RHEUMATIC HEART DISEASE: THE MEANING OF THIS ILLNESS TO PATIENTS AND THEIR FAMILIES

A Study of Male Adult Patients With Rheumatic Heart Disease Admitted to Shaughnessy Hospital (1948 - 1951)

by

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ABSTRACT

The purpose of this study has been to determine, (1) whether there is a connection between a patient's social and personal background and his susceptibility to rheumatic heart disease, (2) whether emotion-producing conditions affect the development and later recurrences of this disease, (3) what the relationship is between specific social and personal pressures and the course of a rheumatic heart patient's illness, and (4) what the social worker can contribute towards alleviating these emotion-producing conditions affecting the patient's illness. Because of the limitations encountered, e.g. incomplete social histories, it has not been possible to determine the first of these.

All patients (25) with rheumatic heart disease who were referred for medical social service at Shaughnessy hospital through a four-year period (1947-1951), have been selected for this study. An analysis of all available records of various branches of the department of veterans' affairs interested in the welfare of these patients, has been made. Material selected has been confined to three broad areas in the patients' lives, (1) early personality formation, (2) social and personal stress surrounding the onset, and (3) social services employed in alleviating emotional stress of patients and their families.

The findings of this study indicate that an ever-increasing cycle of social problems affect the rheumatic heart patient, following the onset of his illness. Economic difficulties form the major source of emotional stress, and these in turn affect and are affected by the earning capacity of physically-limited, chronically-diseased patients. There are indications of personality factors reacting upon the ability of the patients to accept the limitations of their illness and the demands of mature adulthood.

Although this study concerns itself only with war veterans, the majority of the findings are applicable to all patients afflicted with rheumatic heart disease. Included here are, (1) the need for adequate resources, e.g. financial grants, convalescent centres, suitable housing, light employment and retraining programmes, (2) the need for more social workers as well as professionally trained social workers to insure proper use of available resources, (3) the need for more research not only with all rheumatic heart patients but with all forms of chronic illness, and (4) the need for preventive measures e.g. through education, and early diagnosis and treatment of social and personal problems. Problems resulting from increased financial grants given to veteran patients undergoing hospital care, and limitations in medical social service recording under the department of veterans' affairs, are two specific findings which are mainly applicable to the veteran.

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CHAPTER 1

INTRODUCTION

For several centuries rheumatic fever has been[a] recognized but misunderstood disease. At first it was thought to affect only the joints of the body, but it was not until the late eighteenth and early nineteenth centuries that damage to the heart was observed. Even after more advanced discoveries were made, for many years arthritis was considered to be the essential feature of rheumatic fever and heart involvement merely a "complication". It is only recently that carditis has assumed its proper place as the most important of the rheumatic infections.[1]

One recent study estimates that ninety per cent of the defective hearts in children are rheumatic in nature.[2] It is also estimated that rheumatic heart disease is the second most prevalent form of heart disease in adults. (i.e. thirty per cent). About ninety per cent of the disease occurs in patients before they reach fifty years of age, and deaths are most prevalent within the first four decades. At least 75 per cent of all RHD patients[3] have one or more recurrent bouts of disease. In an age where the young breadwinner finds it

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1 William D. Stroud, Diagnosis and Treatment of Cardiovascular Disease, Vol. 1, 3rd ed., pp. 70-71.

2 R. L. Cecil, "Rheumatic Heart Disease", Textbook of Medicine, pp. 1185-1192.

3 For convenience, the abbreviation RHD is used as a substitute for the term rheumatic heart disease.

difficult enough to maintain his economic equilibrium, the added burden of a chronic illness, together with the prospect of short life span, presents a serious problem for individuals, their families, and society.

Although much research on the medical aspects of this disease has been done,[1] still the perfect treatment programme has not been found. As the medical profession has gained increased recognition of the need to examine the "total" patient, there has been a greater awareness that physical medicine is not the complete solution to this pressing problem. More work still needs to be done in the relatively unknown areas of the social and emotional influences affecting the course of a patient's illness. In this respect, some research has been done on the emotional factors contributing to causation and care of rheumatic disease in children,[2] yet very little written material of a similar nature is available on the male adult RHD patient.

The purpose of this present study, is to add something to the greater understanding of the social and emotional factors of RHD in male adults. This study seeks to determine, (1) whether there is a connection between an RHD patient's social and personal background and his susceptibility to RHD, (2)

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1 For a summary of the medical aspects involved in Rheumatic Heart Disease, refer to Appendix A.

2 Elizabeth Richardson in her article, "A Social Worker Looks at Psychosomatic Medicine", Canadian Welfare, pp. 20-25, estimates that approximately 85 per cent of rheumatically diseased children show signs of emotional upsets.

whether emotion-producing conditions affect the development and later recurrences of this disease, (3) what the specific relationship is between these social and personal factors and the course of an RHD patient's illness, and (4) what the social worker can contribute towards alleviating these stresses and strains affecting the patient's illness.

The value to the RHD patient of such a project is unquestionable, for any research which is directed towards the amelioration of his illness serves this purpose. To the patient's "family" - his relatives, friends and other community members - insight into the "total" reactions of the patient, should create new light on the part they play in encouraging or hampering causation and treatment. To the rest of society, there is a need for such a study, not only from the standpoint of pure enlightenment, but also from the economic advantage which is gained. The aid which is given the male adult allows him to function more-adequately as the breadwinner of his family. He is then better able to become a contributing member of society rather than one who must constantly remain dependent upon others for the physical and emotional well-being of himself and his family.

Unfortunately the total acceptance or understanding of concomitant causes other than the purely physical by the public in general, is far from complete. Part of the blame for this is due to the lack of research allotted to the social sciences. Whereas vast sums of money have been spent to bring the field of scientific medicine to the position it is today, public apathy has allowed investigation into the social aspects of

disease to lag far behind. In Canada, as well as in other countries, the stigma connected with mental incompetence has greatly affected this lack of development. Any chronically-ill person who can admit to himself that he is unable to face reality and seeks escape from his social and emotional problems through various physical manifestations, undergoes an extremely "painful" mental process. On the other hand, more social acceptance is gained by such a person when he has been pronounced medically unfit through no fault of his own. Further acceptance is given to his unfortunate encumbrance by the necessary attention doctors, nurses, etc., provide. The case of the RHD patient described in Chapter 3, is a good example of this enigma.[1]

The Patient - As - A Whole

Before an assessment of the meaning of illness to RHD patients and their families can be made, some clarification on what is meant by the terms illness and disease, is necessary. Illness has been defined by Flanders Dunbar, "as the deviation from health or from a state in which all natural activity and functions are performed freely and efficiently without pain or discomfort". Disease, on the other hand, is the "abnormal state of the body resulting from harmful effects of the processes, injurious substances or accidents".[2] From these definitions it follows that illness is the subjective or affective

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1 See p. (49).

