THE REHABILITATION OF
PUBLIC ASSISTANCE RECIPIENTS

An Analysis of Rehabilitation Possibilities
Among Current Social Assistance Recipients,
Based on the Caseload of the Social Welfare
Department, Victoria, June, 1952.

by
WILLIAM HOOSON

Thesis Submitted in Partial Fulfilment
of the Requirements for the Degree of
MASTER OF SOCIAL WORK
in the School of Social Work

Accepted as conforming to the standard
required for the degree of
Master of Social Work

School of Social Work

1953
The University of British Columbia
TABLE OF CONTENTS

Chapter I  Rehabilitation and Public Welfare


Chapter II  "Extrinsic" Dependency: Physical and Economic Factors

Economic and physical eligibility requirements for assistance, and the measurement of individual needs. A sample public assistance caseload. Disabilities of social assistance cases. Temporary dependency - partial and total. Permanent dependency - partial and total. Special groups. Summary ................................................................. 16

Chapter III  "Intrinsic" Dependency: Personal and Emotional Factors

The meaning of emotional dependency. The casework process and the role of the social worker. Casework treatment goals. Comparative case studies: temporary dependency -- partial and total; permanent dependency - partial and total. Summary ................................................................. 40

Chapter IV  Essentials of Rehabilitation in Public Assistance


APPENDICES:
A  Scale of Emotional Maturity ..............................................130
B  Bibliography .................................................................152
TABLES, CHARTS, AND SCHEDULES IN THE TEXT

(a) Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Disabilities of Social Assistance Cases</td>
<td>18a</td>
</tr>
<tr>
<td>Table 2</td>
<td>Composition of Case-load in the Four Groups</td>
<td>20a</td>
</tr>
<tr>
<td></td>
<td>a. Sex and Age Groups</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Family Status</td>
<td></td>
</tr>
<tr>
<td>Table 3</td>
<td>Employment Status</td>
<td>22a</td>
</tr>
<tr>
<td></td>
<td>a. Skill Groups</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. General Work History</td>
<td></td>
</tr>
</tbody>
</table>

(b) Charts

<table>
<thead>
<tr>
<th>Fig. 1</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fig. 1</td>
<td>Duration of Assistance</td>
<td>21a</td>
</tr>
<tr>
<td></td>
<td>a. Partial Temporary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Total Temporary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Partial Permanent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Total Permanent</td>
<td></td>
</tr>
</tbody>
</table>

(c) Schedules (Appendix A)

<table>
<thead>
<tr>
<th>Schedule</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule A</td>
<td>Emotional Maturity Scale-Sexual Adjustment.</td>
<td>145</td>
</tr>
<tr>
<td>Schedule B</td>
<td>Emotional Maturity Scale-Achievement</td>
<td>146</td>
</tr>
<tr>
<td>Schedule C</td>
<td>Emotional Maturity Scale-Social Consciousness</td>
<td>148</td>
</tr>
<tr>
<td>Schedule D</td>
<td>Emotional Maturity Scale-Self-Worth</td>
<td>150</td>
</tr>
<tr>
<td>Schedule E</td>
<td>Evaluation Chart of Emotional Level of Client</td>
<td>151</td>
</tr>
</tbody>
</table>
ABSTRACT

"Rehabilitation" is the term commonly and often loosely used in public welfare to connote the restoration of the physical functioning of the client. Restoration on a physical and economic level has, to a marked degree in the past, taken precedence over the casework treatment process. Although such restoration is vitally important, its lasting value to the client and his family is doubtful if not accompanied by a thorough effort on the part of the worker to mobilize the client's personal resources.

This study examines a public assistance caseload of a small size coastal city with a population of approximately 60,000, as it existed during one particular month of the year, with the view to analyzing the rehabilitation possibilities of the clients. The initial classification distinguishes (a) the temporarily dependent person, that is, one who is receiving public assistance for reasons other than chronic physical or mental illness and likely to become self-supporting, and (b) the permanently dependent person, one who is unlikely to become self-supporting because of age, physical or mental illness, or disability.

Within these classifications, sub-groupings of partial and total dependency were evolved. Factors promoting or retarding rehabilitation have then been analyzed in two groups, summarized as "extrinsic" and "intrinsic". "Extrinsic" factors are physical and economic including the reason for the granting of assistance, the length of time the grant has been in pay, and the degrees of skill and the work histories of the wage-earners. The "intrinsic" include personal and emotional factors conditioning the acceptance of assistance and the potentialities for improvement or readjustment.

Two basic methods are employed: (1) statistical classification of the total sample group (Chapter II) and (2) case description of typical individuals (Chapter III). As a by-product of the study, a rating scale of emotional maturity has been compiled (Appendix A) as an aid to future case recording, assistance in diagnosing rehabilitation problems, and setting or evaluating casework treatment goals for social assistance clients.

It is evident that the rehabilitation plan for persons on public welfare rolls should include an assessment of the
emotional factors of the client's personality development. Because these are vital in the individual's total adjustment pattern, it is recommended that such assessments should be made by qualified social workers during the intake process when the client first applies for assistance. While only a cursory review is made of medical and vocational rehabilitation facilities available for handicapped persons, a provincial coordinator of rehabilitation (including public and private resources) seems indicated to provide integrated and long-range planning for rehabilitation. Finally, it must be recognized that a large proportion of persons in receipt of current public aid are suffering from medical disabilities which are irremediable. For these, the goal of total rehabilitation is not realistic; but a proper function of the social worker is to help such clients accept their handicaps and achieve a limited adjustment.
I would like to record my sincere indebtedness to those who have given generously of their time and thought in helping me to develop this study. It is only through their invaluable assistance and their pertinent suggestions that I have been able to present and evaluate in this treatise the rehabilitation possibilities among public assistance recipients.

To Miss Marjorie J. Smith and Dr. Leonard C. Marsh of the School of Social Work, University of British Columbia, and to Mrs. Edna Alexander, my field advisor, may I express my appreciation for their genuine interest and consideration.
THE REHABILITATION OF
PUBLIC ASSISTANCE RECIPIENTS
Chapter I

REHABILITATION AND PUBLIC WELFARE

Rehabilitation is not a new concept in the field of public welfare. Stated in one form or another, it is one of the basic tenets of public welfare practice. To carry out a programme of rehabilitation, however, constitutes the greatest single problem confronting any public assistance official, be he the elected representative of the people, the administrator of an agency, the supervisor, or the public welfare worker. In spite of the significance of rehabilitation to public assistance recipients, it seems to be one area wherein the specific aspects have not been too clearly examined or defined. It is proposed in this study to discuss the various facets of rehabilitation and, then, to examine a specific public assistance caseload with the view to determining how effectively these facets may be applied and carried out.

It is important to appreciate that there is more than one possible definition of the term "rehabilitation". The definition proposed by the National Council on Rehabilitation, New York, is that "rehabilitation is the restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable". Such a definition is an admirable statement of philosophy, but without further qualification, it immediately brings to mind only the
physical and vocational aspects of rehabilitation. Hence, a more detailed review of individual programmes must be made before any principles can be evolved.

An examination of the available literature reveals that there can be almost as many interpretations of rehabilitation as there are special groups of physically and mentally handicapped persons and aberrations of human behaviour. There is written material on the rehabilitation aspects of the following:

general debility of the aged  
allergy and asthma  
arthritis and rheumatism  
cancer  
blindness and partial sight  
def deafness and limited hearing  
speech disabilities  
dental defects  
disfigurement  
brain injuries  
cerebral palsy  
encephalitis  
epilepsy  
poliomyelitis  
multiple sclerosis  
neuritis  
hemi and paraplegia  
tuberculosis  
silicosis  
chronic bronchitis and sinusitis  
heart conditions  
cardiovascular impairment  
gastro-intestinal disturbances  
malnutrition  
pernicious anaemia  
glandular defects  
 diabetes mellitus  
hypo and hyperthyroidism  
hernia  
severe disablement  
muscular atrophy  
orthopaedic conditions  
occupational diseases  
leprosy  
malaria  
undulant fever  
venereal diseases  
mental deficiency  
neurosis  
psychosis  
exceptional children  
delinquency  
alcoholism  
drug addiction  

There are programmes utilizing the medical, social, psychological, economic, educational, and vocational aspects of rehabilitation. These programmes are available to the handicapped through the facilities of clinics, community services, foster and domiciliary homes, hospitals, rehabilitation centers,
schools, and sheltered workshops.¹

Initially, the rehabilitation programmes are developed by individual practitioners in various professional fields and many are administered and financed by private, philanthropic societies. Examples of such societies are the American Red Cross Society, the Canadian National Institute for the Blind, the B. C. Cancer Foundation, and the Western Society for Physical Rehabilitation at Vancouver, British Columbia. As the specific programmes become more widely recognized, governmental support in the form of financial grants may be made available. In some countries, such as in Great Britain, New Zealand, and the United States, governmental programmes relating to medical treatment, vocational training, and employment placement of individuals are set up on a national basis as a function of government.

In Canada this movement has been slow to develop generally, but considerable interest in rehabilitation is evident at both the federal and provincial levels of government. At the same time, a fairly large number of private agencies are active in the field, and some integration of public and private programmes is attained through the collection and dissemination of information by such organizations as the Canadian Welfare Council, the National Council on Rehabilitation, and the Montreal

Rehabilitation Survey Committee. The Canadian Welfare Council functions as a clearing-house for all matters relating to social welfare in Canada.

Although many provinces are interested in the field of rehabilitation, except in relation to workmen's compensation, the only province at the date of writing which has developed a specific rehabilitation programme within its public assistance scheme is Saskatchewan. British Columbia has enacted social welfare legislation which permits the development of such a programme. However, in practice, public welfare officials here tend to utilize existing private agency resources rather than to develop new facilities to meet the needs of handicapped persons. Throughout Canada generally, workmen's compensation boards have been concerned with the medical and vocational aspects of rehabilitation of the injured workman. Unfortunately, as in most programmes, little emphasis is being placed on understanding individual emotional behaviour in relation to rehabilitation.

Phases of Rehabilitation

All rehabilitation programmes, whether private or governmental, have certain similar elements. They generally provide for a medical examination of the handicapped person and make available medical, surgical, dental, and other treatment if necessary. Psychometric testing, pre-vocational counselling, vocational training, and employment placement are also common factors. The actual programmes of rehabilitation appear to be divided into two distinct phases, (a) the physical aspects, and involving medical and surgical treatment, and (b) the vocational
aspects, involving counselling, retraining, and employment placement. However, one area which does not appear to be given sufficient consideration is that involving the emotional attitudes of the handicapped person. A number of intrinsic factors are emotional in character and vitally affect such a person's morale and his desire to participate in the rehabilitation process. It would seem, then, that the rehabilitation of the handicapped is a complex process: it could involve the combined skills, effort, and co-operation of the professions of dentistry, dietetics, medicine, nursing, occupational therapy, physical therapy, psychiatry, psychology, psychotherapy, social work, teaching, and vocational counselling.

Probably due to differences in understanding amongst the professional groups, many existing rehabilitation programmes place little emphasis on the way the patient or client feels about his specific handicap or injury. In general, an excellent job is being done on the physical and vocational phases of rehabilitation but, except in those programmes utilizing the medical or psychiatric social worker, little attention has been given to the invaluable contribution that the social caseworker can make to such programmes. Perhaps this is because much of the emphasis of these programmes has been on the re-education of the handicapped at the physical and intellectual levels.

Certainly, some considerable progress in the rehabilitation of certain individuals has been made, even with such a limited approach, for there are many persons with handicaps who are able to cope with their own emotional feelings. However,
the experience of all programmes shows that no matter how good
they may be, they never seem to reach some people. Since the
actual treatment aspects are relatively constant from one person
to the next, depending upon the physical condition of the client,
the probable reason for the lack of success in the attempted
rehabilitation of some persons must lie within the individual
himself. It is these individual variations that are the concern
of the social worker.

The effect of the emotions on the well-being and function­
ing of the body was known to the Ancient Greeks, but it is only
in recent years that the standard of general practice of medicine
has taken into account the effect of the emotions on treatment.
This same concept has yet to gain widespread acceptance by present
day professional practitioners in the field of rehabilitation.
Speaking of the tuberculous patient, it has been said that the
medical diagnosis is made, the surgical repair work is done, the
psychometric tests of aptitude and interests are carried out, and
the vocational counselling related to skills and availability of
employment is embarked on - all without any adequate assessment
of the emotional strengths and weaknesses of the client.¹ This
would seem to be equally true of many other rehabilitation pro­
grames, regardless of the type of disability being treated.

Accepting the fact that the emotional attitudes of the
individual affect his physical well-being and, more particularly,

¹ cf. Nitzberg, Harold, "Rehabilitation of the Tuberculous
no. 2, pp. 61-64.
his ability to utilize his capacities and his resources, it seems fruitless to attempt the physical and vocational steps of rehabilitation without the knowledge of whether or not the client is emotionally willing to make use of these facilities. Herein lies the specific function of the social worker in the rehabilitation process, and without his initial psycho-social diagnostic help and casework treatment to relieve the anxiety and hostility that the client relates to his handicap, any such programme is likely to remain, at best, a trial and error process.

Rehabilitation in Public Welfare

In the field of public welfare as in others, there is considerable variation in the meaning of rehabilitation. Traditionally, the public welfare official has been concerned with the cost of public assistance as well as with the problem of meeting the needs of clients. In many instances, the money involved in administering the programme became of paramount importance, and the real needs of the recipients were rarely considered. The efforts of the public welfare workers were focused primarily upon enforcing the eligibility factors in a rigid manner and in removing clients from social assistance rolls as expediently as was possible.

Hence, it is not surprising to find that current thinking on the part of public welfare officials towards rehabilitation is confused, and that almost inevitably the emphasis seems to be directed towards the problem of hastening the termination of the
payment of financial aid. In such instances, "rehabilitation" appears to be the current jargon for the old idea of reducing the cost of assistance, and casework, medical, and other services are only instituted to facilitate the process. The social worker in the public assistance setting also is concerned with the client's becoming self-supporting but his total scope is much broader. In addition, his attention is focused on understanding the behaviour of the client, and on attempting to meet the client's needs through the existing facilities of the agency. As the client gradually is enabled to function on his own, he will no longer require the financial help of the public assistance programme.

Casework in Public Welfare

It has been suggested that public welfare officials should adopt a preventive rather than a palliative approach towards meeting the needs of the clients. In doing so, apart from the provision of financial aid, they would aim to prevent the breakdown in functioning or would facilitate the promotion of more effective functioning of an individual in his relationships with his fellow men. Such an approach would necessitate the employment of qualified social workers who would utilize the same social services as are presently administered by public welfare staff. These social services include financial aid, care of neglected children, care of the aged, medical, hospital, and convalescent facilities, care of the mentally ill, and the like. The aim of the social worker would be to help the client
to use effectively all the resources available to him, such as his own intellectual and physical capacities, his family, his friends, his work or school, and his church, as well as the services provided by the public welfare agency. Thus, the social worker through his use of the casework treatment process not only would enable the client to function more effectively, but also would render him less likely to remain on public assistance for an indeterminate period. However, the success of the social worker should not be measured in terms of the reduction of the costs of public assistance only, but rather, in terms of the improvement in the emotional adjustments of the clients. Granted, some individuals will become economically self-sufficient as a result of casework treatment, but there are adverse factors affecting many clients which preclude such an improvement.

Development of Public Welfare Programmes

In British Columbia, as elsewhere, the development of the current public welfare programme has been slow. Public assistance in its original form in England was commonly known as poor relief. It was designed to meet the needs of those persons who were unable to provide for themselves. Such persons were considered as being less worthy than others in the community who were able to maintain themselves. Poverty was thought to be due to a personal defect within the individual. These concepts of the pauper and poor relief were transplanted to the Maritime Provinces

and to the New England States by the early settlers from England, Scotland, and Wales. Similar institutions to those in the Old Country were built, and comparable schemes to deal with these problems of the poor and destitute gradually developed and slowly spread across Canada and the United States in one form or another.

In time, the causes of dependency were recognized as being a part of the social and economic structure of the community rather than an individual defect or inadequacy. At the same time, the needs of specific individuals as differentiated from others within the general grouping of paupers was noted, and categorical aid programmes for the aged, the blind, and the dependent children were developed.

Concurrently with these categorical aid programmes, the social insurance schemes of unemployment insurance, workmen's compensation, sickness insurance, disability insurance, health insurance, and old age insurance also came into being. These programmes enabled the employed person to contribute sums of money during periods of full employment into funds which would "insure" him against the vicissitudes of economic fluctuation. The individual employee thus established a right to such financial grants and he was no longer dependent upon poor relief funds that the community determined were its duty to provide.

All these financial aid schemes succeeded in removing many persons from the poor relief or general assistance category. Since many are not able to qualify for help elsewhere, poor relief in the form of general assistance has been maintained to provide for the needs of these people. As may be expected, these people
are the aged, the sick, and the infirm, who are likely to be permanently dependent in one way or another during the balance of their lives.

Public Welfare in British Columbia

The recipients of public assistance in British Columbia are no exception to the above rather general statement. The social insurances of old age security, family allowance, workmen's compensation, unemployment insurance and hospital insurance as well as the categorical aid programmes of old age assistance and mothers' allowance are available to specific groups of persons. However, these programmes by no means assist everyone who is in need of help and, consequently, the general assistance programme has been maintained to provide for such indigent persons who fail to qualify for other forms of public assistance and social insurance. In British Columbia, the general assistance programme is called Social Assistance.

The current social assistance programme in British Columbia evolved from the plan of procedure which was set up in the 1930's to meet the pressing demands of unemployment relief. A change came in 1946 when the Department of Health and Welfare was organized and the administration of all categorical assistance programmes was placed under its jurisdiction. The passage of the Social Assistance Act in the same year made legal provision for the granting of aid "to (the) individual, whether adult or minor, or to families, who through mental or physical illness or other exigency are unable to provide in whole or in part by their own efforts, through other security measures, or from income and
other resources, necessities essential to maintain or assist in maintaining a reasonable normal and healthy existence".¹

According to the same Act, social assistance is defined as follows:²

(a) Financial assistance:
(b) Assistance in kind:
(c) Institutional, nursing, boarding or foster home care:
(d) Aid in money or in kind to municipalities, boards, commissions, organizations, or persons providing aid, care, or health services, and in reimbursing expenditures made by them:
(e) Counselling service:
(f) Health services:
(g) Occupational training, retraining, or therapy for indigent persons and mentally or physically handicapped persons:
(h) Generally any form of aid necessary to relieve destitution and suffering:

Thus, by legislative definition, social assistance is very broad and could serve as an excellent base for a good physical and vocational rehabilitation programme.

In practice, a comprehensive medical scheme including surgical treatment is available to all persons in receipt of public assistance, either from their private physicians or from qualified specialists. Trained social workers are employed by the department in so far as is possible, and generally, a high proportion of field personnel have at least some academic training in social work. Nevertheless, these public welfare officials have to rely on the facilities of private organizations and local municipalities to provide the necessary occupational training,

¹ Revised Statutes of British Columbia, 1948, Chapter 310, Section 3 (The Social Assistance Act).
² Ibid., Section 2.
retraining and therapy that are essential for the restoration of active participation of recipients, and no attempt has been made as yet to organize these necessary facilities in centers where they are lacking. Such facilities are extremely limited in the province and can meet the needs of little more than a handful of persons requiring individual service.

The regulations of the Social Assistance Act make it mandatory for the City of Victoria to operate its own social welfare department and to employ social work staff who meet the qualifications set by the provincial Department of Health and Welfare. The provincial department does supply an equivalent number of social workers to the Victoria Social Welfare office, and, in addition, provides liberal means of aid for the reimbursement of a large proportion of the financial assistance that is granted to indigent persons residing within the city.

Method of Present Study

For the purposes of this thesis the total social assistance caseload of the Victoria City Social Welfare Department for the month of June, 1952 is chosen for study. The clients receiving aid at this time constitute, so to speak, the "hard core" of the public assistance caseload. With the employment situation much improved after the slack period of the winter months, there are very few persons in receipt of financial aid who are capable of taking employment. Hence, many of the clients included in this study are the aged, the sick, the infirm, and the women with dependent children.

Each case is reviewed, and the material documented in
schedule form. Since age is a major factor in the process of physical and vocational rehabilitation, a preliminary classification of the heads of the case units was made on the basis of the age ranges of 20 to 44 years, 45 to 59 years, 60 to 69 years, and 70 years and over. Further study of the material has resulted in the final classifications of temporary and total dependency, with sub-groupings for each. Cases which are determined as being temporarily dependent are those in which it seems likely that the head of the family or the breadwinner might become economically self-supporting at some future date. The totally dependent clients are those who are suffering from degenerative or chronic ailments which preclude the likelihood of their ever maintaining themselves financially. A comparative statistical analysis of this material has been made and is reviewed in Chapter II.

Since the material is drawn for the most part from the limited eligibility studies which are so characteristic of public welfare recording, a detailed analysis of the records from the point of view of social casework is difficult, and virtually impossible in many cases. This paucity of background information is very evident in the cases wherein the breadwinner applied for assistance late in his lifetime. Therefore an effort has been made to determine the particular contribution that the social worker can make towards rehabilitation in the public welfare setting. This can best be illustrated by the more detailed subjective study of selected case records. This material, studied from the casework point of view, is the substance of Chapter III.
The material discussed in Chapter I constitutes a review of the essentials of a comprehensive public assistance rehabilitation programme. Of major importance is the suggested plan of revision of public assistance caseloads and the selective assignment of all new cases so that the diagnostic and treatment skills of the qualified social worker can best be utilized.

Definitions

In the following discussion a number of terms in common use in public welfare practice are utilized. However, the specific meanings of these are by no means universally accepted even amongst public welfare practitioners. In the context of this presentation these terms are used as follows:

1. Public welfare, public assistance, and categorical aid programmes are synonymous and refer to those programmes which are financed by general taxation and which require the use of a means test to prove the eligibility of each individual applicant for financial aid.

2. Social insurance programmes refer to those schemes whereby financial assistance is granted on the basis of the right of the individual applicant being established by personal contributions in one form or another. Such assistance is paid without the individual application of a means test.

3. The terms "public welfare officials" and "public welfare workers" are interchangeable and refer to persons who may or may not have formal training in social work. Generally, it can be assumed that these persons have no training.

4. The terms "social worker" and "social caseworker" are used to connote such persons as have special professional training in social work and are graduates from a recognized school of social work.
Chapter II

"EXTRINSIC" DEPENDENCY: PHYSICAL AND ECONOMIC FACTORS

Economic dependency may be reasonably defined as the inability or incapacity, by reason of physical, mental, or emotional defects, to earn a living and to take one's rightful place in the work-a-day world. It is the lack of ability to maintain oneself and to be self-sufficient from a financial point of view. Individual economic dependence, as all public welfare workers know, is a relative matter, and the economically dependent person of today cannot be rehabilitated without an understanding by the welfare worker of the meaning of dependency and insecurity in relation to broader economic issues. The basic premise of any public assistance programme, regardless of its philosophy or of its methods of administration, is that the programme will meet, in one way or another, the needs of those individuals in the community who are unable to provide for themselves the necessities of life.

