting the Rehabilitation of Three Patients.[1]

(Cases in which family factors not predominant).

Patient	Functional Goal[2]	Availability of Employment	Work Pattern	Resources			
				Income[3]			Personal Care
				(a)	(b)	(c)	
"A"	"Employment"	Yes	Steady		x		Self
"B"	"Self-help"	Yes	Steady		x		Family
"C"	"Self-help"	Yes	Steady			x	Family

1 Sources of information were: C.A.R.S. records for all three, supplementary home visits for "B" and "C"; no clinical interviews with a family member were possible.

2 "Self-help" implies that the patient is not capable of becoming employed due to severe disability, and that a lesser goal has been established by the treatment team at C.A.R.S. See also footnote, Schedule "A", page 41- A.

3 (a) patient's personal savings and property.
(b) family employment.
(c) community resources i.e. social assistance.

abilities of the family group which can be recognized in a clinical setting as acting positively to improve the breadwinner's rehabilitation potential, and (2) for means whereby in their absence or presence these abilities may be supplemented or strengthened by social work method.

The content of this chapter, then, is concerned with patient-family diagnosis, and treatment of the patient in a family context.

Patient-Family Diagnosis and Treatment in a Clinical Setting.

In Social casework, diagnosis cannot be considered apart from the on-going process of helping a patient or client through a therapeutic relationship and environmental change to meet his needs. The deduction or diagnostic product which emerges from examining the ramifications of his problem and assessing his abilities--his strengths--to seek a solution are always bound up with a plan for action.[1] Such a treatment plan, conditioned by the problem, the facilities of the place where the person seeks help, and the means at hand to meet his needs, must, to be effective, have the full support and understanding of the person involved. When a treatment plan is extended to the patient in his family group this implies that the social worker has his co-operation.

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1 Ibid: page 164.

When the patient receives casework treatment in his family group the social worker enters the home upon the patient's recognition that he has a problem requiring such help. This recognized problem maybe, for example, lack of income accompanying disability, or a need for nursing care which the worker, if resources are available, must provide. The worker recognizes, at the same time, that there are always attitudinal or emotional aspects to any problem, and that the patient's family is involved. While the worker's focus remains on the patient, in dealing with these so-called "underlying" aspects of the problem, this focus should not preclude consideration of the needs of his family as individual members, or of means to meet them.

Indeed, the caseworker must actively "engage" the family in the treatment of the patient if he is to realize his rehabilitation potential. This may be accomplished through special skills appropriate to the needs of the person interviewed and the present situation.[1] The realistic facts of arthritis as the disease affects the patient's physical and emotional functioning, and the meaning the illness has for him, are seldom fully understood by his family --those nearest him in relationship. The necessity of such interpretation, well-timed, was evident in the previously-described

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1 Perlman suggests that the caseworker's spoken communications with his client are of two main kinds. "One consists of questions and comments, aiming to draw out to a maximum the client's relevant participation. The other consists of information and counsel aiming to provide the client with some necessary knowledge or guidance." (Perlman, Op.Cit.: page 159).

cases, the Rigby case in particular. It will be recalled that outside intervention was finally forced on an emergency basis to retain the patient's job for him. The need was evident for clarification of the limits imposed on him by his illness; of the inevitability of a certain amount of reversal of responsibilities between the husband and wife; of the emotional conflict and strain on their relationship that this would imply.

Counselling regarding ways and means of adjusting to these new stresses and strains may be indicated to help the patient rechannel his energies into another "lighter" form of work. Retraining, particularly for the older patient, is frequently a disturbing experience when he considers the need to "begin all over again", and although free retraining services may be provided through various agencies, the patient requires emotional support im making use of them. Such support and encouragement from his family members, if they are enabled to provide this through casework interpretation plus relief from environmental pressures occasioned by the loss of income, may go a long way to assist the breadwinner in becoming independent.

Patient-Family Diagnosis in a Clinical Setting.

The seven patient-family groups will be examined in accordance with the criteria previously stated of family strength. Patient-family diagnosis, the product of examining the problem of disability of the patient in his family group, and of assessing the abilities of the group to seek a solution, is based mainly upon information obtained from the patient in a clinical setting. The need is evident, considering the concurrent nature

of diagnosis and treatment, for such information to be obtained by a social worker with the patient in his home. However, it is possible from available information to indicate generally the abilities which the group have demonstrated to meet their needs and to adjust to the changed circumstances.

The first of the family groups to be considered is the Wehrner family. A summary of diagnostic information on each family and an assessment of the relative strengths of each is set out in Schedule C.[1]

To repeat, the criteria of family strength, a strong family, in addition to providing assistance to the patient, recognizes the patient's need to be dependent, and at the same time, his need to utilize residual strengths. Family strength might be said to rest upon the clarity and complementarity of the breadwinner and housewofe roles, and the family members' recognition of external realities. The couple's understanding and acceptance of the inevitable changes which occur in their relationship is of paramount importance.[2]

The Wehrner Family

Mr. Wehrner, a 48-year-old arthritic, gave little evidence of any physical limitation although he suffered considerable

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1 Page 57-A.

2 It might be noted here that the broader family group outside the home has not received the consideration in this examination of cases that it may deserve. In the seven cases, relatives of the family did not appear to be sources of assistance to help relieve the load resulting from the breadwinner's disability. A broader sampling of cases might have indicated the importance this "extended family group" could have in the patient's rehabilitation.

pain and had worked only part-time on his farm. The farm was debt-free, but provided little revenue, and Mr. Wehrner had paid heavy medical bills. He could manage his own personal care, and was considered fit to return to lighter employment. Retraining was not indicated because of his lack of educational background. There being no possibility of "lighter" jobs in his residential area, Mr. Wehrner moved his family to an urban area where he obtained more suitable employment and derived much gratification from this.

Income for the family, which included a teen-aged son, had been supplemented by the wife's outside employment in unskilled work.