2 Flanders Dunbar, Emotions and Bodily Changes, 1946, intro. to 3rd edition, p. XlX.

reaction of the individual, whereas disease is the objective observable reaction. As C. G. Robinson has pointed out, illness, therefore, is greater than disease because it can exist with or without objective recognition by others.[1]

Involved here, is an awareness of the total environmental and hereditary forces which affect the individual with RHD or any other disease. This multiple approach to illness is what is meant by the term, the patient - as - a whole. The individual meaning which his illness holds for him, must be examined and treated if the effect of the disease is to be completely understood. The way he feels as a result of his disease, is more than a recognition or observation of physical signs. The RHD patient who continues to work at strenuous employment because he is unable to accept the diagnosis of his doctors, is an example of this. Not only is it necessary to consider the need for physically limiting his activity here, but consideration must also be given to such complicating factors, as this patient's inner need to gain approval through displays of physical prowess, his inability to find or perform less strenuous kinds of work, the immediate financial debts which illness has created, the physical needs of his family, etc.

As a further point of consideration, since a patient suffering from a chronic disease is a member of a family and of society, he is not only being affected by them but they in turn are affected by him. Therefore, it is reasonable to expect

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1 George C. Robinson, The Patient As A Person, p. 3-4.

that they too will need to be "understood" before the total reaction-pattern surrounding the disease is known. The belligerent attitude of the wife of an RHD patient who is forced to assume the position as breadwinner of the family, or of friends, employers, etc., who cannot understand the need for a long convalescent period for an RHD patient who "looks" perfectly healthy, are more common illustrations of this.

Background of Medical Social Work Practice

The recognition of the need to evaluate the patient-as-a whole, is one of the basic elements of social work practice. The development of this more-complete approach, of course has not been confined to the profession alone, but has resulted from advances made in the late nineteenth and early twentieth century by several isolated disciplines. The profession of social work as it is recognized and practiced today, is one which social workers have incorporated from the contributions allied social sciences such as psychiatry, anthropology, sociology, etc., have been making. As a result, newer skills in understanding and treating human behaviour have been developed by the social worker, so that the emotional as well as the environmental problems of the individual are being given consideration.

To understand how social work in a hospital setting emerged as a specialized branch of the general social work field, consideration must be given to the developments which have also occurred in the field of medicine. As the role of the general practitioner gave way to the demands for specialization at the

beginning of the twentieth century, vast storehouses of medical knowledge began to accumulate. Yet, despite this tremendous advance towards medical perfection, the purpose for which it had been designed, appeared to be the elimination of disease, rather than the amelioration of the condition of the individual suffering from this disease. In recent years, many doctors have begun to realize that impersonal scientific analysis of isolated sections of the human anatomy has not been sufficient. The general practitioner, without all the specialized knowledge of today, at least knew his patient as a member of a family and a community. There were times when his treatment of the "whole" patient, was more effective than the medicine he had at his disposal.

As the awareness of the need to base diagnosis and treatment on the patient-as-a whole began to take hold, the contribution of the general practitioner became more evident. However, a return to this form of medical practice appeared impractical in view of the need for specialization which increased medical knowledge demanded. Instead, there arose a growing demand for social workers who could help the doctors understand and treat the social aspects of the patient's illness. Most important here at first, was the follow-up service which social workers could do for a patient whose doctor had prescribed specific convalescent treatment measures inaccessible to the patient.

The role of the social worker in a medical setting has continued to expand, since such a position was first created in 1904[1]

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1 M. A. Dennis, "Medical Social Work", Canadian Welfare, p. 31.

As social workers moved into the medical field, they too found it necessary to broaden their skills, for it was soon learned that "environmental manipulation" was not the final answer to a patient's problems. By this time, advances in psychiatric thinking were opening up new channels for understanding the "whole" patient. The incorporation of psycho-social skills necessary to treat the emotional disturbances displayed by patients, added to the value of the social worker in a hospital setting. Recognition by the medical profession of the need for this latter function to be performed by social workers, is still unaccepted to a great extent.

Emergence of the Treatment Team

Drawing from the general body of social work knowledge, medical social workers[1] continually revised their methods of therapy. While development in this field had much to gain from the advance of case work practices in related fields of social work, it became evident that a difference in approach would be necessary because of the type of setting in which medical social work was being performed. The method of handling emotional problems of patients within the framework of a hospital setting and without the co-operation of doctors, nurses, dieticians, etc., who came in more frequent contact with the patient, appeared insufficient. If it was to be the patient-as-a whole who was to receive treatment, then due consideration had to be given to

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1 Social workers who perform their services in a medical setting.

the part played by each member of the hospital staff interested in the patient's recovery. For example, one of the records used in this study indicated that an RHD patient was continually becoming upset because he felt the hospital staff was "against him" and was punishing him by their "rigid" demands. Consultation with the nurses and attendants involved, revealed that patient was constantly misinterpreting the requirements of hospital routine. Because the hospital staff, in the performance of their daily tasks, were not aware that the patient did not understand what was expected of him, they felt that the patient was just a chronic complainer. As a result of these staff consultations, the members of the treatment team understood why the patient had acted as he did, and were then in a better position to avoid future emotion-provoking incidents. At the same time, the social worker was able to interpret to the patient the reason for the actions of the hospital staff, so that he no longer became upset by their requests.

In many instances it was easy to see where overzealous workers would create resentment from nurses, dieticians, etc. Too often there appeared to be much overlapping of services rendered. As the process of specialization extended to each of these professions, it was necessary for each of them to recognize the resulting narrowing of service this produced, in much the same way as the medical profession had done. For example, whereas nurses had formerly administered earnestly, although unofficially, to the patient's social needs outside of the hospital, it became difficult to accept the social worker who was now taking over this field of endeavour. Some nurses mistakingly

felt their role in the hospital might be taken over completely if such practices were to continue. This problem of setting boundaries of service, has extended to all the growing specialists in the hospital,i.e. occupational and physio-therapy, dietetic service, etc., and is one which today, is still not completely resolved.