Obviously, a clear distinction has to be formed between human needs and human desires. Therefore, to enable such a programme to function, an attempt must be made by public welfare officials to determine the personal factors common to each applicant that will permit him or her to be eligible for assistance. Such eligibility requirements constitute, in essence, a scale of measurement which can be applied to all individuals who seek aid.
The scale measures their needs in relation to the needs that the programme is designed to meet.

With the practical application of the programme involving the measurement of individual needs, the physical and economic factors of dependency play a major role. Such factors are relatively easy to define, and can be determined with reasonable accuracy from one applicant to the next. The emotional factors of dependency, which vary greatly from individual to individual, are, to say the least, subjective. Although they can be defined, they can only be measured in relative terms, which makes accurate and valid comparisons from one individual to another somewhat difficult.

Such measurement is further complicated by the fact that the observations of the public welfare worker as related to these emotional factors of the individual may be coloured by his own personality development. The end result is that the assessment of the applicant's emotional factors may vary from worker to worker unless these workers have had extensive training in this area of psycho-social development and behaviour as have professional social workers. As will be indicated later, it is essential for this reason alone that some professionally trained social workers be employed in the public assistance programme.

With the eligibility study of the applicant emphasizing the physical and economic factors of the situation, it is understandable that public welfare workers tend to consider rehabilitation almost exclusively in terms of these extrinsic factors. Hence, their emphasis is related to efforts which will enable
such persons as may be receiving assistance to become financially and physically self-supporting again.

During June, 1952, social assistance was paid by the Victoria City Social Welfare Department to 467 persons. These persons were single men, single women, and heads of families with and without dependent children. Actually there were 698 individual men, women, and children in receipt of assistance during the month. For the purposes of analysis the total case-load has been directly related to the number of cash grants that were disbursed. The recipient of such a grant is designated as being a single case unit, regardless of the number of persons in the family for which the assistance was paid. Hence, a case unit may refer to a single person, a married couple, or a family with dependent children.

In British Columbia, public assistance is usually granted only to those individuals who are unemployable and who are in need. Temporary assistance may be given to needy employable persons for compassionate reasons. The applicant is designated as being unemployable if he suffers from a medically diagnosed physical or mental ailment.

Therefore, the heads of case units receiving public assistance in Victoria in June, 1952, were suffering from chronic or degenerative physical conditions which precluded their ever becoming self-supporting (Table I.). On the other hand, there were also a number of case units wherein the family head was

---

1 A preliminary analysis of the health of the total group revealed that these individuals suffered from more than 48 different ailments or conditions.
<table>
<thead>
<tr>
<th>Type of Disability</th>
<th>Male 20-45</th>
<th>Male 45-60</th>
<th>Male 60-70 &amp; up</th>
<th>Female 20-45</th>
<th>Female 45-60</th>
<th>Female 60-70 &amp; up</th>
<th>Total No.</th>
<th>Total P.C.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Condition</td>
<td>3</td>
<td>4</td>
<td>15</td>
<td>9</td>
<td>2</td>
<td>6</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>28</td>
<td>6</td>
<td>6</td>
<td>14</td>
<td>2</td>
<td>11</td>
<td>14</td>
<td>39</td>
</tr>
<tr>
<td>General Debility</td>
<td>-</td>
<td>8</td>
<td>14</td>
<td>-</td>
<td>2</td>
<td>11</td>
<td>14</td>
<td>39</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>2</td>
<td>4</td>
<td>11</td>
<td>8</td>
<td>7</td>
<td>7</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Physical Injury</td>
<td>4</td>
<td>10</td>
<td>2</td>
<td>1</td>
<td>9</td>
<td>4</td>
<td>14</td>
<td>30</td>
</tr>
<tr>
<td>Cerebral Hemorrhage</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>16</td>
<td>24</td>
</tr>
<tr>
<td>Gastro-Intestinal</td>
<td>1</td>
<td>11</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>25</td>
<td>5.5</td>
</tr>
<tr>
<td>Arteriosclerosis</td>
<td>-</td>
<td>3</td>
<td>10</td>
<td>-</td>
<td>1</td>
<td>10</td>
<td>24</td>
<td>5.2</td>
</tr>
<tr>
<td>Arthritis</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>Blindness</td>
<td>-</td>
<td>4</td>
<td>5</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>12</td>
<td>2.6</td>
</tr>
<tr>
<td>Genito-Urinary</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>3</td>
<td>11</td>
<td>2.3</td>
</tr>
<tr>
<td>Paralysis</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>11</td>
<td>2.3</td>
</tr>
<tr>
<td>Asthma and Excema</td>
<td>-</td>
<td>8</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>10</td>
<td>2.1</td>
</tr>
<tr>
<td>Cancer</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Goitre and Thyroid</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Diabetes</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>6.6</td>
</tr>
<tr>
<td>Women with Dependent Childern</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>42</td>
<td>12</td>
<td>2</td>
<td>-</td>
<td>56</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>25</td>
<td>87</td>
<td>54</td>
<td>72</td>
<td>45</td>
<td>73</td>
<td>467</td>
</tr>
</tbody>
</table>
employable (the women with dependent children), or was likely to be employable at some future date (some tuberculous clients). These people were capable of becoming self-supporting since the factor which currently made them eligible for assistance probably would eventually be resolved. Hence, it may be assumed that there were some case units which were temporarily dependent and others which were permanently dependent.

The classification of temporary and permanent dependency has been used as the basis for the analysis and for the comparison of the personal and environmental situations of all case units examined in the study. In this chapter, a "cross-section picture" of the total caseload is presented from the point of view of the physical and economic factors affecting the heads of the individual family units.

A. Temporary Dependency

A number of case units, though requiring financial assistance for varying periods of time, were essentially capable of managing without the assistance if it were not for certain factors in their physical or environmental situations (Table I.). One group of case units were receiving aid for a temporary period, although the breadwinners were normally employable. A change in the labour market had left these persons without work and without sufficient funds to manage. Assistance had been granted primarily for compassionate reasons, as the case units were generally families with dependent children. Another group were tuberculous patients, women with dependent children, and families where the male wage-earner was temporarily incapacitated with an
acute illness or injury. These persons would probably be on assistance for a considerable period of time, but both groups likely were to become self-supporting again at some future date. The former group might be considered as being one of partial temporary dependency, and the latter, one of total temporary dependency.

1. Partial Temporary Dependency

The partially temporarily dependent case units were granted assistance on compassionate grounds. Because the breadwinner or head of the unit was employable, it was not expected that the assistance would be continued for longer than a very minimal period. The number of case units falling into this category varies considerably from month to month depending upon the employment situation. The number is greatest during the winter months, and lowest or non-existent during the summer months. Generally, such units consisted of married couples with dependent children, or widowed, divorced or deserted women with dependent children. Occasionally, single persons were granted assistance, but they were in the age grouping of 45 years and over. The younger single persons were expected to make their own arrangements regarding maintenance during such periods of slack employment.

Eleven case units of the partially temporarily dependent type in the Victoria City Social Welfare Department caseload in June, 1952 constituted 2.3% of the total case units receiving assistance during that month (Table 2a and b.). They were comparatively few in number since the employment market was fairly
Table 2. Composition of the Caseload in the Four Groups

a. Sex and Age Groups

<table>
<thead>
<tr>
<th></th>
<th>I. Partial</th>
<th>II. Total</th>
<th>III. Partial</th>
<th>IV. Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Temporary</td>
<td>Temporary</td>
<td>Permanent</td>
<td>Permanent</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-44</td>
<td>4</td>
<td>32</td>
<td>7</td>
<td>2</td>
<td>45</td>
</tr>
<tr>
<td>45-59</td>
<td>2</td>
<td>7</td>
<td>17</td>
<td>3</td>
<td>29</td>
</tr>
<tr>
<td>60-69</td>
<td>1</td>
<td>1</td>
<td>58</td>
<td>15</td>
<td>75</td>
</tr>
<tr>
<td>70 and over</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>50</td>
<td>55</td>
</tr>
<tr>
<td>Women</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-44</td>
<td>3</td>
<td>64</td>
<td>13</td>
<td>6</td>
<td>86</td>
</tr>
<tr>
<td>45-59</td>
<td>-</td>
<td>15</td>
<td>26</td>
<td>7</td>
<td>48</td>
</tr>
<tr>
<td>60-69</td>
<td>1</td>
<td>3</td>
<td>42</td>
<td>14</td>
<td>60</td>
</tr>
<tr>
<td>70 and over</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>64</td>
<td>69</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>122</td>
<td>173</td>
<td>161</td>
<td>467</td>
</tr>
<tr>
<td>P.C.</td>
<td>2.3</td>
<td>26.1</td>
<td>37.1</td>
<td>34.5</td>
<td>100</td>
</tr>
</tbody>
</table>

b. Family Status

<table>
<thead>
<tr>
<th>Family Groups</th>
<th>I. Partial</th>
<th>II. Total</th>
<th>III. Partial</th>
<th>IV. Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Temporary</td>
<td>Temporary</td>
<td>Permanent</td>
<td>Permanent</td>
<td></td>
</tr>
<tr>
<td>Men Family</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>-</td>
<td>16</td>
</tr>
<tr>
<td>Non-Family</td>
<td>1</td>
<td>34</td>
<td>83</td>
<td>50</td>
<td>168</td>
</tr>
<tr>
<td>Women Family</td>
<td>4</td>
<td>57</td>
<td>3</td>
<td>-</td>
<td>64</td>
</tr>
<tr>
<td>Non-Family</td>
<td>-</td>
<td>25</td>
<td>63</td>
<td>64</td>
<td>172</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>122</td>
<td>173</td>
<td>161</td>
<td>467</td>
</tr>
<tr>
<td>P.C.</td>
<td>2.3</td>
<td>26.1</td>
<td>37.1</td>
<td>34.5</td>
<td>100</td>
</tr>
</tbody>
</table>
good at that time of the year. The situation became more serious in July and August, 1952, owing to the extensive strikes in the lumbering industry and the building trades which developed during June, and lasted throughout the summer. Generally, however, December, January, and February of any year are the months when the labour market is slackest, and when the number of applications for assistance might rise to 10% of the total caseload. The amendments to the federal Unemployment Insurance Act, passed in March, 1950, which extended supplemental benefits to wage-earners whose unemployment insurance coverage had expired, has been a material factor in keeping the applications for public assistance by the employable group at a minimum even during the winter months.

Of the eleven case units in this category of partial temporary dependency in June 1952, only three breadwinners were suffering from physical illness. These illnesses were of a minor nature that incapacitated the family head for a period of only two to three weeks. Assistance in the balance of the cases was granted for compassionate reasons. Eight of the case units received assistance for one month or less, two for a period of two months, and one for a period of four months (Fig. 1a). The latter case had been off assistance for a short period during the four months. However, the lumbering industry strike left the family head again without work.

A skilled person has been defined as one who has learned a trade or profession by serving a period of special training or apprenticeship, a semi-skilled person as one who has learned a trade by experience on the job, and an unskilled person as one
Fig. 1. Duration of Assistance

a. PARTIAL Temporary

- 1 month
- 2 months
- 3 months or more

No. of cases
(Time in months)

b. TOTAL Temporary

- less than 1 year
- 1 to 4 years
- 5 to 9 years
- 10 years or more

No. of cases

Men
Women

c. PARTIAL Permanent

- less than 1 year
- 1 to 4 years
- 5 to 9 years
- 10 years or more

No. of cases

(duratiom in years, except Fig. 1 a.)

d. TOTAL Permanent

- less than 1 year
- 1 to 4 years
- 5 to 9 years
- 10 years or more

No. of cases
who has been employed at work requiring no training. With 73.7% of the wage-earners falling into the skilled or semi-skilled categories, it would seem likely that such persons would be re-employed relatively quickly with an improvement in the labour market (Table 3a).

The rapidity of such a group's return to work might also be estimated from a review of the work history of the wage-earner. A steady work history is defined as one wherein the head of the case unit has been employed at his particular job or type of work for more than one year, a seasonal work history as one in which the worker has been employed for some months on the same job or in the same type of work during the year, and a casual work history as one wherein the wage-earner works on a day to day basis during the month for one or more than one employer. Of the wage-earners of the group, 63.6% were steadily or seasonally employed before assistance was granted (Table 3b). Again, it might be expected that these units would be off assistance in a relatively short period of time.

The work histories, however, do suggest another point. Presumably, these wage-earners were not eligible for unemployment insurance, or public assistance would not have been granted. Generally, a steadily or seasonally employed worker is eligible for unemployment insurance special benefits if he is employed for a longer period than 60 days in the immediately preceding 180 days, or 45 days in the preceding 90 days. This would seem to indicate that the wage-earners in the category of partial temporary dependency were not employed in work which necessitated
Table 3. Employment Status

a. Skill Groups

<table>
<thead>
<tr>
<th>Degree of Skill</th>
<th>I. Partial Temporary</th>
<th>II. Total Temporary</th>
<th>III. Partial Permanent</th>
<th>IV. Total Permanent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Semi-skilled</td>
<td>2</td>
<td>11</td>
<td>10</td>
<td>10</td>
<td>33</td>
</tr>
<tr>
<td>Unskilled</td>
<td>3</td>
<td>10</td>
<td>56</td>
<td>42</td>
<td>111</td>
</tr>
<tr>
<td>Unknown</td>
<td>-</td>
<td>14</td>
<td>17</td>
<td>14</td>
<td>45</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled</td>
<td>-</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Semi-skilled</td>
<td>3</td>
<td>9</td>
<td>7</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>Unskilled</td>
<td>1</td>
<td>59</td>
<td>73</td>
<td>43</td>
<td>176</td>
</tr>
<tr>
<td>Unknown</td>
<td>-</td>
<td>10</td>
<td>3</td>
<td>37</td>
<td>50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>11</td>
<td>122</td>
<td>173</td>
<td>161</td>
<td>467</td>
</tr>
</tbody>
</table>

b. General Work History

<table>
<thead>
<tr>
<th></th>
<th>I. Partial Temporary</th>
<th>II. Total Temporary</th>
<th>III. Partial Permanent</th>
<th>IV. Total Permanent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steady</td>
<td>3</td>
<td>14</td>
<td>16</td>
<td>15</td>
<td>48</td>
</tr>
<tr>
<td>Seasonal</td>
<td>-</td>
<td>6</td>
<td>7</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>Casual</td>
<td>4</td>
<td>6</td>
<td>47</td>
<td>38</td>
<td>95</td>
</tr>
<tr>
<td>Unknown</td>
<td>-</td>
<td>14</td>
<td>17</td>
<td>14</td>
<td>45</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steady</td>
<td>4</td>
<td>16</td>
<td>8</td>
<td>6</td>
<td>34</td>
</tr>
<tr>
<td>Seasonal</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Casual</td>
<td>-</td>
<td>13</td>
<td>17</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Unknown</td>
<td>-</td>
<td>10</td>
<td>3</td>
<td>37</td>
<td>50</td>
</tr>
<tr>
<td>None</td>
<td>-</td>
<td>42</td>
<td>58</td>
<td>32</td>
<td>132</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>11</td>
<td>122</td>
<td>173</td>
<td>161</td>
<td>467</td>
</tr>
</tbody>
</table>
payment of contributions to the Unemployment Insurance Commission when they were working. The role of the public welfare worker, then, is to assist these wage-earners in finding work in covered employment which will enable them to become eligible for unemployment insurance benefits. This is preferable to the granting of assistance during periods of slack employment. This conclusion might not be valid, however, as unemployment insurance special benefits cease to be paid after April 15th of any year.

Considering the total group of case units in this category of partial temporary dependency from the point of view of the physical and economic factors, the goal of rehabilitation towards economic self-support involved no major problems. The great majority of the wage-earners were under 60 years of age (63.6% were actually under 45 years), were skilled or semi-skilled tradesmen (70.7%), and had a steady or seasonal work history (63.6%). An improvement in the environmental situation, that is, in the demand for labour, would result in a rapid reduction of this portion of the total public assistance case-load through little or no effort on the part of public welfare personnel.

2. **Total Temporary Dependency**

The families and single persons classified as being temporarily totally dependent were those wherein the head of the family unit was suffering from an illness requiring lengthy treatment, for instance, tuberculosis. Widowed, divorced, and deserted women with young dependent children were also included. Both this category and that of partial temporary dependency
included those cases that might have been considered as being capable of becoming self-supporting. The differentiating characteristics of total temporary dependency were first, that the financial assistance was of a more permanent nature rather than a "stop-gap" measure during slack employment periods, and second, that other agency services were required. These services included extensive medical treatment, prolonged hospitalization, interpretation of the needs of growing children, help in mobilizing personal and community resources to meet the needs of the family, and general moral support and guidance. It is probable that applications from persons classified in this category are fairly constant throughout the course of the year, and from one year to the next, since the incidence of illness, death, divorce, and desertion does not fluctuate as markedly as does employment demands.

The total of 122 case units in this category constituted 26.1% of the caseload for the month (Table 2a and b). Assistance was granted for compassionate reasons in 69.5% of the cases where women were heads of the family, and in 2.5% where men were still in the home. On the other hand, physical illness was the determining factor in the granting of assistance to 90% of the families where the father assumed his customary role, and 24.4% where the mother was the family head. Mental illness and physical handicap as reasons for granting aid occurred in only 4.1% and 2.5% respectively for the total group, regardless of the sex of the breadwinner.
Of the 122 case units, 99 or 81.1% had been in receipt of aid for a period of less than five years, and 50.8% of the total had been granted within one year (Fig. 1b). This probably indicated that the families and single persons in the category of total temporary dependency were fairly mobile, and were not prone to remaining on the public assistance roll indefinitely. Certainly, there was no marked increase in the total agency case-load over the period of three years from June, 1949, to June, 1952. However, a more detailed analysis of the case records over several years is necessary to determine the significance of the duration of assistance.

With 56.6% of the group falling under the heading of unskilled wage-earners, obviously some considerable difficulty would have arisen in returning this group permanently to the labour market when the children ceased to be dependent, or when the health of the head of the family improved. (Table 3a) The degree of skill in almost 20% of the wage-earners was unknown. However, it might be assumed that many of these persons were unskilled. Then, too, the high proportion of women (71.9%) who had no job skills presented a really serious problem if the plan of their eventually becoming permanently self-supporting was considered.

The comparison of the work history of the breadwinners in conjunction with the degree of skill emphasized the point that some consideration of vocational training would have to be made if the persons in this group were to become economically rehabilitated (Table 3b). Those individuals having a casual
work history, or none at all, constituted 50.1% of the total
group, and 67.1% of the women. These figures, too, would likely
have been increased if more detailed information were available
on those whose work history was unknown.

Clearly, the group of total temporary dependency appears
to be one in which the rehabilitation service of a vocational
training nature could have been most profitably utilized, partic­
ularly as 77.9% of the family heads were in the age range of 20
to 44 years. The majority of these persons had no employment
skills and a negligible work history. There would have been no
great demand for extensive medical and surgical care other than
that which was being provided, for only 2.5% of the group were
suffering from physical handicaps.

The need for, and the use of vocational training for such
a group requires much more extensive study than has been given in
this presentation. The issue to be determined is whether or not
the women with dependent children can profitably use such training,
and when they should be encouraged to embark on it. Obviously,
there is no point in training these persons years in advance of
when they will be able to use the acquired skill. Nor can they
be expected to start on a new learning experience without adequate
interpretation or help. However, casework treatment throughout
the process and vocational training at the appropriate time
would give such women the necessary confidence to venture out
from the meagre security provided by the minimal public assistance
grant. They would be placed in a position where they could com­
pete successfully in the open labour market and would become
contributing citizens to the economy of the community.

B. Permanent Dependency

Some case units in the Victoria Social Welfare Department caseload were classified as being permanently dependent because the physical and mental conditions of the wage-earners or heads of the units were such that these persons would never become economically self-supporting. There were, however, a number of these clients who were able to manage as long as they had sufficient funds to feed, to clothe, and to house themselves. They were ambulatory, shopped for their own groceries, prepared their own meals, and generally cared for themselves without outside help. These persons were designated as being partially permanently dependent.

The remainder were those persons who needed the physical care provided by the institutional setting, the medical care of the physician and nurse, as well as the financial aid of the social welfare department. Some of these clients were ambulatory to a degree, but many were totally bedridden. But, as a general rule, they required help of more than just that of a financial nature. They were cared for in boarding and convalescent homes, private hospitals, and other institutions. These were the clients who were totally permanently dependent. With the public assistance programme being related to meeting the needs of residual cases, it might be anticipated that the categories of partial permanent dependency and temporary permanent dependency would constitute the greater portion of the caseload.
1. **Partial Permanent Dependency**

Persons who were single, that is, those who were widowed, deserted, divorced, or who had never married, constituted 95.9% of the group. (Table 2a and b). It may, therefore, be expected that, as they grew older and required more care and attention, institutional care in one form or another would have been required, and since these persons would be without family resources, they would become totally permanently dependent on public assistance.

Assistance was granted because of physical illness in 46.7% of the cases, for compassionate reasons in 23.3%, and due to mental illness of the client in 16.3%. There were 13.7% of the family heads who were physically handicapped. However, 91.6% of these persons were over 45 years of age, and 58.3% were over 60 years. Hence, even with intensive and prolonged medical treatment and vocational training, there was probably little hope of their ever becoming self-supporting.

With reference to the length of time that assistance had been paid to these clients, 64.4% of the grants had been made within the last four years (Fig. 1c). There was, nevertheless, a marked difference between male and female recipients. 81.6% of the men had applied for help within the past four years, whereas 79.4% of the women had been on social assistance for nine years or less. The women not only became dependent at an earlier age than the men, but also they tended to remain in this category for a longer period. This possibly indicated that they did not deteriorate into total permanent dependency as quickly as
did the men.

For the total group, 74.9% were unskilled, and 70.8% had been only casually employed or had never worked for wages at all. (Table 3a and b) Those who were skilled or semi-skilled and who had worked steadily or seasonally were all over 45 years of age. Of the skilled or semi-skilled individuals, 66.7% were over 60 years of age as were 80.7% of those persons who had held steady or seasonal employment.

With almost two-thirds of the wage-earners in this category of partial permanent dependency being 60 years of age or older, and almost three-quarters of them with no skill or steady work experience, it seemed unlikely that any degree of success would have resulted from efforts to enable them to become economically self-supporting. The role of the public welfare worker here then would be to complete periodic eligibility studies and to assist the client in meeting other material needs as they arose. Such needs include housing, medical care, recreation, and so on. Generally, however, the client would be left on his own to manage for himself unless he specifically requested further help.

2. Total Permanent Dependency

The person who required institutional care as well as financial aid to meet his physical needs was defined as being totally permanently dependent. Of the total of 161 persons, all were single units and 88.7% were over 60 years of age. This constituted 92.4% of the men and 85.3% of the women (Table 2a and b).
The clients who were granted aid for compassionate reasons were actually suffering from general debility and were receiving some medical attention. Consequently, those persons who were granted assistance for compassionate reasons, and those who received aid because of physical illness constituted 80.8% of the total group. With almost nine-tenths of them over 60 years of age, the public welfare worker could have done little except to make clearer to them the reality factors of their illnesses and limited capacities, and to help them to accept their environmental situation, thus making this group feel easier in their minds and more resigned to their lot.

Of the total number of clients, 64% had been in receipt of aid for less than five years; 70.9% of the women and 56.2% of the men fell into this group (Fig. 1d). Skills and work history were probably not significant, but 15.5% of the clients were skilled or semiskilled, and 17.6% had a steady or seasonal work history (Table 3a and b). It was pointless to have considered any client in this category in terms of his or her becoming economically self-sufficient. As noted previously, the best the public welfare worker can hope to accomplish is to make the individual feel less tense about his personal and environmental situation.