The C.A.R.S. caseworker found Mr. Wehrner to be emotionally healthy and realistic about his situation. He readily expressed his concern about the loss of status his wife's assumption of the breadwinner role implied for him, but he retained his authoritarian attitude toward his family. Noting that the patient had "many strengths" the caseworker recorded the following as evidence:

"1. His ability in the past to provide for his family;

2. His realization of his own and family's need to do something about the situation;

3. His determination to change his living situation to fit in with his physical limitations;

4. His ability to recognize and change some of his feelings

regarding independence and to accept and use the treatment offered."

The caseworker's impression of the family's ability to meet the patient's emotional needs was indicated by his comment that there existed "a good relationship between husband and wife." The family apparently accepted, but also supported the authoritarian nature of their breadwinner's role in this family, and reinforced his drive for independence.

The Thompson Family.

Mr. Thompson, a 41-year-old spondylitic, with peripheral joint involvement, had not been working on his farm for two years. Though he found walking very difficult he could manage his own personal care and on discharge from the Medical Centre was considered fit to return to "lighter" employment. This required retraining for which he had a high school background and good motivation.

Income had for several years been provided by his wife's outside employment until her health began to fail, and his teen-aged children helped operate the heavily-mortgaged farm on which they had become tenants. Social assistance helped carry the family through the patient's treatment and retraining period until they could move to an area where lighter employment was available. The patient became well-established in a clerical job, and was building his own house.

The Social Welfare Branch worker described Mr. Thompson as "not an aggressive person, but he has shown considerable determination and persistence in trying to remain independent." To the

C.A.R.S. caseworker, Mr. Thompson expressed concern about his wife's having to work, remarking that she was "highly nervous and irritable" at times. He felt that his illness was depriving his family, particularly his eldest daughter who was apparently a source of strength to him.

This family contributed to the income which maintained the patient and were acting positively to meet his emotional needs. His realistic outlook was a strongly supportive factor in their efforts.

The Rigby Family.

Mr. Rigby, aged 34, and the father of three pre-school-aged children, had continued to work at his bus-driving job with a leave-of-absence for treatment at the Centre. His illness (spondylitis), while this had allowed him to accomplish only part of his prescribed duties, left him able to manage his own personal care. Those duties which he could not discharge were assumed by his wife, a woman considerably better-educated and trained than the patient. During his treatment period at the Centre she returned to her previous employment.

The patient was described by the C.A.R.S. caseworker as being a very repressed person who did not discuss his problems, but did indicate his feelings of inadequacy as a breadwinner and as a man. Psychological testing revealed a very unhappy home and marital relationship and this impression was reinforced by direct observation of the wife's behaviour toward her husband.

That this relationship was a negative and actually destructive one was borne out in the wife's assumption of a job

which would, without intervention, have precluded her husband's re-employment in his former job. Under the severe stress of her responsibility she did not appear to recognize that his illness placed limitations on his performance, and that he had no choice in becoming more dependent.

The Lewis Family.

Mr. Lewis, at 55, though his rheumatoid arthritis was of comparatively recent origin, was hospitalized frequently by his illness and reaction to steroids. He was unable to work in any capacity and was completely dependent for his personal needs. Sometime after his discharge from the Centre, he improved under different medication and was able to resume employment. Because of knee and ankle involvement he was not able to manage his personal care. He had no financial resources and his urban home was heavily-mortgaged.

His wife attempted to support the family, which included two 'teen-aged children, but became disabled and dependent through mental illness. The children showed strength in providing their own spending money by working during holidays.

Mr. Lewis, the C.A.R.S. caseworker recorded, though depressed and apathetic, had definite strength and could realistically recognize the needs of his family and his own limitations. He was greatly relieved when social assistance was provided. It appeared that he was the strong person on whom the wife had been totally dependent, and that she was unable to accept the loss of the breadwinner. The family managed to stay together only through resources available from outside agencies.

Family "A"

Mr. "A", a 38-year-old spondylitic, was admitted to the Medical Centre for treatment from the hospital. He returned on discharge to his former employment as a sheet metal worker.

During his five month's illness his wife supported the family of the patient and two school-aged children with an unskilled job, and continued to work following the patient's return to employment. She later left the patient for a prolonged visit to her own home. Subsequent visits of the patient to the Centre showed that the burdens of home, children, and job, in his wife's absence, had resulted in his physical deterioration.

Although he used functional treatment well, Mr. "A" was found by the caseworker to be rigid and unrealistic in his attitude toward his physical and intellectual limitations and his history showed severe emotional deprivation during his childhood. He was very critical and abusive of his wife as a wife and mother, remarking that he was the only one who could "keep the children in line."

In this case, while the wife provided physical resources, it was apparent that this family group, because of the patient's emotional condition, could probably not meet his emotional needs.

Family "B"

Mr. "B", a 49-year-old arthritic, with clerical training, had shown functional improvement and with retraining was considered

employable prior to his treatment in the Medical Centre. However, he could not tolerate steroids, developing ulcers, and his condition regressed after discharge.

His wife took employment to support the patient and their three school-aged children. The patient expressed his concern about this arrangement, remarking that he knew how hard it was for his wife to go to work, adding regretfully that his children did not remember him "as anything else but a cripple." They had asked, he said, why he could not be like other fathers. He was, however, very demanding of their time in meeting his needs for personal care.

Mr. "B" was found by the caseworker to be emotionally rigid, attempting to control his treatment, and in severe conflict over the loss of breadwinner status to his wife. Resentment of his eldest son, who he felt was taking his place in the family, appeared to stem from an emotional disturbance which predated his present illness.

While the family provided income and contributed to his personal care, it was doubtful whether they could adequately meet his emotional needs.

Family "C".

Mr. "C", a 49-year-old arthritic, had after 23 years of hard manual labour suffered permanent knee deformity which made his own goal of re-employment seem impossible to attain.

While his trade union membership guaranteed him a job with the mining company he had served for many years, he was unable

to work because of repeated exacerbations of his illness. With the use of steroids he developed ulcers and had repeated set-backs, regressing after his discharge from the Centre. He became able to manage some personal care, but his wife, a small woman, the mother of two young children, had to lift and help him from his chair.