Since treatment of the patient is carried on in a medical setting, it was only natural that the doctor as the leading specialist in this field, should be called upon to direct the therapeutic efforts of the treatment team. Social workers have been accepting, if not demanding of this. Each member of the team has a job of removing symptoms, while it is the doctor who best determines what these symptoms are and how they can best be treated. Where there are emotional strains in evidence, that member of the team which is specifically trained to remove them, namely, the social worker, should be called upon by the leader. Moreover, it is the medical social worker who is in a logical position to interpret to the doctor as well as to the other team members what psychological and social meaning the patient's illness holds for him. A ready example of this appears in the anxious, disagreeable patient mentioned previously,(p. 9), who seemed unaccepting of treatment because he was beset with fears arising out of his hospitalization. Because he was unable to express these fears to the hospital staff, his anxiety mounted and his behaviour on the wards became worse. The social worker was able to interpret these fears to team members in such a way that they could not only accept the patient's behaviour, but were better able to offer

support to him in the alleviation of his fears, rather than further antagonizing him.

Psychosomatic Medicine

Mention has already been made of the incorporation of psychiatry and medicine into social work practice. More specifically, the utilization of what has been called psychosomatic medicine, has been most useful. Without engaging in any of the controversy centering around the use of this term,[1] recognition is given to the greater understanding which the psychosomatic approach has created in terms of causation and treatment of illness and disease.

Flanders Dunbar suggests that there will come a time when there will no longer be any need to distinguish between the terms psychosomatic and medicine, for they will be accepted as being synonymous. Regardless of what terms are used, as long as they involve the study of the patient as a part of a whole interreacting system, who both affects and is affected by his relationships with others, and who is guided by interlocking intellectual and emotional responses to inner and outer stresses and strains, then the welfare of this individual is best understood. Social workers attempt to incorporate the advantages which this system has to offer, but they do not feel that this is the last answer in research. Much more research is

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1 Further information on this dilemma is discussed in two well-known books on the subject by Flanders Dunbar, Psychosomatic Diagnosis, and Emotions and Bodily Changes.

needed in every aspect of illness. The study of the effects created by RHD, is but one of these specialized projects which must be investigated and incorporated into the existing knowledge that is now possessed.

Research Method Used

To assess the true meaning of illness which RHD holds for male adults, there are many questions which need investigation. For example, what kind of a person are the team members of the hospital staff dealing with? Is there a pattern surrounding the immediate onset of his illness, which, when examined in terms of a personality adjusting to a life situation, reveals an "escape" through illness and disease? What are the patient's environmental relationships? What do his parents mean to him, his brothers and sisters, his relatives and friends? What does his illness mean to them? Is he married and, if so, what effect has his illness on his wife and children? Are there economic difficulties, inadequate sexual relationships, employment problems? Keeping in mind the restricting elements which the individual with RHD faces, how has he accepted these limitations? Is he realistic or does he deny the need for these limitations?

To explore some of these questions, an analysis has been made of case records of male patients at Shaughnessy hospital who were or are afflicted with RHD and who were referred for medical social service. Over one hundred cases of patients known to the hospital since 1947 up to the present time (1951), have been cross-checked with medical social service files and 25 of these, ranging from ages 21 to 83, have been finally

selected. Because of this limitation in case selection, no distinction has been drawn between active or inactive RHD patients.[1] Also, since the majority of these patients in a veteran's hospital are a good deal older than the average person admitted to a general hospital, it has not been possible to select cases where RHD was the only disease affecting the patient. Generally speaking, increasing age has brought with it many other complications for the RHD patient.

It is not possible to assess the representativeness of the cases selected as against the total number of RHD patients treated at the hospital. Because every patient used in this study has at one time or another been referred for social service for some social or emotional problem, it does not necessarily follow that there were no problems affecting those patients who were not referred. However, it may be assumed that this study is dealing with a highly selective group of patients since there is insufficient historical information available in the medical records of patients who were not referred, from which comparisons can be made.

In order to obtain sufficient background material for each of the patients selected, it was necessary to utilize records of other divisions of the department of veterans' affairs, as well as other social agencies in the community. Unfortunately, in many of the cases used, medical social service files were extremely limited. Usually a short contact with the patient

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1 See Appendix A for differentiation of <u>active</u> and <u>inactive</u> RHD.

did not necessitate a lengthy investigation. The most valuable resource available, has been the District Office file, which incorporates not only the medical social service reports, but also those of social service division, veterans' welfare officers, medical examiners, nursing staff, occupational therapists, pensions advocates, etc. In some of the cases where contact had been or was being made by medical social workers who were still on staff at the hospital, a great deal of highly-important additional material was obtained through consultations with them. However, despite these attempts to complement missing material from other resources, on the whole there are many gaps which have not been overcome. Information involving the emotional reactions surrounding the development and prolongation of RHD, and early personality formation, have been the weakest areas of the research.

Presentation of the material obtained, lends itself into three divisions. The first of these cover the social and personal factors involved prior to, during and following the development of, not only the original, but also recurrent attacks of RHD. Included here are the early environmental influences surrounding the development of his illness, such as parental, sibling and community relationships, educational attainment, cultural pressures, kinds of employment, economic stability etc., as well as the later social pressures of marriage, children and the ability to maintain the role of a breadwinner. Concurrent with these social stimuli is the personal adaptation of the individual patient to these multiple outer stresses and strains. The patient's reaction to his illness and his

desire and ability to obtain and follow medical advice, the effect of hospitalization, the mental outlook towards growing physical limitation and employment demands, dependency-independency conflicts in terms of early adjustments and later marital compatibility, make up the major points of consideration here. In essence, this first division attempts to present the patient-as-a whole and the particular meaning which his illness holds for him, as well as the more general characteristics which all RHD patients hold in common.

The contribution of the social worker in a medical setting in alleviating these social and emotional pressures, is included in the second area of presentation. Medical social work is essentially social case work practiced in a medical setting. Case work for the purpose of this study can be defined as a process which uses professional skills or techniques designed to help the individual, alone or as part of a family, to resolve the conflicts which result from his environment and/or from inner tensions. Because these conflicts interfere with the individual's ability to make a satisfactory social adjustment, it has been necessary for him to seek outside help or to be directed to it by others. The particular use of differential therapeutic case work skills, in meeting these individual problems which the patient presents is therefore included here.