It is recognized generally that the permanently dependent and the aged need more than just economic support. Some consideration should be made, of course, for the provision of such forms of recreational activity as films, books, games, and hobbies, and also for the furnishing of facilities for group
participation and interesting social contacts. Such an effort on the part of the social assistance agency and the community would give the totally permanently dependent person a happier outlook on life, and might prove of invaluable assistance in the promotion of client-community inter-relationships. The dependent himself would be encouraged to develop a degree of self-respect and a feeling of belonging if he is made a genuine participant in the life of the community. It seems likely that these recreational facilities can help a great deal in enabling the client to improve in morale and in physical condition so that he can more readily move from one type of institution to another as he requires more intensive or less specialized physical care. But, as this study is concerned with the broader aspects of rehabilitation, no attempt has been made to examine in detail what can be done within the groupings of partial and total permanent dependency.

C. Special Groups

In the total caseload of the Victoria Social Welfare Department, there were three special groups which were to be found in both the temporary and the permanent dependency categories, and which deserved some special consideration in this presentation. These were those persons suffering from tuberculosis, the clients of Chinese racial origin, and the family units with dependent children.
1. **Tuberculous Patients**

The client suffering from tuberculosis, whether he is in or out of institutional care, should not be considered a part of the caseload from the point of view of rehabilitation. While the Victoria Social Welfare Department administers the financial aid for accounting purposes, the provincial government Division of T. B. Control employs the social workers and rehabilitation officers who are responsible for the specific rehabilitation programme.

In the month of June, 1952, 54 persons were in receipt of assistance because of tuberculosis. None were in the category of partial temporary dependency. Rehabilitation prospects seemed excellent in 83.3% of the cases. These cases were those in the category of total temporary dependency. Of this group, 93.3% were under 45 years of age. With adequate casework, and vocational training facilities, coupled with specialized medical care, a high percentage of this group could have been rehabilitated within a reasonably short period of time.

Those patients in the categories of partial and total permanent dependency were over 60 years of age. With all but

<table>
<thead>
<tr>
<th></th>
<th>Total Permanent</th>
<th>Partial Permanent</th>
<th>Total Permanent</th>
</tr>
</thead>
<tbody>
<tr>
<td>male</td>
<td>31</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>female</td>
<td>14</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
one person, the tuberculous condition was quiescent, but it seemed unlikely that these individuals would ever have been able to maintain themselves without some form of public assistance.

2. Chinese Clients

Clients of Chinese racial origin constituted 12.6% of the June 1952 caseload. Prior to January, 1952, when the changes in the federal governmental regulations regarding financial assistance for aged persons became effective, this group made up approximately one-quarter of the caseload. They were particularly difficult to interview since they rarely spoke English, and consequently, eligibility in the individual case was hard to establish accurately. The employment of a public welfare worker of the same racial origin was considered for a time.

All of the eight women in this group were in the category of total temporary dependency. Six were suffering from tuberculosis and were being carried by the Division of T. B. Control for rehabilitation purposes. The other two were women with dependent children. None of the men were partially temporarily dependent.

<table>
<thead>
<tr>
<th></th>
<th>Total Temporary</th>
<th>Partial Permanent</th>
<th>Total Permanent</th>
</tr>
</thead>
<tbody>
<tr>
<td>male</td>
<td>5</td>
<td>18</td>
<td>33</td>
</tr>
<tr>
<td>female</td>
<td>8</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Of the male Chinese clients in the categories of permanent
dependency, 88.3% were over 60 years of age, and all were over 45 years old.

Hence, there would seem to be little need for the intensive casework service that would merit the employment of a caseworker of Chinese racial origin to deal only with such a limited workable caseload. If, however, the expansion of the present minimal service to this racial group is considered, then such a caseworker would be invaluable.

3. Dependent Children

There were 177 dependent children in 74 families in receipt of social assistance in June 1952 in Victoria. 98% of the children were in the temporary dependency category, with 81.9% of them likely to have been on assistance for a lengthy period. 64.5% of the breadwinners in these families were under the age of 45 years, and 90% were less than 60 years old. In only 14.9% of the families were both parents in the home. 20.4% of the children were in these families. The number of children in these families was as follows:

<table>
<thead>
<tr>
<th>Family Head</th>
<th>Partial Temporary</th>
<th>Total Temporary</th>
<th>Partial Permanent</th>
</tr>
</thead>
<tbody>
<tr>
<td>male</td>
<td>24</td>
<td>12</td>
<td>-</td>
</tr>
<tr>
<td>female</td>
<td>6</td>
<td>133</td>
<td>2</td>
</tr>
</tbody>
</table>

It is not within the scope of this study to discuss the psycho-dynamic aspects of raising children without the presence of both the father and the mother in the home. Needless to say,
the difficulties encountered by children who do not have the father with whom to identify or from whom to seek affection are further aggravated by financial, housing, recreational, and other problems. It requires the attention and skill of well-qualified caseworkers to minimize the damage that can and does seriously handicap or hamper the emotional growth of such children and the mature adjustment of their mothers.

Summary

In this chapter, some of the physical and economic factors contributing to extrinsic dependency in a public assistance caseload have been examined. It is noted that these factors can be fairly accurately measured during the completion of the eligibility study of each client, and that they can generally be compared from one client to the next. A much more detailed study of these aspects could be made than has been done here. In such a study, the discussion might include an evaluation of the community resources which would assist in the rehabilitation of the public assistance client and his family. Nevertheless, several facts are revealed in this paper which have a direct bearing on the rehabilitation programme.

Of primary importance to any scheme of rehabilitation is the health and age of the client. In the public assistance group studied, 88.3% of the heads of the case units were suffering from some medical disability, and in 71.6% of the cases, the
ailment was of a chronic or degenerative nature. 55.4% of the clients were over 60 years of age, and 71.9% were 45 years or older. Therefore, it would seem that, regardless of the adequacy of the medical and vocational phases of the rehabilitation programme, more than two-thirds of the clients were not able to benefit from such a scheme if the goal of enabling them to become self-supporting is to be contemplated.

According to the classification used in this study, 71.6% of the heads of the case units were permanently dependent. Slightly more than one-half were women. 60.2% of the total group in this category had received help for less than 5 years. However, the women appeared to apply for help earlier than the men since 79.4% had been on assistance for less than 10 years, while 81.6% of the men had received financial aid for less than 5 years.

It seems significant that 98.5% of the permanently dependent group were either single persons or were living alone. It might be assumed that when these people became more dependent and required extra care, the public welfare agency would have to meet their needs. If they were living with immediate relatives, these relatives likely would have provided the extra care.

In relation to employment status, 64.1% of the heads of permanently dependent case units were unskilled, and 60.5% had casual or no work histories. The skills and work histories of 20.1% were unknown, but it was likely that many of these persons were unskilled, casual workers. 50.8% of the women had never
been employed for wages. It appeared, therefore, that the total group would need fairly extensive retraining, and that they would not be good prospects for vocational rehabilitation since 75.6% of the individuals were over 60 years of age.

The clients falling in the category of temporary dependency constituted 28.4% of the total caseload. 54.9% of the group received help for less than one year, and 82.9% for less than 5 years. There seemed to be no significant difference between men and women in relation to the length of time that they received assistance. 55% of the group were married or had dependents.

In relation to employment status, almost half of the men in the temporary dependency category were skilled or semi-skilled, and had steady or seasonal work histories. 69.9% of the group were women and, in contrast to the men, 69.8% of them were unskilled, and 64% had casual or no work histories. With 8.6% of the women, the degree of skill and the work history was unknown, but it seemed likely that many of these were unskilled, casual workers.

Since 78.9% of the clients in the temporary dependency group were under 45 years of age, rehabilitation prospects seem fairly good, particularly with regard to the men. However, the situations of the women need more intensive study than has been given here. Almost half of them had no previous work experience, and 65.1% had dependent children. The ages of these children, no doubt, would have an effect on rehabilitation plans since the
mothers could not be enabled to take employment when they were needed to care for the young children.

One point which this study did not illustrate but which is well-known to public welfare workers is the fact that a number of women with dependent children never do go off public assistance, even after their children are no longer dependent. This transition of clients from temporary dependency to permanent dependency can possibly be prevented in a great many cases. Herein lies one area where a rehabilitation programme utilizing the services of qualified social workers could probably be successful. Considering the total caseload, it is the clients in the temporarily dependent categories and not those in the permanently dependent groups who are best able to benefit from the rehabilitation programme.

In this chapter no attempt has been made to discuss the possible causes of physical and economic dependency of these clients. In so many cases of disability and dependency, the underlying causes are due to emotional maladjustments which manifest themselves in many ways. Such outward manifestations of emotional malfunctioning are desertion, non-support, inability to apply oneself or hold a job, physical illness, simulated illness or incapacities as in some cases of blindness or deafness, lack of judgement or concern over money matters, general inability to cope with reality, and so on.

Such overt action on the part of an individual reflects his basic emotional attitudes and feelings. These attitudes and
feelings are vitally important for they have a direct bearing on the client's ability and desire to utilize the services of the social worker and the community resources in the rehabilitation process. Therefore, the social worker's aim in the treatment and rehabilitation of public assistance recipients is not just that of taking care of their physical and economic needs or pure "relief-giving", but rather that of diagnosing their emotional needs and meeting these needs reasonably adequately in so far as is possible. The clients can thus be strengthened, and often an improvement can be made in their social and emotional adjustments. It is only through the recognition of the more basic factors of human motivation that the caseworker is able, to some degree, to assist in clarifying and modifying the individual client's current reactive pattern, and to totally or partially rehabilitate him from the dependency state.
While physical and economic factors are generally more objective and reasonably easy to determine and measure, the emotional factors of dependency vary greatly from individual to individual and are, for the most, entirely subjective and relative. Emotional dependency may be defined as the inability or incapacity to accept one's own self, one's assets, and one's limitations with an objective attitude. This includes the ability or inability to relate to others in one's environment in a socially acceptable manner, to cope with most situations reasonably adequately, and, in general, to make satisfactory adjustments to environmental conditions. Such psychological aspects are always hard to define, and are still more difficult to evaluate. Every human being will react somewhat differently to the same or similar external stimuli and stresses. Each person is influenced primarily by his early growth processes, as well as by his current environment, his social contacts, and his previous experiences. Such growth processes and experiences result in the development of a general reaction pattern which is commonly referred to as the individual's personality. The emotional factors within the individual are both positive and negative. The social worker is concerned directly with the
mobilization of the positive emotional strengths of the client to enable him to utilize in the rehabilitation process his personal resources and those of the agency and the community.

Dr. Irene M. Josselyn notes that "it is in childhood that the gradual evolution of the personality should take place, culminating in emotional maturity coincident in time with physical and social maturity".¹ She further states that "it is only through understanding the child that we can evaluate the adult. An emotionally healthy adult deals with reality as such, free from the crippling implications relative to past emotional experiences or to chronic emotional hungers, whereas the disturbed individual does the reverse."² Therefore, Dr. Josselyn argues that it is essential that the significance of a particular situation be understood in terms of its meaning to the individual rather than solely in terms of the actual reality situation. To accomplish this, the worker must have some knowledge of the past experiences and reactions of the adult when he was a child.

The growth of personality or maturing process is, of course, strictly relative, and people vary widely in their particular adaptations to reality situations. However, there seems to be certain common factors amongst all individuals which can be "measured" in terms of the individual's relationships to his

---


parents, his siblings, his marital partner, his children, his friends, his other associates, and to his environment. The difficulty is to determine and to define normal and emotionally mature relationships.

A. The Casework Process and the Role of the Social Worker

In order to diagnose with reasonable accuracy the underlying problems contributing to the client's difficulties, it is imperative that the social worker study how the client has reacted to people and to situations during the past. The worker cannot be content with one or two isolated instances of behaviour. He must strive to ascertain the client's usual reactive patterns, and to determine the reasons why the client has adopted his present behaviour patterns. Since all adults are greatly influenced by their experiences in childhood and adolescence, the worker will find it helpful to know some of the things that happened to the individual early in life, and to learn what these have meant to him.

It has been pointed out that certain generalizations regarding human behaviour have emerged from observation and study. As reported by one writer who has given systematic attention to the subject, these generalizations are as follows:¹

1. Individuals tend to do that which is most satisfying, most comfortable and apparently most safe, and to avoid

that which is painful and produces anxiety. This is the well known pleasure-pain principle....

2. No matter how illogical it seems, the way an individual behaves helps him to maintain a kind of equilibrium in life.... In other words, all behaviour is purposive....

3. People cannot be talked out of their disturbed feelings. In other words, telling an individual that he is silly to feel as he does, that his fears have no rational foundation, does not help him to overcome them....

4. Changes produce anxiety and, often, fear. Everyone resists change to some extent....

5. An individual often has opposite feelings about a given situation. This is the familiar concept of ambivalence....

6. People cannot always take responsibility for their feelings and actions. They blame something or someone else. This is known as projection....

7. When life becomes extremely difficult people often regress to behaviour which brought satisfaction earlier in life....

8. People normally have strong impulses to grow and improve, to reach for something better. This is the growth principle on which the whole idea of rehabilitation is based....

By recognizing his own emotional feelings and by learning to discipline himself, the trained social worker can, on the basis of the above generalizations, gain a clearer insight into the underlying causes of his client's behaviour. Once he has perceived these causes and their relationship to the client's current adaptive behaviour, he has, in essence, diagnosed the problem and can establish the treatment goal. Needless to say, such a goal is never static, but is always subject to modification or change depending upon the skill of the social worker and the movement of the client.
The role of the social worker, regardless of the setting in which he works, is essentially that of a "helping" person. He never does more than help. It is the client who chooses, decides, achieves, and accomplishes. The social worker can only help in pointing the way; in making obstacles and inadequacies clearer, and in aiding the client to modify or sublimate them within and without himself; by relieving as much as possible the pressure of inner tensions and conflicts; and by assisting the client to free himself for his own effort and lasting satisfaction.

The social worker is an understanding, sympathetic, non-critical, permissive person who helps the client to express his feelings freely. In so doing, the client is encouraged to learn why he feels the way he does, for it is only as he understands his feelings that he can modify them. The social worker helps the client to face reality and to accept responsibility for his own feelings and actions. The social worker helps the client to weigh the advantages and the disadvantages of his situation by bringing to the client's attention factors that he may never have considered. Thus, the individual is enabled to make a better decision as to the course of action that he wishes to pursue.

Casework Treatment Goals

It seems obvious that casework treatment is not going to meet with the same degree of success in each individual case.
Whereas one client will be totally rehabilitated and become self-supporting, another whose physical condition is not subject to improvement can only be partially helped, and a third can only be assisted to accept the reality factors of his present situation and to feel easier with his lot.

It is proposed in this study to separate three possible goals. With casework treatment, total rehabilitation may be said to result from working with an individual towards a modification of his usual adjustment reactions, in order that he can gain the most benefit from the rehabilitation programme and is better able to assume responsibility and gain remunerative employment in a competitive situation. It is presumed, also, that he is able to accept to some degree clarification by the worker of some of his less deep-seated emotional problems, and consequently, that he is able to modify, to some extent, the tension and anxiety that he experiences in his inter-relationships with those about him. While he does not require further financial aid from public assistance funds, he may continue to use additional casework help from time to time. The attainment of this goal can be reached in relatively few cases, and only by skilled and experienced social workers.

Generally, partial rehabilitation may result from supportive help on the part of the social worker so that the client can better use his present capabilities and personal resources. Such a client is able to accept work in a sheltered setting which may or may not remove him from the public assistance
role. It is not likely that the social worker would attempt to clarify the client's emotional problems because they are for the most part too deeply embedded in his unconscious. To do so only serves to destroy the defenses that the client has set up to cope with reality. If these defenses are destroyed, the client will regress in his behaviour patterns and will become more dependent than ever. Clients with certain types of chronic physical and mental conditions who are still able to function reasonably well, and the dependency cases who have been in receipt of public assistance for several years may be able to respond to this type of casework treatment. Much of the social worker's time and effort will be expended in working towards the goal of partial rehabilitation.

The third goal of the social worker is simply the easing of tension and anxiety in the individual client. Again, it involves the use of supportive help, but the aim of the social worker is to encourage the client to accept his limitations and his inability to manage without public assistance rather than to encourage him to become more economically independent. This goal is particularly applicable to those aged and infirm persons requiring institutional care who are, to a varying degree, quite helpless. The use of skilled social workers may not be necessary to work with most of these clients except with specific problems. It is the warm, sympathetic understanding and the physical handling by a motherly type of person that is so essential. The real objective, here, is to help the client become a happier and less disturbed individual.
The focus of this thesis is on the contribution that the social caseworker can make towards rehabilitation in the public assistance field. It would, therefore, appear to be relevant to examine the situations of some clients in receipt of public assistance as is recorded in the case files. Unfortunately, most public assistance case records are almost barren of subjective material describing the feelings and attitudes of the clients. In many instances, the files contain little more than the repeated eligibility studies which stress the financial situations and the physical incapacities of the recipients.

For obvious reasons, it is impractical to attempt a detailed analysis of the emotional factors affecting the behaviour of each one of the wage earners of the 467 case units that were reviewed in Chapter II. However, for purposes of comparison, eight cases have been selected, two from each of the four categories suggested in Chapter II; namely, those categories of partial temporary dependency, total temporary dependency, partial permanent dependency, and total permanent dependency. In each of the eight case histories, a more intensive examination and a fuller, more detailed discussion of the intrinsic factors contributing to the emotional dependency of these clients is presented. In each category, the two cases were chosen because of the apparent similarities of the physical and economic factors contributing to the dependency of the two clients. To all outward appearances, these two clients, depending upon which
category they are both in, should be physically and economically equal in their capacities or incapacities to accept and benefit from a rehabilitation programme. Having selected clients with as similar extrinsic factors affecting them as is possible in two different individuals, a more detailed study is made of these persons in order to emphasize the vital importance of also considering the emotional factors contributing to their dependency. Further, it is significant to note that in each category, the one client probably could be rehabilitated successfully to a degree, whereas the other client likely could not be. It is the underlying reasons for emotional dependency that the social worker must look for and understand that is so necessary in the casework and rehabilitation process.

Thus, in the following eight case histories, it is hoped that a clearer picture of all factors influencing a client's dependency are brought into focus, and that a keener awareness of the client as an individual needing more than just physical or economic assistance is pointed out to the worker. The identifying information in all cases is disguised in so far as is possible in order to conceal the identities of these clients. The recording has not been taken verbatim from the files, but has been rearranged and expanded to facilitate the presenting of a clearer and more concise exposition wherever it was possible to do so without changing the context.
B. Temporary Dependency

1. Partial Temporary Dependency

The two cases of this category that were chosen for discussion are similar in the following respects. Both were fairly young men with families, who had been granted assistance for compassionate reasons. Both had a reasonably steady, albeit sporadic, work history previous to applying for assistance, and both were manual labourers with marginal incomes. However, the prospects of total rehabilitation with each of them were quite different. With one case, such prospects appeared to be poor, while with the other, they appeared to be quite good.

Mr. Donald Jones:

a. Background Information

Mr. Donald Jones was a man 36 years of age, slight, thin, and growing bald. He was quiet, mild-mannered, and inoffensive. He appeared to be emotionally flattened, and of below average intelligence. He and his family had been on and off public assistance for years, as had his parents and his siblings. He applied for assistance during April, 1952 when he was unable to locate work. He had been self-employed in the capacity of a chimney-sweep and, in addition, had some janitorial experience.

Mr. Jones expresses no particular feelings on applying for public assistance. He has grown to accept such incidents as a part of his life. As far as he is concerned, providing he receives financial help he can manage by himself fairly well. He is not interested in other services the agency has to offer, except for medical care for his wife when she is pregnant.

Mr. Jones was born in Victoria in 1916. He was the youngest child in a family of three girls and one boy. His sisters were all considerably older than he was. His
parents would have been almost 80 years old had they been living.

Little was known of the inter-personal relationships of the parents or of the other siblings, although they had all been in receipt of public assistance at one time or another. The one point that did stand out was that they were a very closely-knit family group. Each supported the other in times of stress even though they did not have the actual financial means by which to assist each other to any marked degree. Mr. Jones was very dependent upon his wife, and it was she who undertook to send him to the office when help was needed. He was married at an early age to a woman six years his senior. There were nine children of the union, ranging in age from 15 to 1½ years.

Mr. Jones is a very dependent person. He is unable to assume the customary masculine role, and he is quite content to leave all decisions and aggressive actions to his wife. When he applies for financial help on the insistence of his wife, he usually comes into the office and just sits down. It is very difficult for the worker to draw him out sufficiently to discuss his problems.

The degree of Mr. Jones' intelligence is not known. He left school before he completed Grade 5. Even without a psychometric examination, he did not appear to be very intelligent. After leaving school, he worked with his father in the capacity of a chimney-sweep. During the late spring, the summer, and the fall of each year they managed to earn enough money to maintain their families, but in the winter months they were without work and had to apply for social assistance. The business was never very successful as Mr. Jones Senior was not a very aggressive man. When he died in 1947, Mr. Jones inherited the chimney-sweep equipment.

Because of Mr. Jones' general inadequacies, it has been difficult to stimulate him to find employment and thus to become independent of public funds. On many occasions assistance has merely been cancelled when work became more plentiful and he has
been left to find a job on his own.

In 1949, a worker helped Mr. Jones to locate employment in one of the local hospitals and, for the first time in his life, he held steady employment which paid him a reasonable wage. He worked as a janitor and a general handyman, and here he was not under the pressure of excessive competition. He adjusted very quickly into his new job and was considered by the hospital staff to be a slow but a very constant and reliable worker.

The gaining of steady employment is a marked change for Mr. Jones. Heretofore, he had been quite dependent and generally functioned on a fairly inadequate level as far as employment was concerned. Now he is working regularly in the sheltered setting of the hospital and adjusting with unexpected ease to a new situation.

For almost a year nothing further was heard of the Jones' family. Once Mr. Jones gained steady work, the case was closed, and no additional service was offered by the public welfare agency. Then Mr. Jones suffered an accident at work and injured his knee. Prior to the establishment of his claim for workmen's compensation benefits, he applied for public assistance. At this time the worker noted briefly that Mrs. Jones seemed quite happy about the accident.

Because of the limited information on the file regarding the relationship between Mr. Jones and his wife, both before and after the accident, it is only possible to speculate as to the reasons for such an attitude on the part of Mrs. Jones. However, it does seem apparent that Mr. Jones' new-found independence in a work situation in some way upset the adjustment of the couple. Before he obtained regular work, he was known to be very dependent upon Mrs. Jones. Although she was the dominant member of the family, she was never consulted about the matter of his new job in the hospital. It may have been that with more adequate
functioning in the employment situation he tried to assume a more dominant role in the determination of family matters. This may have resulted in considerable friction between the couple and, as a result, may have culminated in the accident. In any event, Mr. Jones has regressed to his former dependency role again, and it appears likely that the move will be more or less permanent.