The family received social assistance and some income from a boarder in their home, which was located in a rural area at the top of a high hill.

The Social Welfare Branch worker found the wife to be "very co-operative although a great worrier. She endeavours to encourage her husband and be cheerful in his presence." Mrs. "C" complained, however, that her husband had "no sympathy or compassion" for her. She suffered from migraine headaches which were severe enough to be apparently disabling.

Mr. "C" was found to be extremely anxious and depressed, expressing a "work-or-nothing" attitude. He said, when functional gains relieved some of this tension, that he regretted the strain his illness had imposed on his wife, who chould not afford a "baby-sitter" and consequently, "she never gets out." During periods of improvement there was evidence that the patient's emotional needs were being met when he was better able to manage some personal care, although he could not become employable.

SCHEDULE C Summary of Family Strength Assessments.
(Seven Cases)

Patient	Criteria of Family Strength[1]				Assessment of Family Strength
	Income Provision	Personal Care	Acceptance of Dependence	Encouragement of independence	
Wehrner	Contributing	Not required	Yes	Yes	Strong
Thompson	Contributing	Not required	Contributing	Yes	Strong
Rigby	Contributing	Not required	No	No	Weak
Lewis	No	No	No	Yes	Weak
"A"	Yes	Not required	Doubtful	Doubtful	"Borderline"
"B"	Yes	Contributing	Doubtful	Doubtful	Some Strength
"C"	Contributing	Contributing	Doubtful	Contributing	Strong

1 Criteria of family strength are described in detail on pages 40-45.

2 This patient-family group would be decidedly weak were the patient unable to meet his own needs for personal care.

Patient-Family Treatment

The economic and emotional depredations which chronic, severe illness of the breadwinner makes on family group strength are illustrated in these seven cases. Had economic assistance been available to supplement income at the onset of the disease, together with treatment of the patient's physical and emotional condition, this degree of stress might have been avoided. Nursing care was indicated in two of the cases.

In two cases there were severe emotional problems which apparently predated the patient's present illness. In the relatively brief treatment period at the Centre, these emotional problems, if recognized by the patients, were not explored. It is possible that, with continued supportive casework for the patients and their families, and interpretation to their wives of the patients' needs and limitations, better results might have been obtained.

A Possible Comparative Rating

The prime purpose of a study of the kind set out so far is to sharpen up analysis and recognition of causative and significant factors. It becomes evident, however, that further development of this kind of analysis might lead potentially to the devising of a rating scale, in this instance, for family strengths for certain classes of patients. Without claiming more than experimental value, this has been tried out in what follows.

The "rating scale" represents an attempt to evaluate and compare the demonstrated ability of each patient-family group to meet their disabled breadwinner's physical and emotional needs, and thereby contribute to his rehabilitation.[1]

In the process of constructing the scale, and in order to strengthen it, it was found necessary to incorporate a "dynamic" aspect in assessing family strengths. In addition to factual material descriptive of the patient-family group's behaviour at the time of the patient's treatment in the Medical Centre which involved a diagnostic "cross-section" of behaviour patterns, an "on-going" aspect was included. This is illustrated as follows: When the criteria of a "resource" family, as previously described, are applied to each patient-family group, actions which favour the patient's rehabilitation tend to be offset by others which do not. For example, the family, while encouraging the patient's independence, may fail to recognize his limitations imposed by illness, thus aggravating his physical condition. Alternatively, the degree of dependence exhibited by some hitherto hard-working breadwinners who have become disabled, if this dependence is totally accepted by their families, may lessen their potential for independence. Also, when the wife is providing income from

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1 Rating scale: page 63-A.

employment outside the home, unless there are others who can meet the severely-disabled patient's needs for personal care, he must meet his own, and may, as well, suffer emotionally from loss of status with this reversal of roles.

The means adopted in rating scale construction to express the dynamic aspect was the positive or negative numerical weighting of each factor (such as provision of income by the family; family encouragement of the patient's independence) as it was objectively or subjectively observed in the behaviour of each patient-family group. A positive rating indicates that the family has in specific ways (documented in the case histories previously presented) provided for or contributed to the patient's rehabilitation by meeting his physical and emotional needs. If the family has not provided for these needs, or if there is evidence that what they have done is discouraging the breadwinner's independence, a negative rating is recorded.

The numerical values are a convenient means of summarizing and comparing family strengths. (A further explanation of assigned values is given below the Table). All families fall between the two extremes of "total" demonstrated adequacy of the family to provide for the patient, and "total" demonstrated inadequacy. For example, it is possible, though a breadwinner was so severely disabled his chances were small of returning to work in any but a protected environment, that with adequate income from savings or the employment of other family members; with family-provided personal care and acceptance of the limitations imposed

by the patient's illness, together with encouragement to use his residual strengths constructively, the patient might be rehabilitated. Such a family would receive a rating of + 8. If, on the other hand, the patient had no family, for whatever reason, and was totally without either income or emotional support, the rating would be -8.

It should be emphasized that these ratings assess only family strengths. The other variables influencing the patient's rehabilitation, such as age, severity of the disease, and employment opportunities, have been excluded in determining the rating. However, the rating actually calculated for each patient-family group reflects that group's comparative importance in relation to the other families among variables relating to the patient's use of the Centre services and his adjustment there. These variables have been considered elsewhere as being related to rehabilitation potential.[1] The basis for this fact concerns the function of the agency from which these cases are drawn, and the type of information recorded by the agency's caseworkers.

The medical-social problem which is at the centre of C.A.R.S. agency concern determines in this setting of skilled caseworkers the information which is obtained from the patient and recorded.

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1 MacInnis, Margaret R., Op. Cit.

If family interraction is closely related to the patient's treatment of his illness, and hence his rehabilitation, there is more information on file concerning family relationships. This was evident in the four illustrative cases outlined in the preceding chapter in each of which the family played a major or even decisive role in rehabilitation. In the group of three cases, while families exerted an influence, they were evidently not as important as such other variables as the severity of the handicap or emotional problems in determining the patient's rehabilitation potential. The patient in Family "A", although achieving re-employment, had presented an emotional problem prior to the illness onset which current family relationships appeared to aggravate.