Although the members of the RHD patient's family are constantly affecting and being affected by the patient, the particular reaction which these members have as a result of the presence of illness in the family, is another area which lends itself to an individual presentation. Since the majority of

the patients are or have been married, it is to be expected that their wives will be most directly affected by the illness. Also seriously involved, however, are parents and siblings as well as the children in the home. The extended effort which the social worker makes in alleviating the stress of the family members, so they in turn can better aid the patient in his recovery, completes the final part of the presentation.

In using only the case records which have been referred to medical social service it is possible that a non-representative sampling of rheumatic heart patients was used. It is felt, however, that this does not invalidate the results obtained, because the major difference between patients referred or not referred, has been in the individual judgement of the doctor on the case. An attempt will be made to show that a random sampling of patients not referred for medical social service would appear to have similar reactions to their illness.

Because these are case records of veterans only, there is a danger in drawing conclusions which do not apply to all male adults afflicted with RHD. Where war service has contributed to the individual's feeling about his illness, this will be noted, but hopefully only as <u>added</u> stresses and strains rather than exclusive precipitating factors. In other words, emphasis will be placed on the <u>types</u> of emotion-producing situations which <u>any</u> male adult with RHD may be expected to react to in a similar manner.

Finally, since this is a social work approach to the meaning of illness, stress is placed upon the social rather than the

strictly medical aspects of the disease and its meaning to the patient. This should not in any way exclude, however, the complications which arise out of the emotional reaction to the physical presence of RHD.

CHAPTER 2

SOCIAL AND PERSONAL IMPLICATIONS

The inability of the RHD patient to cope with his ever-increasing financial burden, is perhaps the most striking, though it is perhaps the most obvious characteristic of the cases examined. In every case referred to medical social service, the patient was either overwhelmed by medical expenses and reduction of income, or was in receipt of some form of financial assistance, e.g. pension or direct relief, which did not completely meet the requirements of himself or those dependent upon him.

Although approximately one quarter of the total number of cases diagnosed as RHD were referred for medical social service, it is reasonable to expect that the majority of those cases which were not referred, also had some financial difficulty surrounding their illness. This conclusion is based upon the fact that admittance to Shaughnessy hospital is mainly determined by the following eligibility requirements. Where a veteran, (1) is in receipt of pension for a disability which prevents him from earning an adequate income, (2) is unemployable and is granted a war veterans' allowance because he is able to meet certain war-service requirements, (3) can pass a means test, although he is not in receipt of veterans' aid, and (4) is over sixty years of age, in financial need, and therefore is eligible for permanent domiciliary care, he can qualify for treatment. The latter forms of eligibility e.g. war veterans' allowance, etc., are more-acceptable substitutes for direct relief or social assis-

tance which municipal and provincial governments provide. This is because the veteran looks upon his particular type of eligibility as a "right", rather than as an admittance that he has failed to adapt himself to social demands.

Incidence of Social Pressures

The RHD patient's financial difficulties are mainly explained by his increased inability to compete on the labour market. In 88 per cent of the cases examined, patients were engaged in some form of heavy physical labour prior to the onset of their illness. As a rule, these patients had little education. Only two patients appeared to have any high school training, none of these completing high school. Many came from low income families and were forced to leave school at an early age in order to help support their families. Regardless of motivation, the general practice was to accept some form of unskilled heavy labour. Of the case records which contained such material, four-fifths followed this pattern. Although three cases reveal some stability in employment, the majority indicate frequent changes in both nature and location of this. Following the development of rheumatic fever and/or rheumatic heart disease, many continued to work in heavy industry. Over fifty per cent of the case records indicate an attempt to find more suitable work, whereas only eight per cent appear successful in achieving this. It is reasonable to expect that their decision to remain with such employment, was largely affected by their need to meet the demands of financial responsibility.

Among the cases examined in this study, only one patient,

a 28-year-old veteran, did not get married. The rest of the case records indicate a continuous series of divorce, separation and general upheaval in marital situations, which seem to go hand in hand with increased severity of physical symptoms, inability to maintain employment, and added financial burdens. Of the 19 cases containing such information, seventeen reveal indications of unhappy marriages and nine show divorce or separation occurring at least once. Children born to these couples, appeared to add to the difficulties. Only 30 per cent of the cases had information about children, but all of these indicate that the larger the family, the greater the financial burden for the patient.

Where adequate financial means are lacking, it is to be expected that inadequate standards of food, housing and clothing are to be found. Although only a few of the records were complete enough to bring out these insufficiencies, these revealed the need for more adequate housing as one of the chief problems which was encountered by the RHD patient and which affected the adequacy of his convalescence. None of the case records indicated housing conditions which were satisfactory, whereas at least 52 per cent revealed deplorable accommodations. For example, one patient would return to his cold, damp, badly dilapidated house-boat, between his successive hospitalizations.

Although cultural differences are important aspects for consideration when one is trying to understand the total patient, this factor is not apparent in the examination of the selected cases. However, racial and religious differences - especially where they apply to "minority" or "inferiority" groups - may

enter the picture insofar as enforced segregation leads to less opportunity for financial gain, adequate housing, etc.

Case Examples of Social Pressures

The first case is that of a 35-year-old RHD patient, who within six years after acquiring his first known acute attack of RHD, suffered rapid physical deterioration and eventually died.

His early history reveals that after failing and repeating grades five, six and seven, at the age of 15 he left school. His employment record indicates that he went from job to job, alternating between various occupations including horse trading, shoe repairing, waiter, bell hop, bar tender, boilermaker's helper, etc., so that by the time he joined the army 14 years later, he had developed little specialized skill. Two years after he enlisted, he was discharged with an aggravated rheumatic heart condition, which was thought to have originated prior to his service career. He then attampted unsuccessfully to engage in various types of strenuous unskilled employment, but on each occasion, an exacerbation of his condition resulted. Four years later his disability was considered 100 per cent.

The patient's marital history is equally as unfortunate. After living in common-law relationship with a married woman and then being involved in her husband's subsequent suit for divorce, the patient married her shortly after his discharge from the army. As expected, marital relationships gradually deteriorated. Two years after their marriage, the patient was reported as harbouring suspicions that his wife was carrying on

with other men, and that he was childishly demanding of her. She was noted as complaining of difficulty in sexual relationships. No children were born to them.

The patient's financial inadequacy mounted with each exacerbation of his condition. At first his wife compensated for this through partial employment, but eventually, she too became ill. Through social assistance from city agencies and a small pension from the department of veterans' affairs, the patient and his wife carried on as best they could. That this was insufficient, is evident, for an investigator's report stated the patient was living in a "crowded, damp and poorly furnished third floor apartment", despite the recommendation of his doctor that the patient required "housing on the ground floor that is kept warm and dry; also, that he live where no stairs need climbing". A year later, he died.