Mr. Jones re-applied for public assistance in April, 1952. He had been classified by the Workmen's Compensation Board as being physically fit for work. Financial aid was granted to him for compassionate reasons until he could either return to his former profession of chimney-sweeping, or find other work in a sheltered setting. He expressed some bitterness over the decision of the Workmen's Compensation Board, and claimed that his knee was still too stiff for him to take on employment. Although he did not say so, his attitude appeared to be one of abject resignation.

b. Diagnosis

1. Physical and Economic Aspects.

According to the medical reports, Mr. Jones had been physically employable for several months, and was capable of accepting employment when work was more freely available. Hence, he was classified in this study as being partially temporarily dependent. Assistance had been granted for compassionate reasons because he had a family. Had he been single, it was not likely that he would have been granted financial help.

The Workmen's Compensation Board had attempted to work out over a period of several months a vocational rehabilitation plan which would have involved counselling, retraining, and employment placement. However, Mr. Jones steadfastly refused to
consider the matter, and continued to claim that his knee injury still incapacitated him. Instead, he preferred to remain at home and to be cared for by his wife. In view of this preference for dependency, the Board determined that he was not a likely prospect for rehabilitation, and thus terminated their contact with him in April, 1952. Mr. Jones was left to fend for himself and to manage as best he could. Here, it is significant to note that if only the physical aspects of the situation are considered, the public welfare worker might be tempted to do the same as the Workmen's Compensation Board had done. But, the social worker should go one step further in assessing the rehabilitation possibilities of the client; he should also consider the emotional aspects relative to the situation.

ii. Emotional Aspects.

When the matter of Mr. Jones' emotional climate is considered, the possibilities of total rehabilitation as defined earlier in this chapter do not appear to be very good. Mr. Jones had always encountered difficulty in asserting himself. Possibly because his father was a mild-mannered and passive person, he had no strong male figure with whom to identify. His mother, apparently, was a warm, motherly person who accepted without question the responsibility of running the home and of keeping the family together, in spite of fairly severe financial difficulties. He married a woman who was very like his mother and who encouraged him to be dependent upon her.
Despite a possible intellectual handicap, Mr. Jones was helped by a female worker to move out of this state of dependency into a sheltered employment situation. The fact that he adjusted fairly quickly into this new position and was able to function with reasonable adequacy on the job would seem to indicate that he had some desire to become more self-sufficient, and that such a move was satisfying to him. Unfortunately, the worker withdrew her support too soon (as is often the case in the present public welfare agency). Nor was Mr. Jones' wife included in the plan and helped to see the possible changes that would likely follow with Mr. Jones' increasing opinion of his own self-worth. Indeed, it was surprising that he managed to remain in the work situation as long as he did. In view of these emotional factors, and his past history, Mr. Jones appears to be partially permanently dependent.

c. Casework Treatment.

Whether or not it will be possible to enable Mr. Jones to move out from his present dependency state seems questionable. His current behaviour of holding tenaciously to his knee injury in spite of the realistic factors of competent medical advice, and of continually refusing to consider vocational rehabilitation plans, appears to indicate that he found the initial independency situation fairly painful. His injury has provided him with an acceptable excuse for remaining dependent, and his wife tends to encourage such dependency.

The primary concern of the worker, then, should be to consider the total family picture, and to involve the wife in
the treatment plan. Obviously, this has not been done before. If a female social worker can establish a relationship with Mrs. Jones, so much the better, for the presence of a strong, but permissive female figure would likely be more helpful to Mr. Jones than that of a male worker. Mrs. Jones would probably accept a female worker, particularly as the four oldest children are boys, and she seems to be encountering some trouble with them. However, the developmental background of Mrs. Jones needs clarification before the effect of a female worker can be determined.

d. Prognosis.

Regardless of the skill of the social worker, the prognosis of a plan of total rehabilitation does not appear to be very favourable. Mr. Jones is not a young man. He has enjoyed his dependency over a long period of time. His experience with independency has apparently been so painful that he has retreated from it. Hence, it seems inevitable that the family will continue to require financial help and other services, at least from time to time, if not permanently. The best the social worker can hope to do is to provide supportive help to enable the couple to raise their children as adequately as possible, and to assist Mr. and Mrs. Jones in maintaining at best the necessities of life.

Mr. Edward Townsley:

a. Background Information

Mr. Edward Townsley was a husky, well-built, active man of 32 years of age. He was rough, somewhat uncouth, very demanding, and quite hostile when he applied for public assistance. This was his first application for financial help and he seemed to resent bitterly having to apply for
such. He had been unable to claim unemployment insurance benefits which he had accrued, as he had been forced out of work by a general strike in the lumbering industry.

Mr. Townsley's initial reaction of aggressiveness and hostility towards the public welfare worker is not unusual. The loss of work and the means by which to provide for the maintenance of his family arouses considerable anxiety and fear within him. The function of the social worker must be related to the relief of this anxiety before any progress can be made towards helping Mr. Townsley view realistically his total situation. In the public assistance setting, the social worker is in the fortunate position of being able to supplement the permissive atmosphere of the client-worker relationship with environmental help in the form of actual financial aid. Such help can aid materially in the establishment of a working relationship with the client.

There was only meagre background information on the case file regarding the Townsley family. Mr. and Mrs. Townsley had been married for ten years. There were five children of the union, ranging in ages from 9 to 2 years old. The family had moved to British Columbia from Alberta, settling in the Greater Victoria area in 1949. There were no relatives living in British Columbia.

According to the Unemployment Insurance Commission, Mr. Townsley's work history was excellent when employment was available. He was normally employed in the capacity of a truck driver for a lumber company and, except for slack periods, he had been employed by the same company for the previous three years. He had drawn unemployment insurance benefits during the later part of December, 1951, and for January, February, and March, 1952.

Mr. Townsley returned to his former employer in the last week of March, and had worked during April, May, and part of June, 1952. When the loggers went out on strike, and other unions struck in sympathy in June 1952, Mr. Townsley was forced out of work, although he did not actually
belong to any union. He was unable to draw unemployment insurance benefits immediately because none of the claims from strike-bound workers were being adjudged by the local Unemployment Insurance Office.

Since he had been dependent upon rather low unemployment compensation benefits earlier in the year, he had been utilizing his credit to maintain himself and his family. He had budgeted his earnings during March, April, May, and June to pay off his debts, and he did not have any extra funds to meet his current expenses now that he was unemployed again.

Obviously there are very realistic factors in Mr. Townsley's environmental situation which account, in part, for his anxieties and fears. He has already been living on a very stringent budget for several months, and after he does regain work, it terminates before he is able to pay off his debts. He is unable to draw unemployment benefits to which he has contributed, and in addition, he is unfamiliar with public assistance provisions in the province.

The relationship between Mr. and Mrs. Townsley seemed to be fairly good, and Mr. Townsley appeared to enjoy his children. However, when his wife intimated that she should seek employment temporarily, Mr. Townsley was extremely upset and simply would not discuss the situation with her or consider such a plan. Nor would he apply for temporary assistance from the local branch of the Order of Saint Vincent de Paul even though he and his family were active members of their church. Then, too, Mr. Townsley found it difficult to accept public assistance for he considered it to be charity. It was only after the worker suggested that the financial grant could be considered a loan and could be repaid that Mr. Townsley felt free to take the cheque. He appeared very relieved to sign a promissory note to repay the money in due course of time.

Certainly, it would seem likely that Mr. Townsley's fears and anxieties are more deeply rooted than merely concern over the means of meeting his family's immediate needs. The loss of employment and income apparently threatens his basic
adjustment towards masculinity, and any suggestion on the part of his wife that she be permitted to help out by going out to work herself results in a marked reaction from him. However, Mr. Townsley's defenses are functioning fairly well, and except in times of unusual stress, he is making a fairly satisfactory adjustment towards reality situations.

Within a period of less than two weeks, Mr. Townsley returned to the public welfare office to make arrangements to repay his "loan". He had found temporary employment as a manual labourer with lower pay than his truck driving job had formerly paid him, but he was glad to take anything he could find until he could return to his previous employment. Although he wished to make some payment on the loan immediately, such a plan was not very realistic when he had his family to provide for, so he was persuaded to postpone such payments until a later date. He, subsequently, repaid the entire amount of the public assistance grant in regular weekly installments over a period of two months.

b. Diagnosis
   
i. Physical and Economic Aspects

   Physically, Mr. Townsley was employable. He was willing to work, but due to environmental conditions he could find no employment. Assistance was granted to him for compassionate reasons until he could locate a job. Because of this, he was classified in Chapter II as being partially temporarily dependent.

   ii. Emotional Aspects

   There was not a great deal of information regarding Mr. Townsley's emotional adjustment. There was some indication, however, that under undue stress his habitual adjustive patterns broke down and his basic adjustment to the masculine role was threatened. Nevertheless, with a minimum amount of support he
was able to continue to function quite adequately, and was able to cope with his problems. With almost no active casework treatment, he was able to seek out employment, to plan realistically regarding the retirement of his debts, and to carry out his plans. Hence, the possibilities of total rehabilitation seemed excellent.

c. Casework Treatment

The plan of casework treatment was related exclusively to supportive help and to the provision of financial aid. Mr. Townsley needed only a minimum amount of assistance and understanding to maintain his current adjustive patterns and to function as adequately as he had done in the past. There was some indication that he might have benefited from more intensive casework treatment, but he was not asking for it nor, indeed, was he aware that he needed any further help.

d. Prognosis.

Because of Mr. Townsley's ego strengths, the prognosis of the plan of total rehabilitation seemed excellent. His current adjustment reactions were adequate, and he was capable of making his own decisions and following through on them. He had a definite sense of goal and achievement, and, under normal circumstances, he accepted his masculine role reasonably well. He also retained a fairly good opinion of his own self-worth throughout the period of resolving his difficulties.

2. Total Temporary Dependency

The following case histories were chosen for several
reasons. In many ways they were quite similar. Both individuals were single men of approximately the same age. They were both suffering from physical disabilities in which the medical prognosis was fairly good under ordinary circumstances. Both men had been in receipt of public assistance in their own right for some time (three years in one case, and five in the other), so that there was some information available in the records pertaining to each of them as individuals. Then, too, both men were from families who had received relief during the depression of the "Thirties" that had been administered through the Victoria Social Welfare Department. Although the information in these files was extremely limited, it did help to fill in with background information. Again, the primary reason for the selection of these two cases was that it appeared likely that casework treatment might be partially successful in rehabilitating one man, and would probably be quite unsuccessful in the restoration of the other.

Mr. John Adams:

a. Background Information.

Mr. Adams was a tall, thin, sharp-featured, sickly-looking, dark young man of 26 years of age. He was aggressive, out-spoken, critical, complaining, short-tempered, and very demanding. He had been in receipt of public assistance from the Social Welfare Department for varying periods since 1949 when he was diagnosed as suffering from tuberculosis. When he was not receiving direct financial aid, he was undergoing treatment in hospital.

Mr. Adams seems to be a person who is apparently harbouring considerable anxiety and fear which he expresses
through aggressiveness and hostility. The anxiety may have
been aroused when he first learned that he had tuberculosis,
or it may be much more deeply seated. However, Mr. Adams
might easily be described by a public welfare worker who is not
trained to search deeper for the causes of behaviour as being
uncooperative and ungrateful and, thus, not worthy of help.

Mr. Adams was born in Victoria in 1926. He was the
youngest child in a family of three girls and two boys.
His brother, who was 33 years of age, was the oldest.
His three sisters were 31, 29, and 27 years old. Had
his mother been living, she would have been about 50 years
of age. His father was approximately the same age.

Mr. Adams' father was reputed to have been an aggres­
sive, domineering, rough, uncouth person. In the old
Unemployment Relief file, he was noted as being a
"wastrel", who was abusive and physically brutal towards
his common-law wife and children. The couple were never
married. The father made no attempt to support the
family financially, and deserted them on many occasions
both before and after Mr. Adams' birth. He finally left
permanently in 1939 when Mr. Adams was 13 years of age,
and had not been heard from again. The mother and chil­
dren were in receipt of relief in one form or another
almost continuously throughout the depression period.

Some of the reasons for Mr. Adams' behaviour are becom­
ing clearer. His response to the threat of dependency, that is,
extended convalescence necessitated by his tuberculous condition,
is one of aggressiveness and hostility which compensates for
anxiety and fear. He grew up in an obviously deprived environ­
ment with a punitive and castrating father, who was home one day
and gone the next. It does not seem likely that such a finan­
cially and otherwise unstable environment could harbour many
satisfying experiences for a growing boy. His fear of punish­
ment from the father-figure might well be generalized to fear of
authority. The medical doctor likely represents to Mr. Adams an authoritative figure, and from past experience, he is afraid. Or again, his fear may be much more deeply rooted.

Mr. Adams' mother was apparently a passive, patient, long-suffering, neurotic woman who never complained of her husband's short-comings or abusiveness. She was a sickly person, and the children were placed with relatives and in foster homes on several occasions when she required hospitalization. She died in 1941.

The emotional deprivation of Mr. Adams' home is now even more apparent, and his difficulties are evidently more basic than it was at first presumed. With his mother sick a great deal of the time, possibly due to her own emotional troubles, Mr. Adams and the rest of the children were moved from home to home and had no opportunity to experience the warm, friendly, consistent, secure, and satisfying relationship with a mother-figure. Such an experience is vital for the child's normal emotional growth and maturing processes. It is not surprising to find, therefore, that Mr. Adams is encountering considerable difficulty in his relationships in areas other than those with respect to his feelings towards his physical illness.

Mr. Adams had been on his own since he was 15 years old. With the exception of a close relationship between himself and his next oldest sister, Mr. Adams had no friends. He did not speak of his mother or of his other sisters. He bitterly hated his father and his only brother.

Mr. Adams' childhood was most unstable. He was apparently in and out of his own home, the homes of relatives, and foster homes from the time that he was a very young child. He had a poor school record and did not complete Grade Six. Mr. Adams had a long history of petty thievery and sexual delinquencies from an early age. He was considered neglected, and was running the streets before he was ten.
In 1939, Mr. Adams was committed to the Boys' Industrial School where he remained until 1941. His mother died while he was in this institution. He was discharged to the home of a relative, but shortly afterwards he ran away and apparently wandered extensively all over Canada for the next few years. In 1946, he was apprehended by the police on a charge of "breaking and entering", for which he served a prison term of almost two years.

In the winter of 1949, Mr. Adams returned to Victoria and was granted temporary public assistance. The doctor who performed the routine medical examination suspected that he was suffering from tuberculosis. This diagnosis was confirmed by the provincial Division of T. B. Control, and shortly afterwards Mr. Adams entered hospital for treatment. He proved to be a most unco-operative and difficult patient, and after several months he left hospital against medical advice. He was readmitted on two occasions to different tuberculosis hospitals, but was never able to accept treatment.

Although the background information for Mr. Adams is far from complete, a fairly clear picture can be gained of how deeply rooted his emotional difficulties are, and what specific short-comings in his environment gave rise to them. To him, the world has always been a hostile, cruel, and unsatisfying place. From birth he has experienced little love and affection, except perhaps from one of his sisters in latter years. Consequently, Mr. Adams feels most insecure, and this has made it difficult for him to assume any responsibility for his actions or feelings. He exists only for day to day pleasures. He is extremely demanding and verbose, and is almost childlike in his wants and desires. He displays poor judgement in relation to finances, housing, medical care, and almost a complete disrespect for others in all his social relationships. He seems to be unable to profit from experience, and he is generally lacking in
honesty. He has no hesitation in fitting the truth to meet his needs. He is known to be overtly homosexual and, in fact, tends to act out his primitive and childish impulses without restraint or remorse.

In June, 1952, Mr. Adams was in receipt of public assistance from the Victoria Social Welfare Department. Because of his inability to budget his funds, he had been given financial aid for some months in the form of grocery orders. His rental was paid directly to the landlord. He was free to choose the type of food that he wished, and he received $5.00 in cash for incidentals. This arrangement, which was partly his own idea, had been worked out with him by the social worker. He had been managing fairly well, and, for the first time since receiving public assistance through the Victoria office, he seemed fairly satisfied and was not continually complaining about the inadequacy of the grant.

b. Diagnosis.

i. Physical and Economic Aspects

From the point of view of the extrinsic factors discussed in Chapter II, Mr. Adams would appear, on the surface, to fit into the classification of total temporary dependency. Physically, his tuberculous condition was arrested and he had a negative sputum. His condition was advanced and the medical situation was such that he might easily have suffered a relapse. The surgical collapse of the diseased lung was recommended, and it was felt that in due course of time his condition might have become quiescent. However, he refused to submit to the operation.

Had he undergone the chest surgery, then psychometric and aptitude testing, and vocational training might have been of some help in assisting him to locate suitable steady employment.
for he was not unintelligent in spite of his obvious lack of schooling. Even without any special training, it was possible that he might have found fairly steady work. Mr. Adams was usually fastidious in his personal appearance, and when he so wished, he could be friendly and likeable. He displayed no hesitation in meeting people and in talking with strangers. With Victoria being a tourist center during a great part of each year, there was considerable employment for young men in various aspects of the tourist business. Hence, with help, suitable work could have been found if he had wanted to seek it. However, in view of the information regarding his poor emotional adjustments, it seems evident that Mr. Adams should be classified as being partially permanently dependent from the economic and physical point of view.

ii. Emotional Aspects

Emotionally, Mr. Adams was extremely immature. Because his basic dependency needs were never met in childhood, he was still fixated at a very infantile level. In fact, his total behaviour pattern seemed related to accomplishing only that which was pleasing to him.

Certainly, he never had a warm, accepting mother-figure in childhood. The institutional setting of the Boys' Industrial School may have satisfied his needs to a limited degree, but in adolescence, when his earlier difficulties relating to dependency were reactivated, he spent much of his time wandering aimlessly around the various provinces. It appeared as if he
was searching for his idealized mother-figure. He did not seem to be able to accept the fact that his mother died while he was in the industrial school.

When he was unsuccessful in his search he returned to his older sister in Victoria, and he continued to return to her after stays in the provincial jail and in various tuberculosis sanitaria. Some of his experiences with this woman must have satisfied his basic needs to a limited degree, or perhaps he may have hoped to satisfy them with a person who was as near to his real mother as he could find. Obviously, however, he was not able to work out his basic conflicts, likely because his sister, too, had her own problems, and the one aggravated the other.

Finally, Mr. Adams developed tuberculosis and was hospitalized, but he refused to undergo treatment for the condition. Here was the institutional setting that was ideally suited to cater to his great dependency needs. But, at every turn, the doctors, the nurses, and social workers were attempting to rehabilitate him. Such rehabilitation would result in his not requiring institutional care and in forcing him to become independent, if only to a degree. It was not surprising, therefore, to find that he was resistive of treatment. It appeared that in the light of his marked emotional difficulties Mr. Adams should have been classified as being partially, if not totally permanently dependent. In view of such a diagnosis, the worker then could do little more than meet his physical and
and economic needs as adequately as possible from public assistance funds.

c. Casework Treatment

It seemed questionable whether or not Mr. Adams was capable of entering into a relationship with the social worker. In spite of the fact that there was some movement on his part towards the worker, the great deprivation that he suffered from the loss of his mother would likely interfere with treatment. Any permanent change could only result from his growth through the various stages of psycho-social development. A female worker might take on Mr. Adams' great degree of emotional dependency that he would display towards an accepting mother person. This substitution for the mother-figure was shown repeatedly by his reaching out for his older sister. However, without close psychiatric supervision or consultation, such an intensive treatment plan seemed dangerous from the social casework point of view.

Hence, in the casework treatment of Mr. Adams, the public welfare worker should be as sympathetic and as understanding as possible, and he should limit himself towards helping Mr. Adams to accept the reality factors of the financial limitations of public assistance, and of his need for medical care to prevent further breakdown and regression.

d. Prognosis

The possibility of enabling Mr. Adams to modify his behaviour in any respect was slight. Because of almost no
super-ego structure in his personality, it will continually be necessary for the worker to actively set limits for him in relation to the realities of the situation in which they are working. Mr. Adams will always require public assistance, of course, and keeping this in mind, the worker's primary function will be to help him manage on his assistance as best as possible.

Mr. William Black:

a. Background Information.

Mr. Black was a tall, good-looking, clean-cut, fair-haired, husky, young chap of 28 years of age. He was rather shy, unassuming, self-effacing, and somewhat effeminate in manner. He had been in receipt of public assistance almost continuously since 1947, owing to an epileptic condition which prevented him from gaining regular, steady employment.

Mr. Black is like the "good little boy" who is seen but is never heard. He is always grateful for any help that is given to him, and he is never complaining or troublesome. As long as he is left alone, he does not present any problem to the public welfare worker. Unfortunately, like the "good little boy", Mr. Black does have problems if the worker is trained to recognize them.

Mr. Black was born in 1924 in Calgary, Alberta. He was the second oldest in a family of three boys and one girl. His oldest brother was 32 years of age, while the youngest was 24 years. His sister was 21 years old. His mother and father were 54 and 67 years of age respectively.

Mr. Black's father was reputed to have been a rather weak and passive person. He had a steady employment history as a labourer except during the depression period. The family moved to Victoria in 1935, and they were on and off relief until 1940. The father then found work which he had retained to the time that this study was made.
Mr. Black's mother was apparently a rather aggressive and domineering woman who was somewhat bitter and disillusioned. She was believed to nag at and to squabble with Mr. Black's father over the lack of money, poor housing, and their general economic and environmental situation.

Part of Mr. Black's difficulty would seem to be in the area of conflict over the concept of the masculine role. Some characteristics of masculinity in Anglo-Saxon culture are independence, self-sufficiency, and aggressiveness. Yet Mr. Black grows up in an environmental situation where the masculine figure is passive and dependent, and the feminine figure, which would normally be the more passive and dependent partner in the family setting, is inclined to be aggressive and strong-willed. It is little wonder, then, that Mr. Black is himself somewhat effeminate.

The relationship between Mr. Black and his father was not known. His mother was somewhat over-protective of him, and she tended to deny that he had epilepsy. None of Mr. Black's siblings were married, and all were living at home with the parents. Particularly when drinking, the oldest brother was inclined to be physically abusive towards Mr. Black, and the youngest brother occasionally was the same. Mr. Black's mother sided with him in the arguments, but she had been unable to prevent the fighting. All this, of course, increased the frequency of his seizures. According to Mr. Black, the arguments centered on the fact that he was not working and bringing money into the home.

Apart from Mr. Black's difficulties regarding his masculinity, his illness and the fact that he is not employed and earning his own money, plus the differences between himself and his siblings must serve to emphasize his low opinion of his essential self-worth. He cannot help but feel that in all respects he is a very inferior human being.
Little was known of Mr. Black's childhood. He presumably started school at the age of six years, but, owing to the onset of his epileptic seizures, he left school at the age of 14 before completing Grade Nine. His work history was poor since he was never able to hold a steady job. Because of his presentable appearance, he had had for short periods such jobs as gas station attendant, helper on delivery vans, and clerk in a grocery store. He lost these jobs when he had seizures at work. He did not drink or smoke. He tended to associate with older men, but had never been in any difficulty with the law.

The picture of an unfortunate young man, stricken with an incurable condition that is quite beyond his control, is clearly presented. However, the social worker knows that this is not necessarily true, for an individual's epileptic seizures can be controlled by medical treatment, and such a person is able to lead a reasonably normal and active life. Hence, Mr. Black's real problems must lie in the emotional area.