The overall ratings indicate that of the seven patient-family groups considered, the rural Wehrner family with its immigrant spondylitic breadwinner is the strongest. The urban Lewis family, the family of a rheumatoid arthritic breadwinner whose wife was disabled by mental illness is the weakest. The others fall between these two on the scale of their demonstrated abilities to contribute to their breadwinner's rehabilitation.

One important difference not indicated by the comparative overall rating is the degree of emotional need of the individual patients. The breadwinners in Families "A" and "B" were emotionally disturbed and would impose relatively greater burdens on any family group to meet their emotional needs.

It should again be emphasized that patient-family diagnosis in this thesis is limited to a study at one short period of time, that is during the time immediately preceding, during and shortly

after the patient's treatment in the Medical Centre. Limited information precluded the more accurate consideration of "vertical" factors in diagnosis i.e. patient-family group behaviour patterns prior to the onset of the breadwinner's illness and after. Obviously the strongest family might in ten years' time become greatly weakened by the increased severity of the patient's illness, or his wife's inability to work with advancing age or illness. A future study of each of these patient-family groups might produce quite different ratings.

Treatment Implications of the Rating Scale

Some patient-family groups, even without outside help, have had positive value for their breadwinner's rehabilitation. Others have little to offer toward his becoming independent and again carrying on in his breadwinner role if there is work suitable to his abilities. Within the limitations imposed by basic information sources as indicated above, the scale presents a picture of comparative strengths of the families studied. Family weakness signals the need for help from sources outside the family group.

With the provision of services in the form of income, medical treatment, and emotional support through casework to reinforce residual strengths in the patient-family group, the weakest Lewis family continued to function for the benefit of its breadwinner and the other family members in spite of the severe stresses. Without these services the family could not have survived as a group.

Table 2 Comparative Rating of Family Strengths.

Patient-Family Group	Demonostrated ability of the Family to meet the Patient's physical needs		Demonstrated ability of the Family to meet the Patient's emotional needs.		Over-all Rating
	Income Provision	Personal Care	Acceptance of Dependency	Encouragement of Independence	
Wehrner	≠ 1	0	≠ 2	≠ 2	≠ 5
Thompson	≠ 1	0	≠ 1	≠ 2	≠ 4
Rigby	≠ 1	0	- 2	- 2	- 3
Lewis	- 2	- 2	- 2	≠ 2	- 4
Family "A"	≠ 2	0	- 1	- 1	0
Family "B"	≠ 2	≠ 1	- 1	- 1	≠ 1
Family "C"	≠ 1	≠ 1	- 1	≠ 1	≠ 2

Ratings: A positive answer rates ≠ 2; a negative answer rates -2;

A qualified answer, "contributing", rates ≠ 1;

A qualified answer, "doubtful", rates -1;

A need met by the patient himself, in the context, rates 0.

CHAPTER IV

IMPROVING TREATMENT RESOURCES

Human needs and their satisfactions are complex and interrelated. When needs are unmet the problems which arise are equally complex and difficult of resolution. The concepts set forth in this thesis relate to problems arising from chronic illness.

When the breadwinner of a family is disabled by arthritis, the loss or reduction of his income and of his independence occasioned by his physical handicap invariably has serious repercussions on the man himself and on his family. It is the resolution of these problems which is the goal of the rehabilitation process. It has to be achieved in his personal environment: in that of his family group, and in his community.

His need for a healthy body and mind--the family's need for an able breadwinner, a stable husband and father capable of playing his part in the family drama--is the primary focus of this process. The man needs health, peace of mind, and security in his family role, but these needs cannot always be met because of the chronic nature and incurability of the disease, and the permanent damage which sometimes accompanies it. Not only does this damage occur to his body, but also to his self-esteem--to his feeling of self-worth and adequacy as a man.

In the absence of other resources from his kinship group or community, he is thrown back upon his family for help in providing income, physical care, and emotional support and understanding. The family may not be able to meet his needs,

but if strong, it is certainly better able to do so. If the family is weak, unless its members may depend on resources outside the family group--relatives, or community agencies--the group is in danger of disintegration under the stress.

Even a strong family cannot be expected to withstand indefinitely the great stress of disabling illness of its breadwinner. When the mother works the family is forced nearer its breaking point. Treatment services must be available in the community to support and maintain family strength; to prevent the weak families from becoming weaker or disintegrating.

Better Diagnosis May Help the Family.

Practising caseworkers in social agencies are frequently involved in the social diagnosis and treatment of persons whose most evident problem is disabling illness. Their objective in assisting such a person must be the reinforcement of his residual abilities, both physical and emotional, to regain the maximum social functioning of which he is capable. In his social milieu, the patient's family is the most relevant to him, and subject therefore to the caseworker's consideration, both as a resource, and as a group of individuals with their own related needs and problems.

A problem facing the researcher in this study has been, "How can we as practitioners improve services to the arthritis-disabled breadwinner in his family group?" Caseworkers in a clinical setting see the patient within limits imposed by time, agency function, and knowledge of the patient's and his family's abilities to meet his needs. Further limits are imposed by the

extent and variety of resources at hand. Within these realistic limits the caseworker must sharpen diagnostic and treatment skills and improve resources. Appropriate treatment is based upon sound diagnosis.

The method used in this study, as detailed in Chapters I and II, is a form of research which is indigenous to social work because it is concerned with the improvement of treatment skills and resources. There can be no such thing as a social "laboratory", of the type available to the physical scientist, to extract and examine the interraction of two isolated variables. Social work research must be developed from on-going casework practice by methods suitable to the particular problem at hand.

Such research may therefore be regarded, "not as the application of special methods, but as a process of obtaining facts or knowledge that help us (as practitioners) determine what decisions to make and what actions to take."[1] In other words, a distinction is made between research as a practice of methodology, or "what is done", and as a process of finding out something we need to know, "what should be done."