Another example, is the case of a 42-year-old veteran, whose rheumatic heart condition appears to have originated during his early childhood at a time when he developed an attack of chorea. Although suffering mildly from various rheumatic aches and pains, he appeared to be in good health until he enlisted in the army in 1939. He was subsequently discharged with a sore back and an inactive RHD condition.

The patient left school at the age of 10 after completing two grades, but later taught himself how to read and write. His work history is very sporadic. In the 20 years prior to his enlistment, it is noted that he was engaged in at least five different types of heavy unskilled labour e.g. farming, relief gangs, etc., but there is no indication how many different jobs

he held or where he worked, except that he did not remain long at one type of work. Much instability was also noted in his post war employment - in one seven-month period he moved through five jobs which were obtained for him by rehabilitation officers. Although the patient was not bothered too much by his heart condition at first, a chronic arthritic condition resulting from his back injury, paved the way for his limited earning capacity and subsequent financial difficulties.

Prior to his enlistment the patient married a blind woman. Little is known of his relationship with her, except he was away from home most of the time. She died shortly after he was discharged, and it was then noted that they had been in severe economic distress most of the time. The patient remarried about a year and a half later, to a young woman thirteen years his junior. During the next eight-year period, she was admitted to the mental hospital five times for a schizophrenic disorder. The patient also spent the major portion of these years in hospital. Two children were born to them, and it is significant, that as a result of the frequent hospitalizations of the parents, the burden of providing and financing foster home care became the responsibility of community agencies. As medical bills mounted for both the patient and his wife, they became completely dependent upon welfare agencies.

As a result of the patient's ever-mounting financial difficulties and further inability to accept employment, it is not surprising that investigators found the patient's living conditions completely inadequate. In 1948, one investigator pointed out that the whole family was living in a "two-room untidy

suite", that both the veteran and his wife were "in poor health and required better food", and that "poor clothing for the whole family" was much in evidence. A more recent study made by an interested community agency, indicated that they were "quite distressed by the deplorable conditions under which the veteran and his family are living".

At the time this study was made, the patient had just completed another six-month hospitalization and was reunited with his family. Considering the latest investigator's report available, it was to be expected that his return to the hospital within a short time was inevitable. Living conditions were classified as below-average, as the family was living in a "dilapidated old building, infested with cockroaches". His wife had recently returned from the mental hospital but it was doubtful how long she could carry on. The patient's total income with which he was expected to create a more suitable environment, was a minimum assistance grant which included the care of his wife but not his children.[1]

These two cases illustrate the ever-increasing interaction of social factors affecting the RHD patient, which ultimately influences his poor prognosis for rehabilitation. It can be said that this developing pattern is characteristic of other chronic illnesses as well as RHD. The writer does not dispute the point, but instead, has attempted to show only that these factors do exist. However, in order to understand the

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1 War veterans' allowance does not include payments for children of veterans.

particular significance of these social factors to the rheumatic heart patient, it is necessary to examine as well, the personality pattern affecting and being affected by this social environment. Although in reality it is not always possible to differentiate between these inner and outer pressures, this is being done because a more convenient division of material is thus obtained.

Personality Patterns

Probably the most inclusive study on the developing personality structure of the patient who is afflicted with RHD, has been done by Flanders Dunbar.[1] In the main, the results of this present study do not conflict with her findings. Whereas her case selection consisted solely of RHD patients, this research project has included patients who suffer from other physical complications as well. Therefore, it is to be expected that some of the differences in findings can be attributed to this discrepance. This problem of case selection has already been dealt with earlier.[2]

Dunbar has shown that the RHD patient is essentially an inadequate person who is in conflict with authority. Because this type of person has developed a sense of inadequacy, he feels he is unable to compete favourably with his siblings for his parents affection. Instead, he is likely to imitate or

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1 Flanders Dunbar, Psychosomatic Diagnosis, pp. 367 - 435.

2 See pp. (12-14) in Chapter 1.

curry favour with one or the other parent. Generally speaking, his parents are strict and he prefers this. By exploiting his abnormality and his ability to suffer, he derives pleasure through the esteem which he receives from being able to take punishment. As he acquires this mode of behaviour, he learns to decrease greatly his tendency to express aggression or resentment. The outlet for this repressed hostility appears in a non-directive urge to activity. The patient then appears to deny the presence or make light of his illness, as he becomes self-neglectful and overexerts himself. Where overt expression of this self-punishing device is blocked, the patient may resort to day-dreams or infantile phantasy.[1]

Unfortunately very few records used in this study, contained sufficient data from which an understanding of early personal and family relationships could be obtained. Judging from the later behaviour of the patients, as recorded in the medical social service files, some similarities do occur, however, in the main, the results of this area of research have been on a more subjective level than would have preferred by the writer. In any event, considering the intangible quality attached to emotions and feelings, the problem of overcoming a subjective analysis of such material is a difficult one.

Probably the most outstanding feature noted, was the marked emotional dependence of the RHD patient upon some mother-figure (e.g. mother, wife, sister, etc.). Crying spells were

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1 Ibid., pp. 429 ff.

frequent, especially when the patients began talking of their frustrations resulting from their marriage relationships. Another outstanding feature, was the appraisal which most wives gave of their sick spouses. Approximately 72 per cent indicated their husbands were usually very quiet; also, that they were usually poor conversationalists in company.

Although fifty per cent of the cases indicated some attempt to curry favour, it is significant that approximately another 35 per cent gave some evidence of being unmanageable because of their aggressive behaviour. At least three patients would defy treatment by indulging in excessive alcoholic drinking bouts. Some of the irritability was accentuated by the hospital staff being unable to put up with the petty fault-finding of these patients. This marked evidence of aggressive behaviour, is one of the more significant deviations from the findings which Flanders Dunbar produced. However, the writer feels that this is not an indication of a difference in personality profile, but instead, is evidence, that for some patients, the mental mechanism of currying favour breaks down to the point where a further retreat to an earlier level of aggressive behaviour takes place.[1]

The rheumatic heart patient, then, would appear to be a person who has not been able to accept the adult role. When

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1 A more-detailed description of the theoretical implications that are involved here, is found in Anna Freud, The Ego and Mechanisms of Defense. Also, as an example of this see p. (36).

pressures become too great, he seems to regress to an earlier desire to exploit his illness, so that he will then be cared for. He is usually timid and lacking in self-reliance and attempts to please in his appeal for sympathy. It would appear that he is in constant conflict with the unsatisfied longing for the security which his unstable childhood never provided him. The long hospitalization and convalescence which follows recurrent attacks, possibly provides the substitute source of this need to be cared for, so that the comfort gained by his acquirement of his disease, would overshadow the suffering which inevitably follows.