Mr. Black first applied for public assistance in March, 1947. He had left home after a fight with his brother, and for a time had been able to maintain himself. He lost his job after experiencing several seizures, and eventually he was admitted to hospital. For a while he responded well to treatment, but when his discharge from hospital was imminent, he suffered a relapse which, of course, prolonged his stay. On the recommendation of his doctor, he was transferred to Vancouver for a thorough examination by a prominent specialist. The findings of this physician confirmed those of his own doctor, and the routine treatment for epilepsy was prescribed, including maintenance drug therapy and temperance in all activities and habits. Since his home environment was apparently aggravating his condition, the local doctor also advised that other housing arrangements be made, and that Mr. Black be encouraged to engage in light employment.

Certainly the treatment seems simple, clear-cut, and easy to initiate and carry out. Mr. Black's seizures can be controlled by drug therapy providing that the emotional upsets of the home environment can be eliminated. The answer to this
problem is to locate other suitable accommodation for Mr. Black, and to assist him in finding a job that is fitted to his physical limitations, thus helping him to keep his mind off his troubles. In addition, the fact that he is working and making his own money obviously will aid in fostering a more positive outlook on Mr. Black's part, will improve his low opinion of himself, and will encourage him towards independence and self-reliance.

Arrangements were made for Mr. Black to board with an aunt in Nanaimo, with his maintenance being paid through the local social welfare office. Although he did not appear to participate in the plan to any degree, he offered no objections. Within a matter of a few weeks, however, he returned to Victoria and to his home where he remained to the date of the study, except for three relatively short occasions. He continued to have a series of epileptic seizures at intervals of two and three months.

Obviously, having Mr. Black follow out the treatment plan is not quite as easy as it originally looked. There is, also, some indication that he does not remain on the drug therapy as regularly as the doctor has prescribed.

On two occasions in 1950, he moved away from home, more or less on his own initiative. For approximately four months he lived in the servicemen's naval hostel in Victoria, and while here his seizures did not recur. He also found part-time work during this period. Unfortunately, the hostel closed, and he was forced to move. A few weeks later he was helped to establish himself in a housekeeping room with a friend from the naval hostel, but this arrangement fell through after a short time, and he returned home.

In the spring of 1952, he was again hospitalized for a fairly long period for he fell on the stove during a seizure and burned himself rather badly. He was very reluctant to leave hospital, but finally did so, and once more he returned home. The doctor felt that little could be done for him other than routine treatment. However, in practice, Mr. Black followed out the doctor's prescribed schedule only sporadically.
b. Diagnosis

i. Physical and Economic Aspects

Because of the fact that his seizure condition was subject to modification and control, and that he was capable of and willing to accept employment at times, Mr. Black was classified as being totally temporarily dependent. He displayed a considerable interest in the field of radio repair work, and had some aptitude in this connection. The possibility of his taking formal training in radio work should be considered. However, this should not be undertaken until the employment situation is reviewed, and the matter of providing him with the necessary testing equipment is settled.

ii. Emotional Aspects

Because Mr. Black was able to function reasonably well when not under pressure, he probably had not been too badly damaged emotionally as a child. Certainly, his dependency needs had been met much more adequately than had Mr. Adams'. Hence Mr. Black would appear to be more amenable to casework treatment.

Mr. Black did move to find work for himself, and he was generally successful in holding a job, if only for a limited time. He tended to exhibit some dependency needs, and was usually lacking in aggressiveness. He revealed some conflict and insecurity when facing new and strange situations, and, at times, he regressed somewhat to more childish forms of behaviour in order to compensate for these feelings.

On the whole, however, Mr. Black would appear to be able
to utilize and benefit from casework treatment. He was classified as being totally temporarily dependent, and it seemed likely that he could be helped.

c. Casework Treatment

The possibility of establishing a treatment relationship with Mr. Black seemed fairly good. He was able to move towards the worker, and was apparently willing to enter into planning. It would be essential, then, that Mr. Black be permitted to decide himself on the actual adoption of the plan of treatment. This, of course, is inherent in good casework practice.

Mr. Black had considerable ego strength. He was able to stand up to his brother to some degree, to move out of the home and establish himself in the hostel, and to show some initiative in finding work for himself. However, there were danger signs too. The primary warning was his regression into dependency in the hospital setting. Another was his failure to take his medication, which aggravated his epileptic condition, and again rendered him dependent.

The worker, in his casework role, gives continuous supportive help, gives freely of genuine encouragement, and assists Mr. Black in the matter of finding other accommodation and of obtaining the radio course. In fostering a desire in Mr. Black to control his seizure condition, the worker can also interpret the vital importance of his faithfully adhering to the prescribed drug therapy and a temperate way of life. Each success will serve to build Mr. Black's confidence in his own
ability, and he can be aided in facing reality and in accepting responsibility for his own actions. Direct reassurance on the part of the worker would do much to help Mr. Black improve his opinion of his essential self-worth.

d. Prognosis.

With Mr. Black, the outlook for fairly adequate rehabilitation would seem to be reasonably good. He had many strengths, and with a positive approach on the part of the worker, Mr. Black might well have learned to modify his behaviour, for he had no great need to withdraw from reality or to rationalize his difficulties. With a clearer and more objective understanding of his condition, and its relation to his way of life, he might be expected to adjust to most situations in his environment with, perhaps, the continued moral support of the worker.

C. Permanent Dependency

1. Partial Permanent Dependency

The two cases chosen as being representative of this category are both older women who had been in receipt of public assistance for some time. Because of their ages and other factors it was not practical to consider total rehabilitation as a realistic goal. However, there were personality variations which indicated that one could be helped to accept her misfortunes more easily than the other.
Mrs. Olivia Smythe:

a. Background Information

Mrs. Smythe was an aggressive, domineering, complaining woman of 63 years of age. She appeared to be hypochondriacal and complained bitterly about the lack of attention she received from her doctor because she was a "welfare case". She and her husband had been in receipt of public financial aid since 1948. Mr. Smythe was over 70 years of age, but due to lack of sufficient residence in Canada, he was not eligible for old age pension.

Mrs. Smythe is like a number of older persons on public assistance rolls. Because of her extreme hostility and bitterness, she is difficult to work with. She complains that nothing in her life is satisfying and states that she cannot manage on the financial grant, that their housing accommodation is degrading, that she is a sick woman, and that no one will pay any attention to her. She continues to live in the past and constantly remarks how much better things were when she and her husband had money and were not "paupers". She blames everyone, particularly her husband, for her troubles and cannot see the part that she plays in them.

Mrs. Smythe prided herself on being a fifth generation Canadian and a direct descendent of one of the prominent Fathers of Confederation. There was little information on file regarding her childhood, with the exception of a notation that she was the eldest in a family of three girls. She had not been in touch with her sisters for several years and did not speak of them. It appeared that they married many years before she did and that both of them were quite wealthy and influential.

Mrs. Smythe seems to have made a poor adjustment to femininity. Her great emphasis on family prestige, on the value of money, and on financial standing might indicate considerable
insecurity in her childhood relationship with her mother. She likely harbours a great deal of repressed hostility towards her mother and sisters.

Mrs. Smythe married when she was 45 years of age. Her husband was 15 years older than she. He was a member of a titled, but impoverished, English family. Although by profession he was a barrister, he was never admitted to the bar in Canada and did not practise law here. Prior to World War II, he occupied a high post in the British Colonial Service in China, but he lost all his investments when the Japanese occupied Hong Kong in 1941. He and Mrs. Smythe barely escaped being interned at the time.

Mrs. Smythe appears to have rushed into marriage rather late in life, possibly during the menopausal period. It is significant that she chooses a man who is considerably older than herself and one whom she likely identifies with her father. With marriage she gains prestige and financial status. She travels extensively, something which she had never done before. Still, it seems questionable that she could have been very happy as her needs are so great.

For a time the couple travelled extensively in Canada and England. They appeared to spend money freely and without concern as to where it was coming from. Finally, they were stranded in Victoria, and in 1948 had to apply for public assistance. Mrs. Smythe was unable to accept this reversal of their fortunes and continued to live beyond their means in so far as housing accommodation was concerned. The couple moved frequently, either because they were evicted for non-payment of rental, or because of personal differences between Mrs. Smythe and the land-ladies.

Each move has made future adjustments more difficult for Mrs. Smythe. As the realities of their financial situation have grown more apparent to her, she has tended to deny them more strongly than ever. While her husband has been almost
completely immobilized, she has become more aggressive and
defensive.

b. Diagnosis.

i. Physical and Economic Aspects

The physical and economic situation of the Smythes was
little different from that of many other older persons on public
assistance. They both were in reasonably good health for their
ages and were capable of managing their own affairs without help.
Granted, they did have the problem of locating adequate housing
but, as a general rule, they occupied better accommodation than
most other persons in this group. They located this accommoda-
tion on their own and were very familiar with housing resources
in the Greater Victoria area.

Obviously, they were economically dependent and would so
remain for the rest of their lives. Mr. Smythe was 78 years of
age and it would not have been feasible to attempt to establish
him in the practice of law in British Columbia. Even if the
$1500 fee were obtainable, it was questionable if he could pass
the bar examinations. Hence, the couple were classified as
being partially permanently dependent in Chapter II.

ii. Emotional Aspects

While it was true that there was little specific infor-
mation on the file to assess Mrs. Smythe's emotional level, the
great degree of "free-floating" hostility was very evident.
Such hostility was directed entirely towards her environment and
never towards herself. Her dependency needs were great but she
could only maintain her equilibrium by denying them. These needs were indirectly expressed in her complaints of her poor state of health which, in actual fact, was quite good.

Her rejection of femininity and identification with the male figure was quite apparent. She spoke only of her father and of her grandfather, and was particularly hostile towards women generally and especially towards landladies. She was extremely domineering of Mr. Smythe and she became almost hysterical if he showed any signs of rebellion or independence. Any display of masculinity on his part was too great a threat to her rather tenuous adjustment in this area.

c. Casework Treatment

The prospects of even easing the tension under which Mrs. Smythe existed seemed poor. Certainly, her emotional difficulties were too deep-seated to attempt any clarification. Because of the length of time during which her defenses have been operating, it appeared unlikely that she could be helped to modify them. It was equally impossible for a social worker to "relieve" Mrs. Smythe's hostility. Over a period of two or three hours she could utilize the permissive client-worker relationship to vent her feelings if the worker allowed her to do so. At the end of such an interview she was still as bitter and hostile as when it began.

d. Prognosis

It seems obvious that little can be done to help Mrs. Smythe. She has successfully projected all her personal
inadequacies on to her environment and she has no desire to alter this adjustment. Since she is able to function reasonably well, it would seem unwise to attempt to upset this balance. Consequently, continued financial assistance is probably all that is indicated here, accompanied by the patient understanding of the social worker.

Mrs. Olga Standing

a. Background Information

Mrs. Olga Standing, 59 years of age, was born and raised in Holland. She was a slight, diminutive woman who seemed almost afraid to speak. She was quiet, mild mannered, and very passive.

At the age of 29 she married Mr. Standing, a man ten years her senior. He was the disinherited son of a well-to-do English family and had been sent to the Continent to live. He was well-educated and considered himself a scholar. There was no indication on file that he ever sought employment to maintain his family or himself.

Mrs. Standing was a very refined woman and apparently also had a good education. She was a talented pianist and, on occasion, played at small concerts in the community. However, she preferred to remain in the home and for many years had not practised her music.

Mrs. Standing seems to be almost overly feminine. She married a man several years older than herself because she likely identifies him with her father. There is no information regarding her reasons for the marriage, but she must have been aware of the reality factors of the situation and that Mr. Standing might not make a responsible husband. The element of self-punishment may have entered into her decision, but again, there is little information to substantiate such a presumption.
The Standings emigrated to Canada in 1925 and settled in Victoria. Their two sons were born here shortly afterwards. Mr. Standing apparently made no attempt to find work or to support his family. He was quite content to remain at home and permit his wife to find what work she could. As well as care for the children, Mrs. Standing did domestic work and sold home-cooked foods from door to door.

Her income from these sources was meagre and their standard of living was very low in comparison to what they had been used to as children. However, Mrs. Standing never complained although her husband was very bitter about their situation. She retained only a few of her personal articles of furniture, including her piano, which she had brought with her from Holland. The rest were sold to meet expenses.

The probability of self-punishment seems fairly evident in Mrs. Standing's adjustment to the reality situation. She accepts her husband's attitude towards responsibility without complaint and even sells her personal belongings to maintain him.

The reason for the self-punishment is not so clear. It may be related to a basic rejection of femininity and envy of masculinity on her part. Although she is dissatisfied with her femininity, she over-compensates to a degree by being very feminine and passive. At the same time, she has a male figure almost totally dependent upon her. Thus, she maintains a balance between two conflicting drives.

Mrs. Standing applied for public assistance in 1950 after considerable hesitation. In 1949 Mr. Standing was granted the old age pension. However, he refused to share any of this income with her or to contribute to the expenses of the home. He bought food for himself but would give none to Mrs. Standing.

Both the boys had left home and did not communicate with their parents. Nor did they forward any money to either the mother or the father, although they were aware of the older couple's poor financial circumstances.
Mrs. Standing continued to work as long as she could. However, in 1950 her health began to break down and she had to remain at home. Since Mr. Standing would not contribute towards her maintenance, she applied for social assistance. She found it difficult to accept help and was extremely anxious lest the neighbours and her husband learn that she was in receipt of assistance. In June 1952, she was still inclined to be secretive about her need for financial aid.

Mrs. Standing finds it difficult to accept the fact that she is dependent. For several months she would not apply for help, and it was only through the direct intervention of her doctor that the matter came to the attention of the public welfare worker. To a limited degree a relationship has been established with a female worker and Mrs. Standing is able to talk about some of her troubles.

b. Diagnosis

i. Physical and Economic Aspects

The physical and economic aspects of the Standings presented no particular problems. Both were in fair health and were able to take care of their own physical needs as long as they were assured of a minimal public assistance grant. They occupied their own cottage which, although not well kept, was habitable. Mrs. Standing was a fairly good manager and they lived reasonably well on their very limited income. When he felt like it, Mr. Standing did pay some of the bills, but for the most part they lived on Mrs. Standing's social allowance. In Chapter II, Mrs. Standing was classified as being partially permanently dependent.

ii. Emotional Aspects

In spite of the fact that Mrs. Standing has some deep
seated personality difficulties, she was able to relate to the worker. She always functioned fairly well even under considerable stress. She had some ego strength and tended to face her problems, for the most part, in a realistic manner.

c. Casework Treatment

As noted previously, Mrs. Standing has been able to relate to some degree to a female worker. She has been able to talk about her troubles, but has not dwelt on them incessantly. She has renewed her interest in music and will play occasionally for the worker. She has shown some interest also in returning to her religious faith which she gave up when she married Mr. Standing. Throughout the contact the worker has been sympathetic, permissive, and supportive. She has encouraged and reassured Mrs. Standing whenever it has been possible to do so.

d. Prognosis

While no progress has been made towards even partial rehabilitation, Mrs. Standing seems to be more outgoing and displays less need to be furtive and secretive. Certainly, she still is unable to rebel against Mr. Standing or even to express any overt hostility towards him. However, she does seem to feel easier about her situation and is seeking some small pleasures for herself.

2. Total Permanent Dependency

The following two cases were taken from the total permanent dependency grouping mainly because the possibilities of rehabilitation were so strikingly different. The one woman
had been ill for a number of years. She was under medical 
and institutional care and little, physically, could be done 
to help her. The second woman suffered from a functional 
paralysis of her right leg, and because of this, she was placed 
in an institution. Almost nothing had been done to assist her 
in spite of the obvious symptoms that she displayed. The 
degree that each of these women could be helped is not known, 
but some action seems indicated.

Mrs. Martha Hoy:

a. Background Information

Mrs. Hoy was a rather tall, slim woman of 65 years 
of age. She was always very tense and seemed unable to 
relax. Her husband died in 1932 and she maintained her­
self from that date until she was admitted to hospital in 
1951 with a chronic heart ailment. She found it very 
difficult to accept the fact that she needed help as she 
had been heretofore a very independent person. She 
rebelled against accepting public assistance and left the 
hospital against medical advice. However, this move 
aggravated her condition and she returned to hospital 
shortly afterwards.

With so little information it is difficult to perceive 
why Mrs. Hoy is so upset by the threat of dependency embodied 
in hospitalization. But, in view of her rather serious medical 
condition, her overt reaction of leaving hospital seems very 
unrealistic.

Mrs. Hoy married a man who was very sickly, and for a 
number of years she personally cared for him without help. 
Prior to his death he required a great deal of attention 
which she gave unstintingly. In spite of the fact that 
she knew that he was dying, her husband's death came as a 
great shock, and for several months afterward she was 
quite seclusive.

Eventually, Mrs. Hoy recovered and, to maintain herself,
she sought employment as a practical nurse. She was inclined to drive herself relentlessly and tended to accept cases that she knew would terminate in the death of the patient. The patients were generally men and their eventual deaths were upsetting to her.

Mrs. Hoy seems to have a greater need to associate with death than is usual. She apparently is attempting to re-experience a relationship to the father-figure that is very painful for her. Her periods of depression and her withdrawal from reality following the death of the patients seems indicative of considerable guilt. Again, the reasons for these feelings are not known.

With the help of a male social worker Mrs. Hoy was able to accept public assistance and was moved to a private hospital. Almost immediately, her behaviour changed. She became extremely dependent and could do nothing for herself. She wanted to be fed, washed and dressed. She complained that no one paid any attention to her and that her doctor was neglecting her.

At the same time, she protested that she did not need the care that she was receiving and that she would manage much better on her own. She refused to give up her housekeeping room but, as she was unable to pay the rental, the landlord moved her belongings to her sister's home. When she was told this, she became very subdued and would not talk to anyone.

It would appear that Mrs. Hoy's dependency needs are very great, and that she over-compensates by being extremely independent. Once she gives this independency up, her basic needs assert themselves and she becomes very dependent. She still clings to the illusion of independence though, as she wants to retain her housekeeping room. When this is gone, she regresses even further into childish behaviour.

In June 1952, Mrs. Hoy was bedridden and almost totally helpless. She apparently looked forward to the monthly
visits of the social worker and tried to prolong the interview as long as she could.

It appears that Mrs. Hoy is reaching out for the attention and the concern of others. Apparently her complete dependency in the institutional setting brings her personal satisfaction and aids in some way to ease the tension of some of her inner conflicts.

b. Diagnosis

i. Physical and Economic Aspects

Physically and economically, Mrs. Hoy is totally dependent. She is receiving good medical and institutional care, and little more can be done for her. In view of her medical condition the possibility of total or even partial rehabilitation is remote.

ii. Emotional Aspects

Some emotional factors have been brought out in the recording that require further study before an assessment can be made of Mrs. Hoy's total situation. She seems to be capable of doing more for herself than just lying in bed and being waited on. Just what caused her to react in this manner is not known, but certainly there is more to the situation than might be expected with the average chronic heart case.

c. Casework Treatment

The possibility of stimulating Mrs. Hoy to do more for herself does not appear to be very good. She has found the answer to her conflicts in her present state of almost complete dependency and she likely will be resistive of any effort to
improve her situation. However, with the continued interest in her relatives and with sympathetic understanding from the private hospital staff and the social worker, some change may be brought about in her attitude towards her situation.

d. Prognosis

It would seem that the prognosis is poor. Unfortunately, the staff of most private hospitals are not prepared to give Mrs. Hoy the continuous attention that she demands. Nor can they be expected to understand the basic reasons why she wants such care. Even her doctor is somewhat of the opinion that she is malingering. But, the more she is rebuffed and denied attention, the greater will be her need to gain it. A private placement in the home of a warm, motherly woman where she is the only patient, plus the continued help of a social worker may provide the solution to the problem. Without such help, it seems likely that Mrs. Hoy will become more and more dependent.

Miss Elsie Lane:

a. Background Information

Miss Lane was a comparatively young woman to be requiring institutional care. She was only 44 years of age. She was a very small, slight woman and was inclined to be shy and uncommunicative. She appeared to be ritualistic and compulsive with regard to her personal hygiene.

In 1950 she was under medical care for a foot injury and was admitted to hospital for examination and treatment. She subsequently developed a functional paralysis of the right leg which did not respond to treatment. Later she was discharged to private hospital care. During the next two years, to June 1952, no action was taken by either her doctor or by the social workers in the public welfare agency.

The above information sums up most of the file on this
woman. Nevertheless, even from this limited knowledge, the deep-seated nature of her problems seems fairly obvious. Her compulsive rituals, coupled with her marked withdrawal from the competitive world are undoubtedly in some way related to the re-activation during the menopausal period of her previous difficulties that she experienced in her childhood and adolescence.

Prior to her illness, Miss Lane held a responsible position as senior clerk-stenographer in one of the provincial governmental offices in Victoria. She was receiving a fairly good salary and she shared an attractive apartment with her younger sister who was also a successful career woman. While Miss Lane was shy, seclusive, and withdrawn, her sister was believed to be active and outgoing, and a person who had many friends.

This is the extent of the information that is currently available on Miss Lane. The reasons for her need to withdraw from reality and seek solace in dependency are not known. However, they do seem related to possible inner conflicts centering around her sister's social acceptance in comparison to that of her own, and around her identification of the sister with the mother-figure. In addition, her personal feelings regarding her femininity and her essential self-worth may also contribute to her present state of emotional dependency. The paralytic condition may be a form of self-punishment connected with sexual disfunction.

b. Diagnosis

i. Physical and Economic Aspects

From the physical and economic point of view, Miss Lane
is totally permanently dependent. She is suffering from a paralytic condition which has not responded to medical treatment over a period of two years. She is a model patient and does all she can to help around the institution. She is without funds and is unable to earn a living since she cannot move about sufficiently to live outside the nursing home. She is receiving adequate care and her physical needs are being met.

ii. Emotional Aspects

It seems apparent that some emotional difficulties are interfering with Miss Lane's adjustment to reality situations. For a number of years, she was able to function fairly well in a competitive work situation. She was capable of assuming considerable responsibility and held a senior position in a governmental department. Then, rather suddenly, she gave this up and regressed into a state of dependency. Some of the possible reasons for this behaviour have been suggested previously. It would seem that an attempt should be made by a social worker to reach this woman before she finds her current adjustment too satisfying for any modification.

c. Casework Treatment

Miss Lane appears to be able to enter into a relationship with the worker. In the past, she has been amiable and friendly towards the worker, but she has been reluctant to discuss her paralytic difficulty. It may be that she would relate better to a male worker, but a more detailed assessment would have to be made before considering this plan, or proposing the treatment methods and goals.
d. Prognosis

It is difficult to determine the prognosis at this point. A great deal of intensive casework treatment will have to be done with Miss Lane if she is to be stimulated to modify her current adjustive pattern. However, she has considerable ego strength on which to build if she can gain some insight into her troubles.

Very briefly, some of the significant circumstances in the lives of these eight people have been outlined. The differences in their emotional development can be readily perceived. In all cases, it is relatively easy to look into the past and to find causes for their current behaviour. The difficult task lies in predicting the possibilities of change in future behaviour and in the ascertaining of the potential aspects of rehabilitation.

Summary

In this chapter some of the underlying factors have been illustrated that affect the adjustment of the client to his environment. Social casework emphasizes the fact that all persons must be considered as individuals. The determination of differential casework treatment, then, is based on the psychosocial diagnosis. Thus, social casework treatment can be integrated into the public assistance programme and can facilitate the rehabilitation process. The differential approach of the social worker towards rehabilitation plans for
the client is implicit in his consideration of casework treatment.