The social research process has, in common with other forms of research, five identifiable steps or stages which are as follows:

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1 Gordon, William E., "Can Research Help Social Work--Some Practical Suggestions", from Tenth Anniversary Celebration, University of Tennessee School of Social Work, Nashville, Tenn., 1952.

1. establishing the goal of the project;
2. analysing the problem;
3. describing or standardizing the activity;
4. measuring the degree of change as a result of the activity;
5. determining the cause-effect relationship of factors which induced this change.[1]

These five steps may be recognized though not always explicitly in the process of diagnosis and treatment of each case. Certainly, the process may be observed both in the on-going practice of casework, and in social work research.

In the research process utilized in this study, three of the five steps are observed as follows: (1) the goal is established of the breadwinner-patient's rehabilitation; (2) the amount of disability due to arthritis in relation to employment potential is analysed in order to identify among the variables affecting employment the specific influence of the patient's family group; (3) the results are applied to the process of diagnosis and treatment of the patient in a clinical setting to consider how his family might be used as a resource in his treatment. A rating scale, a fourth step, could be developed as a measurement

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1 French, David, Measuring Results in Social Work, Columbia University Press, 1952, Chapter V.

addition to the complex process of assessing the degree of change in family strengths over a period of time. This would demand more research, and continued "operational" application of the scale; but it is at least outlined in the present study.

This thesis was confined to the records of on-going practice of diagnosis and treatment of one particular agency, the Canadian Arthritis and Rheumatism Society, B. C. Division, Medical Centre. The material has been recorded by caseworkers over a three-year period with individual rehabilitation goals having been determined for each patient. The second major step in this research process might be described as "getting outside" of the on-going activity in order to analyse the material. This has been done in Chapter II to determine what factors or "variables" could be identified as influencing the rehabilitation of disabled breadwinners. While only a small sample of cases was available, certain variables were identified from the inescapable facts of the nature of the disease, and the basic problems it created for the man and his family by making him temporarily or permanently unable to work.

The conclusion reached from this analysis is clearly that, in the rehabilitation of each patient for whom suitable re-employment was the selected goal, the family was an important influence. In two cases, the family group could be described (or assessed) as a positive, in two cases as, on the whole, a negative influence.

Given this knowledge that families can exert a positive influence on the patient's rehabilitation, the second question

was: how can such knowledge be applied to the practice of case-work in a clinical setting? It was therefore necessary to determine what behaviour characterized a strong patient-family group, and to apply certain criteria of strength in the family to the diagnosis of a group of cases seen in the same clinical setting, and to indicate treatment implications of such a diagnosis. An experimental by-product of this process was a rating scale, developed to bring into clearer focus the comparative strengths of the families whose patients were seen in the clinical setting. If applied periodically, this scale might be considered as a means to measure the degree of change, following the application of various forms of treatment.

Lack of Information, a Limitation.

In this research project a practical limitation, which has been previously-noted, is the lack of information on the patient's family group; their attitudes to the patient's illness, and the ways in which they had met the patient's needs prior to his illness, or even after. This is, of course, related to the focus of the agency on the patient in a medical setting, not in his home, and the need for the caseworkers to rely for information on the patient alone and on sources outside the agency, unless the patient's family resides in the Vancouver area. These outside sources, requested by C.A.R.S. to furnish social and financial information, were apparently oriented to financial eligibility-determination.

Not only in the research process but also in casework practice there is much evidence of the need for family information

as expressed by practitioners. This lack of information as a limitation of the diagnosis of cases prior to their admission to the Medical Centre may be noted on examination of correspondence between caseworkers and the provincial Social Welfare Branch agencies.

The following letter (acknowledged by the S.W.B., but without answering the questions implied) from the C.A.R.S. caseworker is quoted as evidence. (The prospective patient was a 47-year-old widow, the mother of two school-aged sons, who had been referred by a local doctor from a small centre in the B. C. interior).

> "...Some knowledge of (the Patient's) family situation and how she handles it would be helpful to us in assessing how she might be able to settle into the program here and use the treatment available. It is our experience that patients with a lot of unresolved problems at home find it difficult to concentrate on treatment, and tend to want to leave before they have gained as much benefit as otherwise might be the case. We believe (the patient) has had difficulty in the past making up her mind to come to the Centre for intensive treatment, so we are anxious, now that she seemingly wants to come, that she be given help and encouragement to do so, but the realities of her situation need to be taken into consideration and be understood by those trying to help her."

The importance of this information in assessing cases for intensive treatment is a topic which was not specifically dealt with in this thesis, but which is highly relevant to this study. It is interesting to note that the caseworker's experience which had led her to conclude the information was necessary <u>before</u> the patient should be admitted for treatment was clearly borne out in the further development of this case following the patient's admission to the Medical Centre.

While her rheumatoid arthritis had resulted in little physical limitation, her apathetic approach to treatment in the Centre and lack of co-operation frustrated the physiotherapists and occupational therapists, and their impressions are so recorded in case conference notes. She was discharged from the Centre with little physical improvement and no evident improvement in her physical and emotional dependence on her sons. Other treatment resources were certainly indicated in her home environment, but her intensive treatment at the Centre at that particular time, and without supplementary services, was not.

While this example is drawn from another group of patients --the women breadwinners--there were other less-dramatic examples in the male group selected.[1] For purposes of determining what diagnostic information had been received concerning the male group of patients by the C.A.R.S. caseworkers prior to their admission to the Centre, the writer further examined the seven files for diagnostic "items" then available. (Whether the patient's family was at any time, before or during his treatment, interviewed has been indicated in footnotes to Schedules A and B).