Case Illustrations of Personality Patterns

(1) Essentially Passive - The first case is that of a 44-year-old veteran of the first world war, whose social history is quite similar to the previous examples described. The second eldest son of a family of six boys, patient recalled his father as being overly strict and at times unjust in his punishment. His father was the type who did not hesitate to use a whip, especially when he got drunk. The patient's mother was the quiet type who sometimes defended the children and "expressed thanks that they were all boys". The patient was apparently a strong and husky child "in spite of his small stature". He preferred being close to home in his early years, however, when the family came to Canada when he was 21, they decided to return to their native land and he and one brother remained in Canada. He spent a brief period in the British navy at the age of 17, but soon developed his first attack of

rheumatic fever and was discharged with a pension for RHD. While in Canada, he engaged in heavy bush and farm labour. His second attack of RHD, which occurred seven years after the first one, and which demanded five months of hospitalization, forced him to give up this strenuous work.

Shortly after his hospitalization, he married a girl nine years younger than himself, (she was 16 at the time), because he felt sorry for her. He remembers that she had parents quite similar to his own.

The patient was employed almost continuously in spite of his physical handicap. Following his second attack, he was helped to find less exhausting employment, but it was not long before he left this to engage in more strenuous pursuits. His exercise tolerance gradually diminished and so did his financial stability. After moving from job to job, he finally succumbed to another attack of RHD.

Again, after spending the major part of the following year and a half in a hospital, he subsequently died.

During this period of hospitalization, the case was referred to medical social service because the patient was upset over marital difficulties. On being interviewed by a female worker, the patient was shy and nervous, and it was with utmost patience that a social history was finally elicited from him. He was later able to express that he usually felt uneasy with women, although this feeling had somewhat diminished during his early adulthood. His main anxiety surrounded the fear that his wife wanted a separation. An interview with the psychiatrist revealed that the patient had developed impotency and blamed

his wife because she had spurned his sexual advances. He accused her of being unfaithful and said he had lost confidence in her. (It is interesting that she had previously accused him of the same thing.) Of significance, however, is the relationship between the onset of his impotency and the exacerbation of his illness. Attempts to interview the wife, to get her side of the picture, were continually frustrated by the patient, because he was afraid she would resent the fact that he had discussed their marital problem with others.

He maintained that he disliked crowds, did not dance, felt most comfortable with a few friends, read a lot, and felt uneasy with women. In reference to his wife, he felt that perhaps he had been selfish, as he had wanted her to himself and had not realized she might want to enjoy the company of others.

Of the two children resulting from this marriage, the patient was more attached to his daughter (age 15), and the mother was closer to her son (age 7). The patient expressed the conflict which this created, by pointing out that his wife resented the attention he gave to his daughter, and felt that his wife would be close to him again if the daughter married and left home. He had difficulty, however, in deciding whether he was really in favour of his daughter ever getting married.

What type of a person is this and what does his illness mean to him? It can be assumed from his earlier life history that the patient had never really grown beyond the dependency stage. His feeling of inferiority was first expressed by his recollection of his small stature. His fear of his father was well expressed, although he was not so bold in describing his

mother. However, his fear of women in general, plus his marital conflict, seem to indicate much stronger feelings towards a mother-person.

The patient married a girl much younger than himself, so that he could be assured that he would be in control of the household just as his father was.[1] He was essentially dependent upon the good graces of his wife, and when he found that she was unwilling to gratify his needs for love and affection, he turned to his daughter for this still-unsatisfied security he sought as a child. It is quite probable that he resented the attachment of his wife to his son, in much the same way as he would compete with his brothers and sisters for his mother's affection.

The patient's first attack of rheumatic fever occurred after he had left home for the first time. At a stage where the drives of adolescence towards independence are strongest, the patient chose the life of a sailor to achieve this freedom. However, his underlying dependency needs were re-awakened, and he was able to salve his conscience by developing a physical illness which "forced" him to give up his independence. Again, after coming to Canada, he attempted to resolve this conflict and almost succeeded. Finally, after driving himself, he ended up in the hospital once again. Soon after his recovery, he married and presumably he was able to find enough satisfaction

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1 Emulation of a feared superior, especially in phantasy, was a characteristic reaction of RHD patients noted by Flanders Dunbar, Psychosomatic Diagnosis, pp. 367 - 435.

from his wife and was thereby able to carry on. Twelve years later, when his marriage was severely threatened and early feelings of inadequacy were re-aroused by her rejection and his subsequent impotency, the patient succumbed to another attack.

(2) Essentially Aggressive - Another case, that of a 26-year-old veteran who developed RHD while in the Air Force, presents a more vivid portrayal of an essentially immature person in constant conflict over feelings of dependence versus independence. Only a very brief account of his early history is known, however, the pattern is well set and one can expect continuous hospitalizations resulting from his already-weakened physical condition and his emotional instability.

The patient is described as having an uneventful and apparently-happy childhood. The only information which seems to throw some doubt on this peaceful beginning, is the fact that one of his sisters had a "nervous breakdown". After completing Grade ten, he left school to engage briefly in a variety of odd jobs - mainly farm labour and construction work. At nineteen years of age, he enlisted in the Air Force. Failing his air-crew examinations, he became quite upset by his demotion to general ground-crew duties, and it was shortly afterwards, that he had his first attack of rheumatic fever. He was discharged with a thirty per cent pension, and although he was warned against engaging in heavy labour, his first post-service job was in the shipyards performing strenuous tasks. Five years in succession he was hospitalized for lengthy terms. He received considerable help from rehabilitation officers in obtaining employment that was in keeping with his limited capacities, but

he usually rejected most of these. He moved from place to place frequently, and although he had worked at many jobs, two years after his discharge from the service, a routine physical examination report revealed this comment.

> The patient is a tense psychoneurotic individual.... His joint pains are coincident with his desire to leave his employment, which he finds unsatisfactory....

The patient married four years after his service discharge and four months later a child was born. From the very beginning the marriage was a stormy one, and after a series of drinking and gambling bouts, unstable employment, infidelity, etc. - his wife left him.