Human relationships are dynamic, not static, and growth will fluctuate with changing conditions, strains, and stimuli. Therefore, the social worker must be continually evaluating and re-evaluating each client. As the client becomes more able to relate to the worker, the greater will be the worker's knowledge of that person's background and the reasons for his present behaviour. With this increased knowledge of the client, the worker is able to change his treatment goals and to determine how effective casework treatment will be.

In some instances, intensive treatment is not indicated at all, while in others, there is some possibility of success. However, in most cases, the accurate prediction of the degree of success of the rehabilitation plan cannot be made without some understanding of the intrinsic emotional factors within the client. It is these factors that the social worker is specifically trained to seek out and to diagnose with the view to assisting the client in modifying his disruptive behaviour patterns.

Currently, considerable difficulty is encountered in evaluating the ability of the client to utilize the rehabilitation programme and casework treatment. It is possible that, with further research, a method of measuring such subjective factors may be evolved. In a separate section of this paper some of the literature relating to emotional maturity is
reviewed, (Appendix A). An attempt has been made to develop a rating scale to point up the varying degrees of maturity and immaturity in some areas of human behaviour so as to provide a basis from which the social worker can initiate casework treatment, and from which he can measure client movement. However, the discussion therein is more or less related to the description of human behaviour rather than to the determination of the primary causes of such behaviour.

The scale of assessment of emotional maturity is, at best, only a tool to aid the social worker in understanding the client. It may, however, assist the worker in graphically determining the client's level of emotional maturity in relation to the suggested level of normality. It may also help to define more clearly the focus of treatment in the environmental situation by pointing up appropriate and inappropriate treatment plans. If the scale is incorporated into the recording in the client's file, or is tabulated in graphic form, the client may be re-evaluated from time to time. Comparisons of these evaluations at regular intervals would serve to detect movement on the part of the individual. The principle value of such a scale is to enable the social worker to screen his cases more objectively. In a relatively short period of time, he should be able to determine whether or not the client is capable of accepting and utilizing treatment. In addition, the worker is enabled to assess how intensive the casework treatment should be, which areas the client is particularly in need of help, and
at what level this treatment should be directed first. The scale may also help the worker to look at himself more objectively in the client-worker relationship, and to assist him in evaluating his own capabilities, pointing up those areas in which he himself is not functioning at the level of his normal capacity. It is presumed, of course, that the social worker is an emotionally mature, professional person.
Chapter IV

THE ESSENTIALS OF REHABILITATION
IN PUBLIC ASSISTANCE

The aim of this study has been to discuss the meaning of rehabilitation in a public assistance programme. An attempt has been made to outline current concepts of rehabilitation as related to the economic and physical factors of the public assistance recipient, and to point up the limitations of these concepts. It has been suggested that in order for the rehabilitation programme to be effective, these current concepts must be broadened to include the emotional factors which govern the behaviour and the attitudes of the client towards the goal of rehabilitation. While the contribution that casework can make to rehabilitation is important, a comprehensive approach to the total problem obviously is necessary if the programme is to be really effective. Hence, in this chapter some material is introduced which, although discussed previously, appears to be an essential part of the broad scheme of rehabilitation.

A. The Need for Social Workers

The need for utilizing the services of qualified social work personnel in the rehabilitation programmes has been
repeatedly emphasized. However, it is imperative that public welfare administrative officials give serious thought to the question of how the social worker can best be integrated into the total programme. There is no point in accepting blindly the principle that trained social workers are required to administer public assistance, and then to embark on the recruitment and placement of such personnel without first specifically defining the job that the social worker is equipped to do. Quite apart from the appalling waste of money in the payment of salaries to an unnecessary number of workers, the loss of potential talent attracted by the higher wages from other fields utilizing social work skills, and the permanent damage inflicted on young inexperienced social workers by the pressure of work unrelated to their training is hardly justifiable.

1. **Social Work Function**

   A detailed job analysis of the total public assistance programme is not required to show that many of the specific administrative functions are of a routine clerical nature. In the generalized public welfare programme in British Columbia, categorical aid schemes and general assistance are administered by the one public welfare worker within a specified district. A great deal of his time is, of necessity, spent completing and notorizing application forms, confirming residence, age, and disability, evaluating negotiable assets and real property, and the like. Many such workers are trained social workers, yet much of the work can be reviewed just as efficiently, accurately,
and rapidly by sympathetic and understanding clerical staff.
The difficulty in job definition lies in segregating the purely
social work function from the clerical eligibility study.
Herein is to be found the solution to the dilemma of classifi-
cation.

2. Current Public Welfare Thought

During the past two decades, public welfare officials
in Victoria have tended to become "category-conscious". They
are inclined to think generally in terms of old age pensioners,
mothers' allowance recipients, neglected children, and so on.
In so doing, they seem to have partially lost sight of the fact
that these same old age pensioners, mothers' allowance recipients
and neglected children are individual human beings. Whether or
not this apparent oversight by the workers is due to lack of
training or to pressure of work is probably a matter of conjec-
ture. Like many other persons in the world, these clients have
personal as well as financial problems.

3. Assignment of Clients.

The job of the public welfare worker should be to assess
all clients in terms of whether or not they need and can utilize
casework treatment, rather than just to consider these clients
in the narrower terms of whether or not they need and can
utilize financial assistance as is done at present. While the
need for financial aid may be very real to the client when he
first applies for assistance, the social worker is primarily
concerned with the diagnosis and casework treatment of the indi-
vidual's underlying problems. If the client is not a good
prospect for rehabilitation, that is, if he is permanently dependent, and he can function reasonably well without casework treatment, then he can be supervised by an experienced although untrained public welfare worker for routine maintenance. On the other hand, if he is only temporarily dependent and can utilize casework treatment, he should be assigned to a qualified social worker.

In Chapter II, the statistics show that in the Victoria City Social Welfare Department caseload for the month of June, 1952, more than two-thirds of the case units were permanently dependent. While some of the wage-earners in these units no doubt needed casework treatment, the greater majority of them functioned reasonably well without such intensive treatment. There seems no point in utilizing the talents of trained casework personnel to perform the routine work of granting social assistance to these persons. The remaining one-third of the caseload consisted of younger persons with and without dependent children. Certainly, it seems more logical for the trained social workers to concentrate their efforts on working with this group although, again, some of these clients did not need such specialized services. Obviously, the assignment of clients should be made on the basis of the needs and problems of the individual client as related to the capabilities of the public welfare worker. At the present time, assignment is made on the basis of the category of assistance that the client is eligible for, or on the residence of the client within a
certain area. Naturally, there are factors which will necessitate modification of this rule of selective assignment, but to some degree, the principle can be adhered to in most offices. Some of the modifying factors are the topography and the population of the land area under the supervision of a specific office, the difficulties of travel in the area, the number of public welfare workers, and the degree of social work training that the social workers have.

4. The Selection Process

The screening of clients for assignment to workers can best be done during the initial contact when the individual first applies for assistance. This necessitates that highly skilled social workers be utilized to handle all intake interviews. The role of such an intake worker in the public welfare agency should be differentiated from that of a receptionist. Currently, the practice appears to be one of assigning the majority of intake periods to the relatively inexperienced or unskilled worker. Such workers are primarily receptionists and are not equipped to diagnose the client's underlying problems. Therefore, they can not determine which worker in the agency is best qualified to carry out the specific treatment process. The assignment of the client to a specific worker, then, is determined by the intake supervisor on consultation with the qualified intake social worker who makes the casework diagnosis. Hence, the intake supervisor must also be a trained social worker.

Ideally, the intake process should be handled by a
separate section of the social welfare department and would require the employment of one or more social workers as well as a supervisor. Such a section is particularly adaptable to larger social welfare offices in metropolitan centers, but is not particularly feasible for small offices in a rural setting employing only three or four workers. However, regardless of the size of the office, there is generally a supervisor in charge, and such a person should be trained and be prepared to handle the assignment of cases on the same basis as outlined above in so far as it is possible.

5. **Size of Caseloads**

The tendency in recent years in public assistance agencies in Canada and the United States has been to develop generalized caseloads in which the worker administers to clients the categorical aid programmes and the child welfare services, as well as the general assistance programme. It has been suggested\(^1\) that the social worker can deal with more aged persons than with families having dependent children since many of the aged persons do not require the intensive casework treatment that the families with children often do. Although there is no universally established optimum caseload, it is recognized that the workers should not carry a "mixed" caseload of more than 225 to 250 individuals. A "mixed" caseload is one wherein there are clients of different ages requiring different forms of assistance and services.

In the Victoria City Social Welfare Department in June, 1952, the average individual caseload consisted of approximately 400 clients. Naturally, the greater percentage of these clients were in the older age groups but, even so, the number of persons needing help was too great to permit the worker to spend more than a very minimum amount of time with each person. Intensive casework was almost out of the question.

With the assignment of caseloads as suggested above, it is visualized that the social worker in this office who is to give intensive casework treatment will carry only 30 to 50 such cases. The less specialized worker who is doing a much less intensive job will probably carry the same number as he did in June, 1952, and more staff will be needed. However, a detailed review of the total agency caseload as related to the demands of the client for services will have to be completed before a more definite statement can be made as to the proposed size of the various individual caseloads in this particular office.

B. Evaluation of the Rehabilitation Process

Any programme, regardless of its focus, must at some time or other be subjected to review and evaluation if it is to be successful in reaching the objectives that it was designed to meet. Because rehabilitation programmes are dealing with human lives, it is essential that such evaluations be conducted continuously. Nor should public assistance programmes be exempted from such scrutiny, although in actual practice, all
too little review, research, and long-range planning is presently attempted.

It would seem to be true that rehabilitation in the public assistance setting can only be as effective and as far-sighted as the personnel who are employed to do the work. Hence, it is essential that all public welfare officials, from the chief administrative officer to the worker in the field who deals with the clients, have a deep conviction of the value of the programme. It has been suggested that there are four basic concepts which, in effect, constitute the philosophy of an effective public assistance rehabilitation programme. These are first, that recognition be made of the essential worth and dignity of each individual applicant; second, that the client has within himself the potential ability to utilize these social services, with help if necessary, and become an asset to the community; third, that everyone has the right to a satisfying and effective existence; and fourth, that as all persons are not created equal, the community must provide equality of opportunity through the medium of social services to compensate for this variance in status.

1. The Role of the Supervisor

While it is necessary that the administrator be familiar with, and favourable to social casework practice, it is the supervisor of the social workers who is the key person in the

---

rehabilitation programme. After consultation regarding the initial individual diagnosis, the casework supervisor is directly responsible for guiding and evaluating the casework treatment plan embarked on by the social worker. At the same time, the supervisor is evaluating the skill of the worker and is able to utilize the supervisor-worker relationship as a teaching situation whereby the social worker learns to function more effectively with the client in the treatment process.

Hence, the position of supervisor should be filled by a skilled social worker who has the vision and foresight to be able to perceive the practising social worker's short-comings and lack of self-awareness. Through the medium of direct interpretation, such a supervisor is able to help the social worker to correct these personal lacks. Naturally, if the supervisor is to function properly, he must be free from much of the weight of the routine administrative details of office and programme management, unless he has only two or three workers to supervise.

In practice in British Columbia, the emphasis is on the recruitment of persons for supervisors in the public assistance programme with administrative as well as with casework capabilities. The position of supervisor in district offices, of necessity, requires considerable attention to administrative detail. Consequently, these supervisors have little time to concentrate on the purely casework aspects of the job, and this lack is reflected in the mediocrity of casework practice by
many social workers in the field. There is little stimulus for growth in the young, newly-trained social workers who have potential casework abilities, but who are lacking in experience to develop these abilities. Even in the inexperienced in-service trained public welfare workers, the experienced casework supervisor and social worker can instill the basic casework principles which will promote more adequate functioning by these workers. Hence, it would seem that the degree of success in the rehabilitation of the public assistance recipient is directly related to the skill of the casework supervisor as well as to that of the social worker.

2. Staff Development

The importance of the effect of the social worker's own attitudes and level of emotional maturity on the client in the diagnosis and treatment process is a factor that cannot be overlooked. The role of the social worker in relationship to the client in a programme of emotional rehabilitation is of primary concern, and is one which has been studied elsewhere.\(^1\)

It is imperative in practice that the social worker be aware of himself, and that he recognize the importance of controlling what he brings to the interview from his personal experiences and adjustments. He must continually strive to increase his self-awareness and self-discipline, and at the same time, to increase his knowledge of human behaviour, if he is to improve

---

in his professional functioning.

While the supervisor-social worker relationship is basic to the promotion of good social work practice, there are other methods of staff development which can be utilized in a group setting, and which are designed to help the worker to function better on the job. However, it must be kept in mind that, to be effective, a good staff training programme requires detailed and continuous planning with all specific phases being integrated into the total scheme.

Such a training programme involves regular and planned staff meetings in which the social workers are encouraged to discuss their problems in relation to specific clients, the resources available to help the client, and the gaps in the rehabilitation programme. In this manner, social workers are able to participate in agency policy-making which will be directly related to the needs of the client, for no one knows these needs as intimately as does the social worker. The availability of books and current periodicals on social work practice in other fields as well as in public welfare is invaluable. Films, exhibits, pamphlets, prepared case records, and other forms of visual aids are also extremely helpful in promoting discussion and self-evaluation.

The attendance of social workers at conferences, institutes, workshops, and the like can be encouraged. Agency delegates, by attending such conferences, can report back to staff meetings. Case conferences on the individual clients can bring in other professional groups such as doctors, nurses,
and teachers, who are also interested in the individual client. This can do much to broaden the vision of the social worker by making him aware of the scope and the limitations of his own and other professions. The employment of part-time professional consultants in psychiatry and social work by the agency can do much to sharpen the social worker's focus of the treatment of the client. Field visits by social workers to other agencies dealing with related public welfare and rehabilitation programmes can serve to stimulate staff thinking. Of paramount importance in the development of staff is an adequate scheme of educational leave, with some provision for financial assistance. Not only will this serve to bring academically trained social workers into the public assistance field, but also it can be used to stimulate the experienced worker who has been on the job for several years.

Continuous staff development and education is one of the most important responsibilities of public welfare administrative officials. All the effort that is expended in the task of continuous staff development is well repaid with the growth of an energetic, active, and socially conscious staff; a staff that takes a personal pride in doing the job well; a staff vitally interested not just in the job, but in the welfare of the people with whom they are working; a staff who are not just investigators, but who are professional social workers with a professional job to do and a goal to aim for; and lastly, a staff that is conscious of its responsibilities as an integrated unit serving the community.
3. **Recording**

As a general rule, the recording in the files of most public assistance clients is totally inadequate if casework treatment is to be attempted. Certainly, there is no need for a detailed social history on all applicants for assistance. In cases other than those that are selected for intensive treatment, such extensive recording would be a great waste of time since it would never be used. However, in specific cases, the social worker will find it necessary to record in detail, not only the pertinent facts of his treatment progress with the client, but also the developmental background information of the client. Such recording is useful in making the diagnosis, in planning treatment, and in evaluating the client's progress and the functioning of the social worker.

It is not intended at this point to present a tabulated outline of recording. However, diagnostic recording should give a clearer picture of the client's usual adjustive behaviour pattern in some of the areas where he is encountering difficulty, as well as point up some of the important events in his childhood, and the meaning of these events to him. The recording should include such face sheet information as the names and ages of the husband, (if married), wife, and children, the date of marriage, the nationality, the racial background, and the religion of the family group. The details of the particular crisis situation which brought the client in for help are important. Some notation, with specific illustrations, of the
chief difficulties, of the duration of the troubles, and when the troubles started, is helpful and pertinent in facilitating the diagnostic procedure.

With reference to the background of the client, it is necessary to know his place in the family, the attitudes of his parents to him and to the other children, and the attitudes of the siblings and other persons toward the client. Information regarding illness of a serious or minor nature should be recorded, and particular attention should be given to minor complaints which have existed over a long period of time. A review of educational background related to the work history, adjustment, and the current financial status of the client should also be made.

The details of the couple's courtship and marriage, including periods of stability and instability, and the causes and durations of separations, are necessary. It is also important to record the attitudes of the client to the present and any previous marriage. The client's sexual adjustment, and whether or not he finds it satisfying should be noted, as well as any indication of pre-marital or extra-marital affairs. It is helpful to ascertain any marked changes in the attitudes of the client towards his environment and marital situation on the birth of his children or during the children's adolescence. Strong ties or antipathies between the client and his children are significant. In the case of the unmarried person, any unusual sexual practices should be recorded if they are apparent, or if they are divulged by the client himself.
Of vital importance are the client's personal ideas of what his troubles are, the part that he plays in the troubles, how he adjusted previously, what he wants to do now, and how he expects the social worker to help him. All these ideas are affected by his cultural characteristics, his religious beliefs, his basic attitudes to life; and his strong likes and dislikes. Hence, these details, too, need to be recorded if the social worker is to see the client in true perspective.

4. Statistics and Research

At the present time, statistics for the Victoria City Social Welfare Department are derived from forms developed and utilized by the provincial authorities. These statistics are essentially the result of a process of enumerating the monthly increase and decrease of case units in the different categories of assistance. While they give a general picture of the monthly and annual fluctuations in the numbers of case units in receipt of assistance, and also the activity of the workers, much more detailed information is needed to denote specific trends. Even the general classifications of temporary and permanent dependency used in Chapter II could clarify the situation more than is done now.

What is really lacking is the use of an adequate staff of research specialists in the provincial Social Welfare Branch. If such a staff unit could be added to the present Department of Health and Welfare, and a sufficient number of qualified personnel employed, they could be utilized to develop and coordinate statistics and research in both the health and the
welfare fields. With this material available, provincial and municipal departments could develop programmes designed to meet the needs of persons within their own jurisdictions. Overlapping of services could be prevented, and joint efforts could be bent towards developing services where they are needed and can be used most effectively.

C. Measurement of Client Movement

The accurate measurement of the growth or progress of clients during casework treatment has created a problem for social workers for a long period of time. It is suggested in Appendix A that the social worker may be enabled to judge the relative improvement in the individual client's adjustment by plotting on a simple chart (see Schedule E) his estimate of the client's situation over regular intervals. However, since the material used in judging behaviour depends to a degree on the subjective interpretation of the worker, this method of measuring growth is difficult to validate statistically without extensive testing on many individuals by different workers and comparisons of the results.

This problem has been studied by several authorities for some time, and two schemes have been developed which appear


to measure movement on the part of clients with a considerable degree of accuracy. The movement scale developed by Hunt and Kogan utilizes the records of "anchor" cases depicting varying degrees of movement against which the individual case to be measured is compared. The scale plots movement in the areas of the client's adaptive efficiency, disabling habits and conditions, verbalized attitudes and understandings, and environmental circumstances. Preston, Mudd, and Froscher have developed the conference judgement method wherein two professionally trained persons (caseworkers, psychiatrists, or psychologists) make independent analyses of the client's case record, using a prescribed check list of 31 items. The two specialists then meet in conference and compare the results, item by item. Any disagreements are reconciled by reference to the case record. The final product is the conference judgment of the client's movement. The Hunt-Kogan movement scale would seem to be the most advantageous of these two methods since it can be applied by one person with reasonable objectivity in a relatively short period of time.

D. Factors Affecting Rehabilitation

There are a great many factors affecting the rehabilitation of the client. Some are personal, that is, they are peculiar to the individual client, and others are environmental or are a part of the community facilities in general. Some personal factors are as follows:
1. **Innate Intelligence**

The primary requisite to be considered in the rehabilitation plan of the individual is his innate intelligence and, to a degree, his aptitudes. Obviously, the physical content of the vocational training or retraining programme will be different for the mental defective than that for the person of average or greater than average intelligence. Then, too, the degree of mental deficiency is also important for, while a person with the intellectual capacity of a high grade moron may learn to complete simply repetitive tasks, the imbecile can hardly learn to meet even his most simple personal needs, and the idiot is totally dependent upon others. Aptitudes are factors which must be considered as well. Some people are mechanically inclined while others are artistically bent. Therefore, the interests and abilities of these persons does provide a rather general guide to the particular type of work or trade at which they are likely to be successful.

2. **Age and Sex**

The age of the client is important if the social worker is considering total rehabilitation as the goal of treatment. The older the individual, the less likely he is able to become economically self-sufficient. He is restricted as to the type of work that he can perform and, generally, he has lower stamina and less resistance to infection. The attitudes of employers also militate against the older person in spite of the fact that, in some instances, his productivity and steadiness on the job may be higher and his absenteeism lower than
those of younger persons.

The sex of the client has a bearing on employability. Apart from differences in the physical capacities of men and women, discrimination against women is still to be found in many employers as is evidenced by the difference in salary paid for the same job, in the types of positions that women can occupy, and in the kind of work that they may undertake. While these employer prejudices are slowly being broken down by the numerical weight of the women in the labour market at the present time, there are still many women who unconsciously harbour the thought that these prejudices are valid. If such is the case, it will affect the individual's approach to retraining in certain areas of work, and the social worker must be aware of these.

3. **Illness, Handicap, and Disability**

The medical prognosis of the client's condition is important. If the ailment is degenerative or chronic, there is less likelihood of the worker doing much more than easing the tension of the individual as related to his condition. The area and degree of handicap are also important since these will determine whether or not surgical repair should be attempted. With acute illness, the slowness or rapidity of recovery will affect the worker's treatment plan. The medical treatment of malnutrition, diabetes, anaemia, and the like, and the future prevention or control of such conditions must also be considered as a part of the rehabilitation plan if it is to be successful.
4. Emotional Attitudes

The effect of the client's emotional attitudes on his behaviour has been discussed in Chapter III. Worthy of emphasis is the client's real opinion of his essential self-worth and his resulting acceptance of masculinity. The person with a low opinion of himself may overcompensate and become aggressively masculine, or he may become quite feminine and dependent. Whatever his adjustment may be, it will give rise to feelings of hostility, guilt, or anxiety, which will interfere with his efficient functioning. The degree of this interference will affect the client's progress in the rehabilitation plan, and it may well be that he can never participate in these plans until he learns to cope with this anxiety, fear, tension, hostility, and guilt. The client's attitude towards authority is also important, and it is directly related to the satisfactions that he received as a child from his parents. Unless he has learned by experience to cope with and, to a degree, to resolve his feelings and attitudes in this area, he will find it difficult to enter into the rehabilitation programme.

5. Educational Background

The educational background of the client is helpful in setting up the limits of the vocational training aspects of the rehabilitation programme. Not only does the record of past educational achievements, including apprenticeship, vocational and specialized training as well as formal schooling, give clues as to the type of training that may be embarked on, but
also, it serves to indicate the duration of time that this phase of the rehabilitation process may require. The amount of academic or vocational education that the individual has absorbed during his past education experiences is, of course, relative. But it can, with some degree of accuracy, be determined through the medium of psychometric testing.

6. Employment Skills and Work History

Past employment skills can be lost by the client in two ways: first, through accident or bodily injury to that part of the body utilized to practise the skill, and second, through disuse due to the time that the person has been out of employment in which the skill was used. In the case of accident or injury, it may be possible for the client to concentrate on the learning of new skills which are related in some way to the first, or may require training in an altogether new field. With the second, practice in a sheltered work situation may be all that is necessary to restore the client's confidence and to revive the old skill. The review of the work history of the client can be helpful in determining his stability in a competitive situation, and, when related to employment skills, can serve to evaluate the client's probable ability to undertake a new learning situation.