These "items" were judged by the writer in the process of analysing the disability-employment problem to be essential to

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1 A caseworker's comment is recorded on the record of the patient from Family "A" (see Chapter III) that the patient's "marital difficulties might sabotage treatment plans." The marital relationship proved to be a negative factor in the patient's rehabilitation.

the determination of rehabilitation potential, and were the components of variables influencing re-employment, listed in Chapter II. The items selected were both the "objective" ones of age, duration of the illness, and employment history as related to the onset of the disease and its severity, income sources, and, secondly, the "subjective" items or those requiring descriptive material which was, as the case analysis has further indicated, important to rehabilitation of the patient. These items were, firstly, the attitude of the patient to his present situation (reflected in his attitude to proposed treatment which he understood would contribute to his independence) and, secondly, the family's attitude to the patient's dependency. Included also for this purpose was a closely-related item--housing of the patient and his family. Would the patient have to cope with stairs or steep grades in going to and from his work?

These items were listed and each case was checked for pre-admission information. Results showed that while a home visit might have been made to a rural or urban family, that, with the exception of housing on which information appeared in only one case, the objective information available was provided mainly by medical reports; that subjective information on the family's attitudes was seldom available. Further, it was necessary to rely on the C.A.R.S. medical consultant's estimate of the patient's "motivation" to use treatment on the basis of one or two interviews held in a clinical setting. This estimate appeared to rest upon the patient's employment record and his expressed feeling about being unemployed.

These estimates of motivation, without knowing what, in fact, the patient was "up against", were not in all cases borne out in his performance after leaving the Centre. The estimates were made on the basis of inadequate information.

Concerning the patient's attitude to treatment, in one case (Family "C"), the consultant who saw the patient in the clinic said he was "doing remarkably well in spite of his deformities," and the S.W.B. worker who briefly visited the home to determine financial eligibility, said he was "remarkably self-sufficient." The physiotherapist who treated the patient in his home remarked, however, in a note to the travelling consultant, that he was "too dependent on his wife, although capable of self-help. He needs a great deal of encouragement." The possibility of over-identification with the patient's wife who the physiotherapist described as "a small woman...who has to lift and help the patient" cannot be discounted in determining her degree of objectivity. The difference in these accounts, however, cannot be ignored, and the need for a more thorough study (and recording of the results obtained) in the patient's home environment is indicated before his admission to the Centre.

Treatment Implications of this Study.

Treatment of individual patients following from analysis of each case in Chapter II have not been described in detail in this thesis of which the ultimate purpose is to indicate how, from its assessment, a family group might be enabled as treatment resource for the patient. C.A.R.S. provides treatment

both in a clinical setting and, through "self-help aids" developed for each individual patient by the occupational therapy department, and physiotherapy, in the patients' homes. The social service department of C.A.R.S. devotes much time to helping the patients use such treatment resources, and, if the patient's home is within the environs of the Medical Centre, interpreting to the family members the need for their support of the patient if he is to become more self-reliant.

"Full" treatment of the patient necessitates regard for his total well-being, as a person, as a family member, and as a member of his community. This is an ideal which in its realization is limited by the skills of those who would help him, and the resources available.

Various approaches to treatment must be co-ordinated to assure that the patient is not "segmented" by specialized helping persons--doctors, physiotherapists, occupational therapists, and social workers--and that he is not considered apart from his family. The team approach to rehabilitation is a practical recognition of this concept of "full" treatment of the "whole" person, but there are varying degrees of such co-ordination. If the family is over-looked as a resource and, indeed, as a part of the team, the rehabilitation services are inadequate, and the process of rehabilitation handicapped from the beginning.

That the patient's family should be regarded as an "extension" of the treatment team is the contention of Dr. John A. P. Millet, Psychiatrist In-Chief of the American Rehabilitation Committee. Outlining certain basic approaches to the task of rehabilitating

the disabled, Dr. Millet states as follows:

> "..the structure and attitudes of the family, as well as their economic status, should be fully and sympathetically investigated by the social worker on the team, whose role is to act as ambassador from the rehabilitation team to the family, and to see that the family is made to feel a part of the team. At times her specialized skills may be called for if some member of the family is in need of supportive therapy."[1]

Dr. Millet made these further comments on the financial needs of the family group in relation to the patient's rehabilitation which are relevant to the present discussion of treatment implications of this study:

> "Families vary all the way from being extremely embarrassed and reluctant to accept assistance to making angry protests against the niggardly subsidy which is provided...Since it is highly important to the patient that his family be as free from anxiety and hostility as possible, the approach which the...worker has to the very delicate business of investigating and reporting on the situation is quite important. In some cases anxiety due to some other cause may lead to undue anxiety about money, so that adequate financial subsidies do not necessarily bring the relief that might be anticipated."[2]

It might be noted again that social workers from the C.A.R.S. rehabilitation team do not visit the patient's home unless the patient is within the urban environs of the Medical Centre. This is obviously an inadequacy in the team's approach to treatment, although the difficulties involved in covering the large geographic area from which the patients are drawn is acknowledged.

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1 Millet, John A.P., M.D., "Understanding the Emotional Aspects of Disability," an address at the Institute on Rehabilitation, June 1956, Bryn Mawr College. Op. Cit.; page 61.

2 Ibid; page 62.

Supplementary casework services which the provincial Social Welfare Department might be expected to provide are not available. The task which that Department recognizes in practice, the determination of financial eligibility for the patient's treatment at the Centre, though it may appear to be a relatively straight-forward procedure, is a process invariably charged with emotional content for the patient and his family. This may be the basis, in the hands of a skilled social worker, for actively engaging the family as a resource and as part of the treatment team to help the client use available facilities. This could mean the difference between the patient's successful rehabilitation and his regression into permanent dependency.

The need for skilled social workers to enter the patient's home on whatever basis is indicated by the needs of the patient and his family is elemental to the rehabilitation process.

This study has emphasized a particular environmental approach to consideration of the patient's needs and problems, noting behaviour of the patient in his family group and the manner in which its members meet his needs. Obviously this is not the whole of the casework approach, just as the "whole" person is not simply to be described in the roles he plays. Neither is the family composed of persons whose total activities are centered within the family group. The family lives in a social and cultural milieu which must be taken into account in determining the ways they customarily use to meet their needs, their concepts of role playing, and their attitudes to receiving assistance from outside sources.