As expected, this was followed by a very brief period before his next hospitalization occurred. On admittance, it was noted that "...his pain seemed out of proportion to the findings". A month later, the case was referred to medical social service because he was disturbed over employment and marital difficulties. Interviews with the patient revealed that,

> Numerous jobs held by the patient would appear, for the most part, too heavy in view of his medical condition....Some, he lost through his illness but most, admittedly, through heavy drinking bouts.
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> The patient describes himself as impetuous....He gets depressed and drinks to combat this,...goes absolutely crazy when drunk, then "black" out completely. Feels guilty about this....The patient seems immature and dependent....The patient showed worker a letter he wrote to his wife but had not mailed. In it he begs her to come out, so that he can see her and the child. He points out that he has cried himself to sleep.... He reiterates his determination to give up drinking... but he admits that whenever he receives a shock he "goes off the deep end".

It was felt at this time, that the patient's marital situation was extremely precarious, and that it would be increas-

ingly difficult for him to accept treatment, because of his restlessness. Hospital records indicated he would absent himself from the ward each evening, and would return in a drunken state.

It was five months before he was finally discharged from the hospital. Four months later - having worked at two jobs during this interval, he had joined Alcoholics Anonymous and was also reunited with his wife. This time he requested aid for his financial problems, and was helped to obtain work as an orderly in various hospital settings. He seemed to be adjusting fairly well, until a year and a half later, when he once again manifested RHD symptoms while working as an orderly in a small-town hospital, which allowed him to return for further treatment.

By this time the pattern of dependency appeared more in evidence, as an examination did not reveal sufficient physical basis for his symptoms. A psychiatric appraisal, however, indicated patient's "personality setting played some part in his present complaints". He was discharged a month and a half later, after consistently defying the authoratative requirements of the hospital, and when last heard of, continued to display impetuous, irresponsible and immature behaviour. It was also noted, that his pensionable disability had increased to fifty per cent.

In this case, as in the other example used, the interreaction of a personality make-up and environmental stress, is indicated. The patient developed his first attack of illness in the Air Force, at a time when his feeling of inadequacy had

possibly been aroused. By failing to become a member of the air-crew, he became extremely dissatisfied with the role he was then asked to play. The development of rheumatic fever provided him with an acceptable outlet and he was able to escape from a frustrating situation. Subsequently, his pattern of illness became well-established. Initially he left the dependency of his home environment in order to assume an independent status. His first means of escape from unsatisfying employment, was to join the service. Following discharge, he continued to show ambivalent feelings, as he consistently opposed the authority of an employment setting and satisfied his dependency need by his acquired escape into illness.

His marriage added a further burden to him. He made impossible demands of his wife, especially after the birth of the child, and when she finally left him, he was once again overwhelmed by increasing feelings of inadequacy and guilt.

The patient displayed at least two escape mechanisms which he used to cover up his inability to face reality demands - one was illness, the other was alcohol. The latter allowed him to realize his ambitions in phantasy if not in fact. Flanders Dunbar points out that the taking of stimulants such as alcohol in large doses, is one way in which an RHD patient could satisfy his need to excell. Therefore, if the patient could not be a success at anything else, at least he could excell as an alcoholic.[1] The guilt and further depression which followed each

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1 Flanders Dunbar, Psychosomatic Diagnosis, pp. 367 - 435.

drinking bout only served to remind him of the added proof of his inadequacy.

In contrast to the type of patient who tends to repress his hostility, this patient expressed it more openly. Although he sought the security of the hospital setting to cover up for his inadequacy, this did not allow him sufficient compensation. His frequent absences from the hospital appeared to be a defiance against authority, although it is noted that he became drunk on these occasions. The writer feels the patient may have sought the extra stimulation of alcohol as an escape from the guilt he felt, whereas the former patient gained sufficient satisfaction from the attention and sympathy which his illness afforded him. However as indicated previously,[1] this is probably also an indication that the latter patient had regressed to an earlier level of behaviour adaptation. Because of this, his "primitive" desires would be more-readily expressed, and his ability to combat these urges more-difficult to arouse.

The social and emotional problems which appear to be affecting the course of illness of an RHD male adult patient, have been presented. As suggested previously, it is possible to produce members of society who undergo similar stresses and strains, yet do not develop RHD. The importance of this information to the social worker lies in the recognition that such social and emotional problems do appear in the RHD patient and are influencing the physical aspects of the disease. The

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1 See p. (27).

special skill which the social worker can contribute as a member of the hospital treatment team combatting this illness, is brought out in the following area of presentation.

CHAPTER 3

CASE WORK WITH RHEUMATIC HEART PATIENTS

Essentially the problem of RHD is a medical one, and it is not the purpose of this study to minimize the role which medicine has to play. However, as has been suggested before, the concomitant factors which appear to be affecting the course of the illness, occur too frequently to be classified as mere coincidence. The social and emotional climate in which the patient lives, is of prime concern to the social worker, and it is towards the alleviation of these problems affecting the illness, that his specialized skills can best be put to use. Because he is concerned with the patient-as-a-whole, his work on the patient's behalf will extend beyond the boundaries of the hospital. The social worker maintains that essential contact with the patient's family and community and attempts to utilize the services which they as well as the hospital staff can render to the patient on a continuing basis.

The writer has pointed out that there is a paritcular set of social and emotional factors which affect most RHD patients. The social worker, needs such information in order to guide his application of case work skills towards alleviating these pressures. However, at no time should the social worker attempt to base his diagnosis and treatment on this generalization alone, for in each person there are individual differences which largely determine the depth and duration of emotional reactions to illness. For example, where illness has become an escape mechanism for the patient, treatment involves more than just

breaking down this defense. In this sense, illness has provided the compensation for a painful mental conflict. If this is to be exposed, the patient must first be helped to find a more-acceptable solution to his difficulties. What is involved in case work treatment, then, is an "understanding" of these individual differences and a gearing of the case work process to the level of adjustment which a particular patient is functioning.

LEVELS OF CASE WORK TREATMENT

Florence Hollis has outlined four levels at which case work treatment can be used.[1] The first of these, environmental manipulation, has been defined as "all attempts to correct, or improve the situation (of a patient) in order to reduce strain and pressure, and all modifications of the living experience to offer opportunities for growth or change...."[2] For example, this process can involve a changing or manipulating of environmental pressures, such as providing financial assistance, finding more-adequate living quarters, or even helping relatives to be more understanding of the meaning of illness to the patient. Social workers are probably best known for their work in the area of environmental aid, for the very beginnings of social work practice have been founded on the use of this

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1 Florence Hollis, "The Techniques of Case Work", Journal of Social Case Work, June, 1949, pp. 235-44.