7. Race and Religion

Racial origin of the client can affect the individual rehabilitation plan. Employer and community prejudice against specific racial groups can negate the whole purpose of the
programme. Fortunately, such prejudices are not so widespread as they were in the past, but they must still be taken into consideration. A language handicap can also be a difficult barrier to overcome, and cultural habits and patterns of some racial groups can interfere with treatment unless the worker makes allowances for such cultural variations.

The religion of the client is another aspect which should be considered. Some religious groups indulge in vastly different and often more restrictive practices than do persons of more orthodox faiths who may constitute the majority of the population of the community. Again, if the worker is not aware of these differences and able to accept them as part of the client's total personality, then he may commit serious blunders which may result in the actual withdrawal of this client from the rehabilitation plan.

8. Morale

Like the term "rehabilitation", morale is commonly, but often loosely, used in current discourse. Generally, morale is thought to be the mental attitude of the individual, indicating the possession of or the lack of confidence, zeal, hope, and courage in himself and in his relationships. Morale appears to be closely related to self-worth, and good morale is typified by the expression of a sense of belonging, of purpose, of objective recognition of capacities, achievements, and limitations on the part of the individual.

The mental, physical, and emotional health of the individual are probably the prime factors affecting his morale.
Environmental and extrinsic influences also play an important part in the composite of his morale. The self-confidence of the individual in himself and in others accompanied by a realistic adjustment to most situations or crises is commensurate with good morale. The possession of an inner sense of security, personal prestige, and self-recognition by the individual promotes good morale. The assurance to him of income and adequate care during a period of illness or disability insures his inner feeling of protection, and as a result, promotes freedom from unnecessary worry and anxiety.

Morale was not discussed in relation to the emotional aspects of rehabilitation in Chapter III. In Appendix A an attempt is made to differentiate between mature, self-centered, and self-deprecatory attitudes relating to individual self-worth, but it does not seem possible to apply such a specific classification to individual morale. Morale seems to be either high or low. A poor or low morale depicts, essentially, self-deprecatory attitudes by the person towards his own self-worth in all or in specific areas of human relationships and behaviour. There is, of course, variance in the intensity of these attitudes. On the other hand, a good or high morale connotes self-confidence and self-respect, an objective view of his own abilities and potentialities, and a recognition and acceptance of his limitations.

However, a self-centered person, whether to a limited degree or in the excess, generally displays a high morale as
far as his opinion of his own self-worth is concerned, but there is little or no acceptance of personal limitations or inadequacies. There is a lack of co-operation with and understanding of others, and as a result, high morale in the self-centered person is chiefly a self-glorification process. Here, again, these exaggerated attitudes exist to a diversifying degree in different individuals.

Naturally, an emotionally mature person also displays a high morale in most instances, but he is not necessarily self-centred, either to a limited or to an excessive degree. Rather, he has good insight and an objective approach to most situations and relationships. He is optimistic, but not unduly so.

Essentially, then, 'morale' is a broader, more expansive view of self-worth as related to all phases or areas of human inter-relationships, of reactions to situations, and of adjustment to ever changing environmental conditions. From the point of view of the worker in the rehabilitation programme, good morale on the part of the client is indicated by his willingness to participate in and to devote his full energies to the task of becoming independent.

E. Rehabilitation Facilities

Quite apart from the ability of the client to utilize the rehabilitation plan and the skill of the social worker in diagnosis and casework treatment, there are many environmental factors which can facilitate the success of the programme. Some of these factors are as follows:
1. **Administration of the Programme**

As noted previously, there are many administrative details which vitally affect the total programme. Of major importance is the philosophical belief of the staff as a whole from the administrator to the social worker, in the inherent value of a rehabilitation programme. Far-sighted legislation can be drafted, a comprehensive programme can be formulated, and an efficient organizational structure can be established, but unless the personnel who are employed to put the thinking into practice have an empathy for the clients who need the service, a rigid interpretation and application of policy may result which will negate the original intention of the planners.

The routine procedures of handling applications, issuing funds, and reviewing continued eligibility will reflect this basic philosophy of the staff, and will permeate the whole programme. A niggardly, depreciatory approach to the clients should be avoided if any attempt at actual rehabilitation is to be made.

Then, too, the actual assistance grants paid to clients must be sufficient to provide for minimal nutritional and housing standards, and must be related in some way to increases or decreases in the actual cost of living. It seems very short-sighted to embark on a rehabilitation programme, make provision for extensive medical care, and so on when the amount of the financial aid is so low that it serves to create the very problems in clients that the balance of the programme is trying to overcome.
It goes without saying that the effectiveness of the rehabilitation programme is directly related to the amount of money available for the programme, and the number of qualified personnel employed to administer it.

2. Co-ordinator of Rehabilitation

This paper has not attempted to explore in detail any specific gaps in the current programme in British Columbia. Nevertheless, a cursory review of the present situation serves to point up considerable lack of co-ordination, not only among programmes operated under private auspices, but also among those within the provincial governmental structure itself.

Certainly, a more intensive study of the actual scheme seems indicated. The development of equivalent rehabilitation facilities in the small towns throughout the province is neither feasible nor very practical. The greater proportion of the population of the province is located in the vicinity of Greater Vancouver and Greater Victoria. Employment which is suitable for handicapped persons is also more readily available in these two areas. Since employment placement in the urban areas likely is necessary for those handicapped individuals residing in rural communities, the development of comprehensive rehabilitative facilities in Vancouver and Victoria would serve two purposes. First, the needs of those persons residing in the neighbourhood of the cities would be met. Second, individuals from rural areas who move to the city for training would be enabled to become acclimatized to urban community living, thus
making easier their transition from dependency to gainful employment.

There are private agencies operating specific physical rehabilitation programmes for adults; for example, the B. C. Cancer Foundation, the Canadian Arthritic and Rheumatism Society, the Canadian National Institute for the Blind, and the Western Society for Physical Rehabilitation. The Children's Hospital and the Queen Alexander Solarium are two private institutions with physical rehabilitation programmes related to meeting the needs of children. The provincial government is functioning in the rehabilitation field through its Division of T. B. Control and V. D. Control as well as through the quasi-provincial department of the Workmen's Compensation Board. This latter agency is expanding its rehabilitation programme rapidly and is presently constructing a new building to house its facilities. The federal government has long been operating rehabilitation programmes for war veterans in the Department of Veterans Affairs' military hospitals. Among all these agencies there is little or no co-ordination, with the exception of the Canadian Arthritic and Rheumatism Society and the Western Society for Physical Rehabilitation which share the same physical facilities.

With reference to the vocational counselling, training and employment placement aspects of rehabilitation, lack of co-ordination is even more obvious. Apart from the provincial Child Guidance Clinic and certain specific agencies which have their own counsellors, the British Columbia Counselling Service
in Vancouver is the only vocational testing and counselling agency with facilities available to the general public. In the vocational training area, only the Vancouver Vocational Institute is designed to meet the need, except for the privately operated commercial schools for specific trades. Most of the employment placement of the handicapped is dealt with by the federal National Employment Service. On the whole, the public assistance agencies in the province make little use of these services.

The Greater Vancouver Community Chest and Council has a voluntary committee dealing with the problem of co-ordination of services, but elsewhere in the province, no such integrated planning exists. It seems essential, therefore, that the provincial government should take immediate steps to develop a staff division within the structure of the Department of Health and Welfare to deal with this problem. The director of the division might well be entitled the Co-ordinator of Rehabilitation. He should be a person who is well qualified and trained in the vocational rehabilitation field, and should also have an appreciation of the function of the social worker.

The Co-ordinator of Rehabilitation would be responsible for the development of three distinct functions within his department. First, he would be responsible for integrating the vocational aspects of the rehabilitation programmes now operated by the Workmen's Compensation Board, the Division of T. B. Control, and the Mental Health Services. In addition, he should institute new services for the use of the Social Welfare Branch,
or expand the present services of the above departments so that this Branch can utilize them. He also should assist with the development of the programme designed to meet the needs of adult and juvenile delinquents in the institutional setting. Second, he would be required to establish a research and statistical unit with adequately trained staff. This unit would not only initiate studies and surveys, and prepare statistical data, but would gather, publish, and circulate to all agencies engaged in this work in the province, material pertinent to the field of rehabilitation. Third, he would act as the liaison person between all agencies to promote co-ordination in the field. His position in this area would be greatly enhanced if he is permitted to disburse funds to these agencies to subsidize certain aspects of current programmes and to establish and develop new facilities where gaps are found to exist.

It is not intended to suggest that the provincial government should relieve the private agencies of the financial burden or of the responsibility for operating their specific programmes. Rather, it is hoped that the organization of an overall planning agency would serve to integrate the present programmes, avoid duplication of services, and stimulate the development of long-range planning in all aspects of the field of rehabilitation in British Columbia.

3. Family Resources

The degree of success in the rehabilitation of clients can be increased by the use of the resources of the client's
own family. Apart from the financial aid that they may be able to give in certain areas, their attitudes to the client and their emotional support and praise of his efforts to improve his situation can be of great help. Such support improves the client's morale and enables him to participate more wholeheartedly in the treatment plan.

Then, too, these relatives may provide such extras as housing, transportation, physical care, special treatment, and so on. If the worker is aware of the fact that clients are people who live in families, and uses his skills to enlist the support and sympathy of the client's family towards the treatment plan, he will be well rewarded with the positive benefits that both he and the client will reap. There are so many little things that families can provide that cannot be budgeted for in the public assistance grant.

4. Community Resources

There are many community organizations which can supplement the resources of the family if the social worker gives the matter some thought. There are service clubs, fraternal organizations, philanthropic societies, and church groups who are willing and anxious to meet some of the needs of public assistance recipients. The organization, planning, and integration of such groups into the rehabilitation programme must be done carefully if the interests of the individual participants are to be maintained and the group's help used effectively.

There are recreational agencies and community centers whose services can be utilized to draw in interested public
assistance clients. Through the facilities of such agencies, special handicap groups can be formed, but there is a danger in segregating the public assistance recipient or the handicapped person which cannot be minimized. This should be avoided if it is at all possible. Such persons should be integrated into the normal programmes of the agency, and thus encouraged to retain contact with other members of the community rather than to withdraw from social relationships. To stimulate the client's interest in the community, and to promote his social relationships, the rehabilitation plan might well consider the importance of such personal factors as general appearance, dress, makeup and cosmetic aspects, the development of "social graces", and the acquisition of some skill in various activities (for example, dancing, cards, games, and so on). The effect of these factors on the client's general morale, and on his success in the overall rehabilitation programme cannot be overlooked.

5. Economic and Employment Conditions

To a degree, the economic conditions of the community and the province have an effect on the rehabilitation plan for the individual client. The demand for goods, the price of commodities, and the availability of markets in which to sell industrially produced articles are of particular interest to the employer. When these are favourable, the employer's business prospers, and he is able to pay adequate wages and to provide full time work for his employees rather than to furnish
employment of merely a sporadic or seasonal nature. The employer tends to expand his business in times of prosperity, and this in turn provides more job opportunities.

Part of the objective of the rehabilitation programme is to train its clients in skills which can be utilized both in times of expansion and in times of recession. However, the job of placement of the client is made easier in periods of full employment and provides a wider range of trades from which he can choose for the purposes of vocational training.

Conditions of employment, such as the attitudes of employers towards handicapped persons, the conditions of industrial plants, the work hazards, and the diversification of industry must be considered by the social worker and by the vocational counsellor. The accessibility of the plant, the nature of the work, and the factors of the specific job, such as the hours of work, days off, sick leave, and break periods are important to the individual client. Sheltered workshops are helpful in carrying the client through the transition period from unemployment to steady work, and, in addition, they provide a setting wherein the older or more handicapped person becomes an active contributor to his maintenance rather than just a passive recipient of assistance from others.

6. **The Medical Care Programme**

All aspects of medical care are vital to the rehabilitation programme. The availability and calibre of the physicians and the medical specialists in all fields directly affect the client's ability to utilize the treatment plan constructively.
Hospitalization, and diagnostic and treatment facilities are important as well as the availability of convalescent and institutional care. Such ancillary services as dental treatment, medical treatment for cosmetic defects, provision of orthopaedic appliances, and optometrical accessories facilitate the client's progress. Some provision must also be made for the re-examination of and the follow-up care for the client as it becomes necessary.

7. The Vocational Counselling and Training Programme

Before vocational training can be embarked on, some assessment of the client's capabilities, aptitudes, and interests must be made. The tests are generally administered by a qualified psychologist who may also fill the role of the vocational counsellor. It is a part of his function to interpret to the client that person's potentialities in the light of currently available employment and possible employment demands in the various fields. Vocational training or retraining is correlated with the psychologist's findings. When the course of study is complete, the job placement is made and the follow-up contacts are maintained with the client to help him with his early adjustments in the work situation.

It will be noted that no attempt has been made to set up ideal or even minimum standards of the physical or vocational phases of rehabilitation. It seems obvious that the maximum of success for any programme of rehabilitation can be expected only when these facilities are available to a reasonable degree.
It is essential that some provision be made for the medical, surgical, and psychiatric care required to improve, in so far as is possible, all physical and mental handicaps. It is important, also, that vocational counselling, training, and employment placement be available. Without these facilities, the job of the social worker generally is limited to the relief of tension, and the true meaning of rehabilitation in the public assistance field can hardly be realized.

F. Subjects for Further Study

It is apparent that much more time must be given to the study of all aspects of the rehabilitation programme before a concrete scheme can be developed in British Columbia. Priority should be given to the study of the various programmes that are presently operating in the province in order to assess more accurately the gaps that exist, and to recommend how these gaps can best be overcome. Such a study would bring to the fore the drastic need for co-ordination, integration, and overall planning as has been suggested in this paper.

The place of a vocational rehabilitation programme in the public assistance agency merits further attention. The statistical material in Chapter II indicated that there was a group of persons receiving financial aid who might have been able to utilize vocational testing, counselling, and training facilities. However, this group should be reviewed over a longer period than was done here from the point of view of the emotional as well as the physical and economic factors affecting
their dependency. A study of this nature is presently being conducted by the Aid to Needy Children Bureau of the California State Department of Public Welfare in co-operation with the Bureau of Vocational Rehabilitation of the California State Department of Education. The material derived from this project might well provide a basis for further study in British Columbia.

With the majority of public assistance clients being more or less permanently dependent, it would also seem advisable to conduct additional research into the need for and the use of facilities which would prevent their becoming totally dependent. Certainly, in the institutional setting alone much can be done to prevent the premature ageing of clients. These activities can include the provision of books, films, games, and barbering and hairdressing services, with facilities available for the formation of friendship, social, interest, and hobby groups. Such programmes can do much to enable the client to maintain contact with reality and with the community about him, and such may even stimulate him to the point where he is able to function on his own and leave the institutional setting.

The development of useful statistics on a province-wide basis seems essential and needs further study. A differentiation should be made between social statistics and financial statistics, and this should be more than just a matter of "counting noses". If adequate statistics were developed, comparisons could be made between the clients of the various municipal and provincial welfare offices, and differences in

the geographic areas in the province would become apparent. In general, much more emphasis should be placed on research in the public welfare field, at least at the provincial level of government if not at the municipal level.

Conclusion

A great deal of emphasis in this study has been placed on the attempt to determine the emotional components of personality development, and to illustrate the effect of these components on the individual's behaviour in relation to his physical and economic situation. The purpose here is not to suggest that the rehabilitation of the client can be attained only through growth towards emotional maturity. Rather, it is intended to bring out forcibly the fact that the client's emotional feelings and reactions have a direct effect on the success or failure of the total rehabilitation plan. Knowledge of these emotional factors can serve as a guide to the social worker, and can prevent him from wasting time pursuing ineffectual goals.

Essentially, it would seem that all behaviour on the part of the individual is the result of his attempts to satisfy his basic needs. Such a person thrives on the love, affection, and acceptance of himself by his fellowmen. Yet, in the culture of Western Civilization, great emphasis is placed on aggressiveness. Such aggressiveness tends to bring about the
denial of love and affection by others. It is the attempt to satisfy the need to be loved in antipathy with the need to be aggressive that results in human behaviour.

From birth, the individual is confronted with the necessity of resolving these conflicting needs. The methods or the behaviour by which he learns to accomplish this in childhood are retained as he matures chronologically, and they shape the adjustive patterns that he adopts towards the reality situations in his life. Such conflicts arouse anxiety and this is directly related to the success of his adjustment methods.

When the client is unsuccessful, the anxiety may become so great that he is immobilized, and he will then regress towards utilizing inappropriate and infantile reactions which, at one time, were successful in meeting his needs. In so doing, he hopes to satisfy his needs and to disburse the anxiety. The task of the social worker is to support the normal functioning of such a person in so far as it is possible and to relieve his anxieties and tensions. He determines the client's difficulties or areas of conflict by observing the degree of anxiety that is aroused in the client in response to conflict situations, and then the worker is able to establish the diagnosis and treatment goal accordingly.

In the public assistance setting, the social worker has the resources of the financial aid programmes to assist him in meeting some of the material needs of the individual, and these can serve to mitigate some of the anxieties. This financial
aid, coupled with the worker's knowledge of the client's difficulties, enables him to help the person to strengthen or to modify his adjustment patterns. Thus, the fundamental objective of the rehabilitation programme for the emotionally dependent is more closely reached, for the client then is better able to compete successfully with others, to resolve his inner conflicts, and to satisfy his own individual needs.

The importance of the effect of the social worker's own attitudes on the client in the diagnostic and treatment process cannot be overlooked. Unless the social worker is aware of his own attitudes and feelings, and disciplines himself accordingly, he can completely negate the rehabilitative aspects of the public assistance programme. Instead of helping the client to build new adaptive patterns, he only succeeds in reinforcing the unhealthy defense mechanisms that the client has already set up. Instead of enabling the client to become independent, he forces him further into a state of dependency.

However, it has not been the intention here to deal with the role of the caseworker and with casework treatment as such; neither is it within the boundaries of this treatise to attempt to interpret the caseworker's direct influence on the client. Rather, the purpose has been to show that the emotional factors contributing to the individual's personality do affect the degree of success of the rehabilitation plan. It is hoped that in the future a broader and more comprehensive
view of all factors contributing to the rehabilitation programme will be considered by the public assistance agency. But it must be remembered that although the social worker can help to a great extent in guiding persons to a more useful, independent, and satisfying way of life, he is limited to working with the material at hand, and he is bounded by the client's own level of maturity, by the individual physical or mental handicap, and by the existing economic and environmental situation. Thus, although the worker can do much, he cannot be expected to perform miracles in the area of the total rehabilitation of the public assistance recipient.
APPENDIX A

A RATING SCALE OF EMOTIONAL MATURITY

During the process of evaluating the emotional factors of dependency of the individuals outlined in the case histories in Chapter III, some considerable difficulty was encountered when an attempt was made to compare the levels of emotional development of these different persons and to determine the treatment goals applicable to each. Comparison was almost impossible as each worker had recorded the varied reactions of the clients in many different and often unrelated reality situations. The solution to the problem appeared to lie in the determination of common areas in which individual human behaviour could be observed and recorded as objectively as possible. It is pertinent, then, to first consider a brief discussion of normality, emotional maturity, and neurotic trends. A rating scale for assessing the client's emotional maturity is suggested as a possible guide to assist the social worker in refining his diagnosis of the client's problems, and to determine more accurately from a subjective point of view a valid and practical treatment goal for the possible rehabilitation of the client.
A. Aspects of Normality and Emotional Maturity

It has been suggested that emotional maturity is but one aspect of normality and, while this paper is essentially interested in discussing emotional maturity as related to dependency, it seems desirable to consider all the aspects of normality. Dr. Maurice Levine notes that normality can only be a relative approximation based on statistical averages of groups if such averages are not contrary to individual health. It includes physical normality, that is, the presence of good structure, function, and maturity, and the absence of physical disease; intellectual normality, with relative freedom from neurotic or psychotic symptoms; and emotional maturity.

The same author continues with a discussion of some of the essential points of emotional maturity. He suggests that emotional maturity in each individual may be determined by that individual's ability to be guided by reality rather than by wishes and fears, by his ability to live in terms of long-term values rather than short-term values, and by the display of a grown-up conscience instead of one of a childhood variety. Further evidences of emotional maturity are the ability to be independent, the capacity to love someone other than oneself, and the display of only moderate reactions of fear and hatred. Finally, Dr. Levine states that the capacity to be reasonably

2 Ibid., pp. 18-25.
dependent on others, to use healthy defense mechanisms, to have a good sexual adjustment, and a good work adjustment are other aspects of emotional maturity. He further notes that there are other facets of maturity not mentioned here, such as dependability, the capacity to meet emergencies, the acceptance of individual differences, the capacity to learn by experience, the capacity to persevere and carry through, and the integration of contrary drives, but he proposes that these are fundamentally aspects of those factors already presented.

B. Neurotic Trends

Before attempting to draw up criteria by which to evaluate an individual's emotional level in relation to maturity, it is worthwhile to consider some of the deviations from the normal. Dr. Karen Horney suggests that there are at least ten neurotic trends of behaviour.¹ These trends are related to the need for affection and approval, the need to be dependent on someone else, the need to restrict one's life within narrow borders, the need for power, and the need to exploit other persons. Other trends are those related to the need for social recognition or prestige, the need for personal admiration, the ambition for personal achievement, the need for self-sufficiency and independence, and the need for perfection and unassailability.

¹ Horney, Karen, Self-Analysis, W.W. Norton, New York, 1942, pp. 54-60.
The author points out by examples that it is the extremes of individual behaviour in these areas that are neurotic. She stresses that all persons tend towards one type of behaviour or another, and that several types of reactions may be present in varying degrees in the same person. However, while the objectives may be the same for the neurotic and the normal person, the basis and the meaning of the strivings are entirely different. The neurotic goals are not what the person really wants, but rather, they are what he is driven to in order to maintain an equilibrium between his inner drives and outer restraints.

While the above noted criteria of Levine and Horney are helpful to the social worker in the determination of emotional maturity and the recognition of neurotic behaviour, no directions of enquiry for each individual case are indicated. If the worker wishes to compare the emotional development of different clients, or of the same client at different intervals, it would seem to be essential that he consider the client's particular behaviour in certain distinct areas.

C. Scale of Assessment of Emotional Maturity

For comparative purposes, it is proposed that objective descriptions can be made of an individual's attitudes, feelings, or behaviour in the four areas of sexual adjustment, achievement, relationships with others in his environment, and
evaluation of personal self-worth. For the sake of brevity, these areas will be referred to as sexual adjustment, achievement, social consciousness, and self-worth in the balance of the text. A five point scale has been drawn up for each one of these areas (Schedules A, B, C, and D). In the following discussion, the pronoun "he" has been used throughout to signify both male and female persons, thus simplifying the task of writing. The context, therefore, must be altered where necessary when evaluating a female client.

Attitudes and behaviour depicting excessive and limited self-centeredness are set at one end of the scale, while those typifying excessive and limited self-depreciation are placed at the other. Emotionally mature behaviour is interposed between the two extremes.