The methods and objectives of the social caseworker have been briefly noted in Chapter I.[1] Social diagnosis is the product of an on-going process of helping the person who seeks help in carrying out one or more of his everyday tasks through a therapeutic relationship and environmental modification to meet his needs. Such a relationship is fundamental to the helping process and must be established not only with the disabled person but also with his family members if the family is to be considered a treatment resource.[2]

The patient's "environment" includes not only his external but also his "internal" environment--the psychological import of his experiences. The question is not which of these two aspects of total environment should be emphasized--a question which has had a profound influence on the development of casework method--but of how the "whole" person might best be understood and involved in seeking a solution to his problem. Increased

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1 See pp. 5-6

2 Helen Harris Perlman, has recently written as follows: "... casework diagnosis and treatment must of necessity deal not merely with the person who asks for help, the person called the "client", but with the living network of those people with whom he is in vital interaction, whom he affects and by whom he is affected. In large part this is what is implied by the idea of "family diagnosis", an idea which has captured much interest and effort today--the idea that the family is a dynamic network of relationships and that any member does not simply dwell within it, but rather is in continuous interaction with it." (Perlman, Helen Harris, "Social Casework Today", Public Welfare, The Journal of the American Public Welfare Association, April, 1959, page 53.)

knowledge of both sociodynamics and psychodynamics has become available to caseworkers in recent years, and today's challenge is to select and use what is valuable from these sources in the process of helping persons who seek agency assistance. Each patient presents problems in which there appear varying proportions of situational and psychological pathology. It will be recalled from the cases described in Chapters II and III of this thesis that two of the patients, those from Families "A" and "B" were clearly in need of help to free them from emotional blocks to living satisfying and productive lives in their family groups; to perform adequately in their family role. Others were to a greater degree the victims of adverse external circumstance which had left them without sufficient educational background to compete for other than manual labour, and yet they felt that they must continue to be the family breadwinners.

When, in the process of social work, environmental modification is attempted by the caseworker, the necessity for further refinement of treatment skills is evident. The role of the social worker in enabling each patient-family group to accept the changes in their lives resulting from the enforced dependency of their breadwinner, and to help the patient use treatment requires skill in interviewing several persons at one time, and involves the art of motivating the family "to use themselves in the interests of others...to achieve some balance between the

simultaneous and often conflicting wants and needs of several people. These are no easy tasks."[1] The social worker's role in each family will be conditioned by their needs and capacities to use available help.

The worth of involving the family in the treatment process, however this may be accomplished, is indicated in results of social research conducted at The Research Centre of the University of Chicago's school of social work.[2] Those persons who brought inter-personal problems, particularly marital and parent-child conflict to agencies tended to continue to work with the agency when other people in their lives were supportive rather than undermining. Conversely, if the role played by other people in their lives was impeding they tended to drop out of service.[3] The relevance of these findings to the problems of families of disabled breadwinners who are experiencing the disturbed relationships consequent to role reversal, would bear further consideration which will not be accorded here.

With the factors of patient-family strength which have been presented in this thesis as the minimum diagnostic knowledge requirement to be recorded, the caseworker may prepare a patient-family diagnosis which should indicate the means to strengthen

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1 Perlman, "Social Casework Today", Op. Cit., Page 54.

2 Ripple, Lilian, "Factors Associated with Continuance in Casework Service." Social Work, Vol. II, January, 1957.

3 Ibid.

the family as a group and as a resource to meet the patient's special needs. Helping the patient to use resources should provide further assurance that any gains he makes from intensive treatment services such as are provided at the C.A.R.S. Medical Centre are not lost upon his return to his home.

One must conclude that much environmentally-induced stress on all families and the disintegration of weak families might be prevented by the early treatment of the patient, with the provision by community agencies of adequate income for himself and his family, and, if necessary, personal care for the patient in his home. When the wife works, emotional repercussions may negate the achievement of the rehabilitation objectives, and there are, apparently, few families who, though initially strong, could stand up indefinitely under the strains of chronic illness without outside help.

In the above, the patient has been considered in interaction with his family group. Some indication will be given here briefly of the interrelation of the family with the larger community, and the implications of family patterns for patient-family diagnosis and treatment.

The family cannot be considered apart from the external forces and hereditary patterns which shape and influence the role concepts which the family members will have of what, for example, constitutes the role of a good husband and father; of how he should behave in relation to his family. The family behaviour patterns sketched in Chapter II suggested that while the patients reacted to role reversal in similar ways--with the

determination to become re-employed--that each was motivated to solve his problem in different ways which bore some apparent relation to family expectations. Mr. Wehrner, the eastern European immigrant, feared the loss of authority implicit for him in earning the family income, and upon his recovery, experienced satisfaction in being able to "talk back" to his employer. His decision to move his family was made while at the Centre, without doubt of his family's support of any plan he should make, although this implied a major change in their living arrangements. Mr. Rigby, who had married a woman better-educated than himself, had no such authority in his home, and the role-reversal which was practically forced upon him, could have meant his regression into complete dependence. Mr. Thompson, the son of a labourer, was motivated for "something better" for his family, and himself took advantage of re-training opportunities with marked success, while Mr. Lewis, deprived of an education in his early life, was very anxious to re-train and establish himself independently in business.

A notable factor in the four cases was that the extended family group--the kinship relationships outside the home--were not of significance as sources of family financial support. Mr. Wehrner belonged to a religious group noted for its solidarity and support of its adherents. This would conceivably have been the group to which he would have recourse rather than apply for social assistance.

It may be said that such factors as family structure,

kinship relations, religious affiliation, and social class are of vital importance to caseworkers in determining how a patient will use agency help.[1]

Suggestions for Further Investigation

This study suggests two problems for further investigation. These are (1) arthritic disability of the mother of dependent children and the means whereby her family might be strengthened to meet her needs and those of her dependent children; and (2) the lack of well-timed supplementary casework services for disabled persons and their families in the province of British Columbia. A related problem, the evident inadequacy of information available from the provincial Department of Social Welfare to C.A.R.S., which specialized agency provides a range

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1 The implications for the caseworker of such socio-cultural factors in family life are examined by Dr. Herman D. Stein in his article, "Socio-cultural Concepts in Casework Practice". (Smith College Studies in Social Work, Feb., 1959, Smith College School of Social Work, Northampton, Mass.). Defining "ethnic" as referring to "any group with a core of cultural homogeneity", Dr. Stein writes as follows: "As social workers we tend to be accepting of difference and interested in ethnic differences. However, there is more to this ethnic component than meets the eye. We are beyond the superficial differences of dress and food preferences. Social workers have, for example, begun to note differences in family structure among ethnic groups. Studies have given us more insight to differences in relation to authority, to seeking help, to attitudes towards discussing personal problems, to responses to illness, and the like. The implications for diagnosis are extensive. When the client is not of the same ethnic group as the worker, it becomes most important systematically to raise such questions as...how does the client see the agency, the worker, and his problem? Would he tend to see the agency as authoritarian, as a political outfit, as essentially hostile, as belonging to him?...In those ethnic groups with modified extended kinship types of family systems it is rare to find individuals who would naturally discuss personal, intimate family problems with strangers, even professional strangers. In the American middle class this is quite common because of our reliance on the outside expert."

of treatment services in the Medical Centre and in the patient's home, limits the effectiveness of treatment. The provincial Department, in sponsoring these patients, and in granting funds to the Society, has a financial investment in effective treatment. The need to strengthen provincial welfare services, and to examine relations, responsibility, and co-operation between public and private agencies generally must be recognized if human resources of the disabled are to be utilized to their fullest extent. The B.C. community as a whole may also be said to derive, at the very least, the benefit of a self-maintaining and stable family.[1]

Community Implications of This Study

In Chapter I the writer has indicated that the problems presented by these patients and their families, because of the wide-spread incidence of arthritis and the age of its victims, might be more prevalent in Canada. The value of early medical diagnosis and treatment of the disease has been indicated by medical estimates that four out of five rheumatoid arthritics treated in the early stages of the disease do not suffer serious physical deformity. However, the Dominion Bureau of Statistics

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1 A recent study of the cost of the rehabilitation program provided by C.A.R.S. (B.C.Division) for a sample group of 36 rheumatic patients has shown that the basic cost of the program has been recovered to the community in "earned" income over a two-year period subsequent to the patients' discharge from the Medical Centre. The decreased cost in the two years to the community in financial support of the hitherto dependent persons was estimated at $6,000.00. (Robinson, Harold S., M.D., "The Cost of Rehabilitation in Rheumatic Disease", Journal of Chronic Diseases, Vol. 8, No. 6, December, 1958, pages 713 - 718).

estimate that there are some 50,000 totally - or severely-disabled, and another 115,000 partially-disabled Canadians, would seem to indicate that such early diagnosis and treatment is not available or is not utilized by the patients.

From examining the few cases presented in Chapters II and III, it is evident that the patients had worked as long as they possibly could without financial assistance, a practice tending to cause deformities which existing treatment services could not fully repair. The employment of wives, the mothers of young children, was a "last-resort" of the patients invariably having emotional repercussions which in certain situations could negate rehabilitation efforts.

At the present time in Canada the "totally" disabled person has a right to social assistance upon proof of need through categorical or non-categorical schemes, with supplementary benefits payable to recipients in British Columbia, Alberta, Saskatchewan, Ontario, and the Yukon. There is no guaranteed minimum income for most employed Canadians who are unable to work because of sickness or temporary disability.

The writer would suggest that the following measures are indicated to encourage the earlier and more effective use of treatment services such as are now provided by the Canadian Arthritis and Rheumatism Society, the pioneer service in meeting the needs of the rheumatic disease patient:

1. A national program, such as a cash sickness benefit program to provide a greater measure of financial security for all persons who are unable to work because of sickness or temporary disability.[1] Such a scheme must provide income to the disabled person and his family as a right and not as a "last-resort".

2. A national scheme of health insurance to cover medical expenses is required. Hospital insurance on a national scale is a welcome step in the relief of families from some of the burden of illness on their incomes.

3. Treatment services focused on the individual in his family group should be available to supplement present clinical resources. Medical care is a necessary first step in the patient's rehabilitation, but by no means the whole of it. Services such as are presently provided by C.A.R.S., of occupational therapy to suggest creative outlets for the disabled person and "self-help" aids to his personal care, lighten the burden on his family members. Casework to help the patient and his family use these and other resources is essential.

4. There is need for agencies to examine closely the residual skills and abilities of each disabled person in relation

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1 As recommended by the Canadian Welfare Council. (Social Security for Canada, a policy statement adopted by the annual meeting of the C.W.C., January, 1958. The Canadian Welfare Council, Ottawa).

to the present employment situation and to available jobs in his neighbourhood. The term "light employment" which is frequently used by medical practitioners is meaningless in assessing the actual employment potential of the disabled person without a full social assessment. Employment can go far in meeting the needs of such a person--particularly if he is the nominal breadwinner of a family--for self-respect and a goal in life. For the many who cannot compete for jobs in the regular employment market, sheltered workshops are urgently required wherein the disabled person might have a work try-out experience, and, if he is able to do so, eventually "graduate" to compete in the regular market. Rehabilitation workers have frequently noted the heartbreak of the person who has utilized available treatment to the fullest only to become discouraged by his inability to find a suitable job. Further, the physical improvement which has resulted from the application of a variety of costly, specialized services in the interest of the patient's well-being, if he must return to heavy manual labour, is undone.

4. There is need in the B. C. community for greater awareness of the impact of chronic illness on families, and the problems which will arise requiring community attention. The problems are consequent to family's needs. Through its program of research, treatment, and education, The Canadian Arthritis and Rheumatism Society has exposed the unmet needs of the person disabled by rheumatic disease, and is pointing the way to further development and expansion of these services. These efforts must receive increased financial support and encouragement.

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