1. Sexual Adjustment

In the area of sexual adjustment, it is suggested that the emotionally mature person enjoys a hetero-sexual partnership, and has the capacity to give and to receive love and affection. He has a normal sex urge and a desire for love and
sexual satisfaction. The co-operative relationship involves mutual understanding, and promotes the growth and development of shared sexual pleasures and satisfactions. The sexual act itself is satisfying for the most part to both the individual and to his partner. He also has accepted the importance of his own sex role, and has a mature appreciation of the fact that men and women each have their own assets and limitations.

The sexual adjustment of the excessively self-centered individual is related to the gratification of the self only, with little or no capacity to give love and affection to others. He needs to be aggressive in the sexual act and thus to dominate the partner completely. There, perhaps, is considerable evidence of promiscuity on the part of this person, and he likely is inclined to boast of the number of sexual conquests or orgasms he has per night. The individual also is probably actively homosexual, generally being the aggressor in the relationship. Such a person usually practises frequent masturbation with the exclusion of hetero-sexual intercourse.

Limited self-centeredness in the area of sexual adjustment implies that the individual has partial insight into his partner's sexual needs, but that he is predominantly concerned with self-gratification. Likely, he desires a quick repetition of the sexual act, and may indulge in occasional "affairs". He may evidence some degree of masturbation accompanied by occasional sexual intercourse.

At the other end of the scale is the person who is excessively self-depreciating in his sexual adjustment. He
lacks the capacity to receive love and affection, and is unable to enter into a satisfactory relationship. He evidences severe inner tension and feelings of inadequacy which may result in impotency. If he indulges in homosexual practice, he is the passive partner.

The individual whose role is that of limited self-depreciation in the sexual adjustment area is one who is unsure of himself in the sexual act. He probably has some feelings of guilt or anxiety due to repression of the sexual drive, with inner tension limiting free expression. Such a person encounters difficulty in relaxing in the love relationship and gains little, if any, real satisfaction from it.

2. **Achievement**

Emotional maturity in the area of achievement is typified by the display of a good sense of goal with clarity of purpose on the part of the individual. He displays a desire for efficiency and an avoidance of waste. Money is regarded by him as a means to an end and not the end in itself. His judgement and sense of proportion is good, and he has the capacity to evaluate realistically his assets and liabilities. He appreciates his own abilities and skills, and shows a reasonable degree of self-confidence in most situations. He harbours reasonably strong impulses to grow and to improve, and learns by experience to adapt his behaviour to outside stimuli and situations. He is able to maintain a steady and sustained effort over a reasonable period of time, aided by systematic organization of his work and by his ability to plan and concentrate on the matter in question.
He exhibits a sense of responsibility, and has a capacity for independent unsupervised activity. He is dependable, adaptable, flexible, and resourceful in meeting most emergencies as well as capable of admitting an error or mistake in judgement. While he expresses some ambivalence, he is able to weigh the reality factors in the situation and arrive at a logical decision. He is able to accept frustration and postponement of plans most of the time.

The grading of excessive self-centeredness in the area of achievement is indicated when the individual displays an excessive sense of goal for the purpose of self-glorification. He expresses the belief that he is infallible or that he is omnipotent and can do no wrong. Achievement becomes an obsession, and to attain this goal, he drives himself relentlessly, exhibiting destructive tendencies towards the plans, the ideas, and the success of his competitors.

Behaviour indicative of some sense of goal and achievement on the part of the client falls in the classification of limited self-centeredness. Such a person likely is unduly optimistic, and while he has a certain drive towards achievement it is irregular and not sustained. He has some ability to meet emergencies, but is inclined to exercise snap-judgements, and hence, needs considerable supervision. While he is adaptable to a degree, he tends to be rather rigid and to resist change. His decision is influenced by the possible gain for self.
The person who is excessively self-depreciating is one who finds no personal satisfactions in achievement. He has no sense of goal, and can assume no responsibility. Hence, he needs constant supervision in the employment situation. He always works in jobs which are below his actual capacity, and occasionally, he over-works to compensate for his feelings of anxiety and inadequacy. He is not dependable, and finds it difficult to complete the particular task. Frustration or postponement of plans results in regression to childish attitudes and irresponsibility. He tends to seek dependency, and to resist any attempt to encourage his independence.

The classification of limited self-depreciation infers the display of uneven ability on the part of the client to relate to particular situations. In other words, the client lacks initiative, is unable to plan a job and to concentrate on a task, and is unsystematic and disorganized most of the time. On occasion, he does show some degree of purpose, although it is very limited. Usually he needs supervision in the work situation. He is unduly pessimistic, and belittles his own capabilities and potentialities. He is easily satisfied and has a tendency to drift along.

3. Social Consciousness

The attitudes and feelings of the individual that affect his relationships with other persons in his environment are classified as being in the area of social consciousness. The emotionally mature person expresses a sense of give and take in his inter-personal relationships. He is able to make friends
easily and get along with people of different economic, religious, racial, and cultural backgrounds. He generally is lacking in prejudice and can accept individual differences in his fellow men. He displays a considerable degree of sympathy, understanding, honesty, and integrity. He can be attentive and imaginative, and has a good sense of humour. He has the capacity to see the point of view of others, and can show deference and humility when necessary. He can give praise when it is deserved, and in turn, he can accept advice and criticism when it is pertinent and merited. He may display moderate reactions of anger and hatred, but he can redirect them into positive channels. He is reasonably self-assertive in his relationships with others, but he is also willing to compromise when it is discerning to do so.

The excessively self-centered individual has an inflated image of himself in relation to all others in his environment. His interest in social intercourse is limited to self-gain. He feels superior to others because, to his mind, he is perfect. He is generally inclined to be very aggressive, and craves to dominate others in his environment. His relationship with others is characterized by attitudes on his part of antagonism, restriction, and denial. He commands and orders his subordinates without regard for them as individuals. Such a person exhibits frequent outbursts of temper, anger, and hatred, without real justification. Generally, he is completely disrespectful of the rights of others. He expresses marked disapproval of the
actions and desires of those with whom he comes in contact. He is very prejudiced and biased, and is not cognizant of individual differences. He is actively critical of others without just cause, but he can not accept criticism or advice himself. He is skeptical, sarcastic, jealous, and envious. He is excessively formal and ritualistic since the difference and separateness of himself from others is his one source of security. He values everyone and everything in terms of how he can make use of them. He is unco-operative, and reveals no ability to "give and take".

A person exhibiting limited self-centeredness is successful in some inter-personal relationships, but is inclined to show immature behaviour in most situations. He is aggressive in some areas, and finds it difficult to accept criticism and advice. He is ambivalent to a degree, and shows some envy and jealousy of others. He is indifferent to others a great deal of the time and daydreams considerably. He is also rather distant and sullen on occasion. He tries to control others by flattery and pretense when he feels he has to compete with those about him in social relationships.

The person displaying excessive self-depreciation places total emphasis on the positive abilities of others in contrast to his own. His evaluation of himself is entirely dependent upon his acceptance by others. He feels that any frustration is indicative of personal dislike or discrimination on the part of others. He severely represses his own feelings, and is excessively submissive or excessively amiable and willing to
give in. He has no opinions of his own, and dreads making demands of others or of asserting himself. He is extremely fearful of hostility, criticism, or reproach on the part of others in his environment, and is continually disparaging of himself and his efforts in order to compete with others socially.

With reference to limited self-depreciation, an individual in this area has the tendency to be dependent, and to relate to others on an infantile level. He represses his feelings in some areas of his social consciousness and tends to be reserved. He lacks the ability to be self-assertive or aggressive. He prefers to remain inconspicuous, is modest, and is prone to belittle his abilities in relation to those of others. He is lacking in imagination, and accepts criticism too readily, usually without question. He finds it hard to move out towards others and hence, he has difficulty in making and holding friends.

4. Self-Worth

The area of self-worth is that area which involves the individual's feelings and attitudes towards his own value and position in relation to his environment and to society and his fellow men. The emotionally mature person has a good opinion of himself as is shown by his display of self-esteem, self-respect, and by his self-confidence in his own abilities and potentialities. He has the emotional capacity for looking at himself objectively in relation to others and to his environment.
He adopts a "common sense" viewpoint, possesses a grown-up conscience, and shows stability in balancing inner conflicts with outer pressures. He has good insight, and can admit most of his inner feelings and conflicts even though it may be painful for him to do so. He utilizes only those defense mechanisms which are not harmful to his emotional growth. He can accept criticism, and does not conclude that he is totally unworthy because of censure. He shows a capacity for self-assertion and self-criticism, and, on the whole, can recognize his own capacities and limitations. Basically, he is able to accept the masculine role.

The excessively self-centred person is primarily narcissistic. He has an exaggerated opinion of his self-worth, and is absorbed in worshipping his personal perfections. He is dogmatic and bigoted regarding his opinions. He is always self-sufficient, never makes mistakes, and cannot accept criticism. He is resistant to change, and is often negativistic and rebellious towards any intimated correction of inadequacies or suggested improvements in the situation. He reveals many defense mechanisms which he uses frequently. He projects his mistakes, failures, and shortcomings onto others. He has no sense of humour and no insight into his inner feelings and conflicts. He is excessively masculine to compensate for his feelings of inadequacy regarding the masculine role. It might be noted here, that in the female client, exaggerated femininity may manifest itself, but, that in many such excessively self-centered persons, especially where there is a rejection of the
feminine role, a marked tendency towards characteristic masculine behavior sometimes occurs.

The individual who indicates limited self-centeredness in this area is self-confident in some situations, and defends his self-esteem to some degree. He has unwarranted attitudes of superiority at times, but he is generally aware of his own feelings in those situations where there is no threat or pain to himself personally. He employs harmful defense mechanisms to a limited degree.

The excessively self-deprecating individual lacks self-esteem to a marked degree and is overly self-critical. He is very insecure in most situations, and may try to over-compensate for real or supposed inadequacies. He is inclined to be depressed and to indulge in excessive self-punishment. He has intense feelings of inferiority, and displays severe anxiety states and extreme tension. He represses, distorts, and displaces his real feelings, having no insight into what his real feelings are. He dreads the possibility of his being inadequate, of his being humiliated, or of his being a failure. He is afraid of the unknown and of new situations. He may be excessively feminine as he cannot accept the masculine role. On the other hand, the female client who is excessively self-deprecating does not take on the masculine role, but rather, also tends to emphasize the feminine and to simulate an exaggerated attitude of submissiveness.

Limited self-deprecation in self-worth is recognized
in the person who shows some inner conflicts and insecurity when facing new or previously difficult situations. He has some feelings of inferiority and inadequacy. He lacks the capacity to integrate conflicting drives, those drives that by the mature person are sublimated and redirected into positive channels. He feels that personal limitations block self-expression and self-assertion. He expresses little sense of humour. He has mixed feelings regarding masculinity and femininity, with the feminine aspects occasionally out-weighting the masculine.

Conclusion

Briefly, this study suggests that the emotional maturity of the individual may be rated with some degree of objectivity if the social worker on intake notes the client’s specific behaviour, attitudes, and responses in the general areas of sexual adjustment, achievement, social consciousness, and self-worth. The classifications of excessive self-centeredness, limited self-centeredness, emotional maturity, limited self-depreciation, and excessive self-depreciation are proposed in order to give a clearer picture of the client’s general reactive patterns in the above areas (Schedules A, B, C, and D).

Such a subjective description of the client would enable the intake worker to diagnose more accurately the client’s underlying personal and emotional problems. The
intake worker and the casework supervisor are then better able to determine with some degree of precision desirable and appropriate treatment goals in relation to the professional skills of the social workers employed by the agency. In the intake process, the worker may facilitate the casework treatment to be planned for the client by summarizing on a chart the information as it is elicited from him (Schedule E). Such a concise description of the client would be an aid to the social worker to whom the client is assigned. As is noted on the chart, however, a complete and comprehensive appraisal of the client's emotional level should be evaluated in detail in the recording of the client's file. Thus, it is hoped that with a deeper understanding of the client in all his relationships with others and his environment, the social worker is enabled to carry out effectively a broader, more intensive treatment programme in the rehabilitation field.
Schedule A. Sexual Adjustment

**Excessive Self-centeredness:** The individual displays
1. a marked lack of capacity to give love and affection.
2. a concern with self-gratification only in the sexual relationship.
3. aggressiveness and the need to dominate in the sexual act.
4. a marked inclination to boast of orgasms and sexual conquests.
5. promiscuous behaviour.
6. active homosexual tendencies wherein he is the aggressor.
7. excessive masturbatory tendencies to the exclusion of hetero-sexual intercourse.

**Limited Self-centeredness:** The individual displays
1. partial insight into the needs of the sexual partner.
2. a tendency towards self-gratification.
3. a desire for frequent repetition of the sex act.
4. a tendency towards masturbation with some hetero-sexual intercourse.
5. the need for occasional "affairs".

**Mature Behaviour:** The individual displays
1. the ability to give and take in the hetero-sexual relationship.
2. the capacity to give and receive love and affection.
3. a normal sex urge and a desire for love and sexual satisfaction.
4. a co-operative attitude leading to understanding, growth, and the development of shared sexual experiences.
5. satisfaction in the sexual act with concern for satisfaction of sexual partner.
6. the ability to accept his own sex role.
7. a mature appreciation of the fact that men and women each have their own assets and limitations.

**Limited Self-depreciation:** The individual displays
1. insecurity in sexual relationships.
2. some feelings of guilt or anxiety due to repressed urges.
3. some inner tension limiting free expression.
4. difficulty in relaxing in the love relationship.

**Excessive Self-depreciation:** The individual displays
1. a marked inability to receive love and affection.
2. an inability to enter into a satisfactory relationship leading to frustration of self and sexual partner.
3. severe inner tension and feelings of inadequacy.
4. impotency.
5. active homosexual tendencies wherein he is the passive partner.
Schedule B. Achievement

<table>
<thead>
<tr>
<th>Excessive Self-centeredness:</th>
<th>The individual displays</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. excessive glorification of self and achievements.</td>
<td></td>
</tr>
<tr>
<td>2. complete belief in own infallibility.</td>
<td></td>
</tr>
<tr>
<td>3. emphasis on own magic power of will.</td>
<td></td>
</tr>
<tr>
<td>4. an obsession with achievement regardless of means.</td>
<td></td>
</tr>
<tr>
<td>5. destructive tendencies to defeat all others.</td>
<td></td>
</tr>
<tr>
<td>6. a pride in own exploitative skill.</td>
<td></td>
</tr>
<tr>
<td>7. admiration for strength and power and contempt for weakness.</td>
<td></td>
</tr>
<tr>
<td>8. inability to admit personal errors or mistakes.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Limited Self-centeredness:</th>
<th>The individual displays</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. some sense of goal and achievement.</td>
<td></td>
</tr>
<tr>
<td>2. undue optimism.</td>
<td></td>
</tr>
<tr>
<td>3. irregular drive for achievement.</td>
<td></td>
</tr>
<tr>
<td>4. a tendency to act impulsively.</td>
<td></td>
</tr>
<tr>
<td>5. some adaptability, but is generally rigid.</td>
<td></td>
</tr>
<tr>
<td>6. the need for supervision of work.</td>
<td></td>
</tr>
<tr>
<td>7. a tendency to let self-benefit weight thinking.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mature Behaviour:</th>
<th>The individual displays</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. a good sense of goal with clarity and self-confidence.</td>
<td></td>
</tr>
<tr>
<td>2. a desire for efficiency and avoidance of waste.</td>
<td></td>
</tr>
<tr>
<td>3. a regard for money as a means to an end.</td>
<td></td>
</tr>
<tr>
<td>4. the ability to enjoy work as such.</td>
<td></td>
</tr>
<tr>
<td>5. good judgement and ability to evaluate realistically.</td>
<td></td>
</tr>
<tr>
<td>6. an appreciation of own ability and skills.</td>
<td></td>
</tr>
<tr>
<td>7. reasonably strong impulses to improve performance.</td>
<td></td>
</tr>
<tr>
<td>8. a capacity to learn by experience.</td>
<td></td>
</tr>
<tr>
<td>9. a capacity for sustained effort.</td>
<td></td>
</tr>
<tr>
<td>10. a sense of responsibility without close supervision.</td>
<td></td>
</tr>
<tr>
<td>11. some ambivalence with ability to weigh reality factors.</td>
<td></td>
</tr>
<tr>
<td>12. a willingness to accept change.</td>
<td></td>
</tr>
<tr>
<td>13. an ability to accept frustration.</td>
<td></td>
</tr>
<tr>
<td>14. an ability to admit personal errors or mistakes.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Limited Self-deprecation:</th>
<th>The individual displays</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. an uneven ability depending on the personal meaning of the situation.</td>
<td></td>
</tr>
<tr>
<td>2. an uneven sense of goal and achievement.</td>
<td></td>
</tr>
<tr>
<td>3. a tendency to save rather than spend.</td>
<td></td>
</tr>
<tr>
<td>4. undue pessimism.</td>
<td></td>
</tr>
<tr>
<td>5. a tendency to be easily satisfied and drift along.</td>
<td></td>
</tr>
<tr>
<td>6. a tendency to belittle own capacities or potentialities.</td>
<td></td>
</tr>
<tr>
<td>7. capabilities and capacities but cannot use them.</td>
<td></td>
</tr>
</tbody>
</table>

continued
Schedule B. Achievement

continued

Excessive Self-deprecation: The individual displays
1. no personal satisfaction in achievement.
2. no sense of goal or responsibility.
3. a marked inability to learn by experience.
4. a tendency to work in jobs beneath his capacity.
5. inability to complete tasks without supervision.
6. inability to be dependable
7. inability to accept frustration or postponement of plans.
8. a tendency to regress to childish behaviour.
9. a tendency to fight against the development of independence.
Schedule C. Social Consciousness

<table>
<thead>
<tr>
<th>Excessive Self-centeredness: The individual displays</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. an interest in self-gain only.</td>
</tr>
<tr>
<td>2. marked aggressive tendencies and domination of others.</td>
</tr>
<tr>
<td>3. complete disrespect for others.</td>
</tr>
<tr>
<td>4. excessive formality to maintain security.</td>
</tr>
<tr>
<td>5. a tendency to evaluate all things in terms of prestige.</td>
</tr>
<tr>
<td>6. a marked lack of co-operation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Limited Self-centeredness: The individual displays</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. some immaturity in relationships with others.</td>
</tr>
<tr>
<td>2. marked ambivalence with envy and jealousy.</td>
</tr>
<tr>
<td>3. aggression in some areas.</td>
</tr>
<tr>
<td>4. difficulty in accepting criticism and advice.</td>
</tr>
<tr>
<td>5. indifferent sullen behaviour.</td>
</tr>
<tr>
<td>6. a tendency to disrupt and interrupt others.</td>
</tr>
<tr>
<td>7. a tendency to control by flattery and pretense.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mature Behaviour: The individual displays</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. inter-dependence in relationships.</td>
</tr>
<tr>
<td>2. gratification from inter-personal relationships.</td>
</tr>
<tr>
<td>3. an ability to make friends easily.</td>
</tr>
<tr>
<td>4. an ability to accept individual differences without prejudice.</td>
</tr>
<tr>
<td>5. a considerable degree of sympathy and understanding.</td>
</tr>
<tr>
<td>6. honesty and integrity in relationships.</td>
</tr>
<tr>
<td>7. a sense of humour.</td>
</tr>
<tr>
<td>8. attentiveness and imagination.</td>
</tr>
<tr>
<td>9. a capacity to see the point of view of others.</td>
</tr>
<tr>
<td>10. a desire for absence of restraint imposed by others.</td>
</tr>
<tr>
<td>11. moderate realistic reactions of anger and fear.</td>
</tr>
<tr>
<td>12. reasonable self-assertion.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Limited Self-deprecation: The individual displays</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. some need for dependency.</td>
</tr>
<tr>
<td>2. some repression in certain relationships.</td>
</tr>
<tr>
<td>3. a lack of self-assertion.</td>
</tr>
<tr>
<td>4. a preference for remaining inconspicuous.</td>
</tr>
<tr>
<td>5. a tendency to belittle own social capacities.</td>
</tr>
<tr>
<td>6. a lack of attention.</td>
</tr>
<tr>
<td>7. a lack of imagination.</td>
</tr>
<tr>
<td>8. a tendency to accept criticism too readily.</td>
</tr>
<tr>
<td>9. frequent untoward unrealistic responses.</td>
</tr>
<tr>
<td>10. difficulty in making and holding friends.</td>
</tr>
</tbody>
</table>
### Excessive Self-depreciation:

The individual displays

1. a marked tendency to devalue self.
2. marked feelings that frustration indicates dislike by others.
3. marked repression when relating to others.
4. marked fear of asserting self.
5. marked fear of hostility and criticism from others.
6. a marked lack of inter-personal relationships.
7. a marked tendency to continually disparage self.
### Schedule D. Self-Worth

#### Excessive Self-Centeredness:
The individual displays
1. an exaggerated opinion of his own self-worth
2. a tendency to be dogmatic and bigoted in his opinion.
3. an appearance of being very self-reliant.
4. the use of many rigid defense mechanisms.
5. no insight into own feelings and conflicts.
6. marked use of projection for failures and mistakes.

#### Limited Self-depreciation:
The individual displays
1. some confidence in self.
2. a tendency to defend self-esteem.
3. some feelings of superiority in some areas.
4. some awareness of inner feelings in areas that are not painful.
5. the use of some defense mechanisms.

#### Mature Behaviour:
The individual displays
1. a good but not inflated opinion of self.
2. the capacity to look at self objectively.
3. good insight into inner feelings and conflicts.
4. the use of unharful defense mechanisms.
5. an ability to accept criticism without tension.
6. a capacity for self-criticism.
7. a capacity for self-assertion.
8. an ability to recognize own capacities.
9. an ability to recognize own limitations.
10. an ability to accept own masculinity or femininity.

#### Limited Self-depreciation:
The individual displays
1. some tendency to depreciate self.
2. some anxiety over frustrations and insecurity when facing new situations.
3. some feelings of inferiority and anxiety.
4. a lack of capacity to integrate conflicting drives.
5. some blocking over self-assertion and expression.

#### Excessive Self-depreciation:
The individual displays
1. a marked lack of self-esteem and is very self-critical.
2. marked insecurity in most situations.
3. intense feelings of inferiority.
4. severe anxiety states and marked tension.
5. a tendency to displace and repress real feelings.
6. marked rejection of masculinity or femininity.
7. a marked fear of inadequacy, failure, the unknown or new situations.
Schedule E. **Evaluation Chart of Emotional Level**

<table>
<thead>
<tr>
<th></th>
<th>Sexual adjustment</th>
<th>Achievement</th>
<th>Social Consciousness</th>
<th>Self-Worth</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Excessive Self-Centeredness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Limited Self-Centeredness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mature Behaviour</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Limited Self Depreciation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Excessive Self Depreciation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **Note:** It is suggested that this type of chart be used by the social worker to summarize the client's emotional responses as they are elicited. Annotated descriptions of behaviour similar to those outlined in Schedules A, B, C, and D could be briefly consolidated on this sheet. A complete and comprehensive appraisal of the client's emotional level would be evaluated in detail in the recording.
APPENDIX B

BIBLIOGRAPHY

Books


---


Articles


Shimberg, Myra E., "The Employment Program of the New York City Department of Welfare", Public Welfare, October, 1951, vol. 9, p. 188.


Statutes

Revised Statutes of British Columbia, 1948, Chapter 310 (The Social Assistance Act).