2 Gordon Hamilton, Theory and Practice of Social Case Work, p. 247.

helpful device. Josselyn[1] speaks of "environmental therapy" as being the least artificial approach, and points out that sometimes this is the only type of treatment possible. Environmental manipulation must be purposive, if it is to be constructive. The important thing to remember, is that the patient must want to be helped and should be encouraged to participate in as much of the changing as possible. The medical social worker should only perform such action which the patient is unable to do for himself.

The other three levels of case work which Hollis describes, (psychological support, clarification and insight) involve a more direct approach to the patient's inner emotional strife, and differ as to the degree in which he is helped to work through these problems. An accurate diagnosis, based on a careful analysis of the patient's problem, will determine the type of help he can best use.

Psychological Support is a technique used to encourage the patient to talk about his problem. Discussion is focussed upon helping him to be aware of and re-enforcing his inner strengths, first through guidance, release of tension, and then through various forms of reassurance designed to bolster his self-confidence. Psychological support is useful for carrying the basically well-adjusted person over a period of severe stress and strain caused by painful life experiences. The approach is also helpful when working with infantile and

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1 Irene M. Josselyn, "The Case Worker as a Therapist", Journal of Social Case Work, November, 1948, pp. 351 - 355.

immature patients who are in need of guidance. The worker expresses a sympathetic understanding of patient's feeling and accepts his behaviour. A sincere interest and desire to help, along with respect for and approval of action taken when it is warranted, aids in building up the patient's confidence. Here again, the patient's ability to make his own decisions, is all-important. Finally, psychological support is a technique designed to create a permissive relationship, which is intended to relieve anxiety and feelings of guilt.

Clarification is a more-intensive case work technique designed to help the patient understand himself and the people with whom he is associating. It may be a matter of helping him to look at the probable results of a decision, or evaluate the opinions of others, or even to become aware of his own feelings and attitudes in a correct perspective. Ordinarily, clarification is given only when a high degree of psychological support is used, unless the patient is relatively healthy in his personality adjustment or the problem treated is one which is unaffected by personality conflicts. Although emotional experiences may be examined, clarification is ordinarily given to create an intellectual understanding of conscious material.

Whereas Clarification deals with fully conscious material the development of Insight involves a much deeper level of treatment. This device attempts to reach for and bring out, suppressed, rather than unconscious formulations, and is based upon an awareness of these earlier experiences of the patient. The medical social worker does not attempt to go beyond these levels of treatment, as the problem of working with

unconscious symbolism and other difficulties arising out of early personality formation, is a task which calls for the services of a qualified psychiatrist.

The social worker in working with the patient, is of course, not bound by any particular type of case work treatment. All four levels are interchangeable, depending upon the emotional adjustment of the individual. Even though patients may need psychological help badly, they may not be able to face what is being said to them, and will either draw upon another set of defences or else break down completely because of this exposure. The social worker consciously seeks to determine, through accurate diagnosis, the degree of help which a patient can use at a given interview. As the patient is able to feel accepted and understood, he will be able to give up more and more of his defences and thereby profit from a more intensive level of therapy. Case work is a gradual, sensitive, purposeful, process which is designed to meet a particular client at his own level of operation and bring him to the highest level of adjustment of which he is capable. Therefore, by "helping the client to help himself", at the individual pace which he alone can determine, the most effective use of case work services is made.

The majority of the patients examined in this study, indicated strong dependency feelings. Even under normal circumstances, the extent to which the essentially-immature person can profit by case work, is limited, for with RHD patients there is the added complication of physical deterioration to overcome. It is not surprising, therefore, that the most

important level of case work help which can be best utilized by the RHD patient, is that of environmental manipulation. Psychological support and clarification can be given mainly in aiding the acceptance of a change in the environment. The giving of insight to an RHD patient who must remain dependent because of his physical handicap and who has little inner strength to use, is of doubtful value, however.

The writer has already pointed out how damaging environmental pressures can be to the RHD patient.[1] The social worker must utilize those available resources which exist within the hospital and the community at large, in order to ease these pressures. The amelioration of these problems of financial aid, employment, housing, etc., is primarily a social, rather than a medical responsibility. It is not unusual, therefore, to expect the community, of which the patient is a member and in which these social problems exist, to create welfare services which would combat this social dilemma. In the unique set-up of a veterans' hospital, however, the bulk of these necessary services are available through the generosity of federal legislation for veterans. Pensions and war veterans' allowances, plus various other funds such as the "Army Benevolent Fund", offer partial solution to this economic problem. Employment difficulties for the handicapped, are handled through retraining programmes and selected job placements. Convalescent homes, such as the George Durby Health and

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1 See Chapter 2.

Occupational Centre, (G.D.H. & O.), provide an adequate substitute for the inadequate type of housing and diet to which the RHD patient is often forced to return. Even help in finding more-adequate housing, can be arranged for the veteran.

The social worker recognizes the special role which the welfare officer plays in making available these resources, for he is also a vital member of the treatment team. However, availability of these resources does not necessarily mean that adequate use will be made of them. How a patient feels about accepting environmental aid is something which the social worker is equiped to handle. For example, it has been pointed out that the RHD patient is one who attempts to cover up his strong dependency needs by an equally strong independent drive. By accepting help, he may be admitting failure to become independent. In order to keep up his defenses, he may then project the cause of his inadequacy on to his environment, and thereby become overdemanding of his basic rights as a citizen, or as a war veteran. The problem of "pensionitis" is one which is very familiar in veteran's hospitals.[1] It is much too easy to play into the patient's basic dependency drives, so that the stronger is his need to keep up his defenses, the more difficult is his recovery. As one patient so aptly phrased it "Well, it

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1 In providing a system of pensions, the government has not only developed a fair means of compensating those handicapped, who, because of war service, cannot compete on the labour market, but has also created a dilemma. Many veterans have sought a solution from their personal inadequacies by consciously or unconsciously clinging to or increasing physical handicaps, as an "acceptable" way of solving their financial insecurity. This manipulation of veteran legislature by the veteran, has become known as pensionitis within the department of veterans' affairs.

sure isn't my fault I'm sick, is it?"

The Use of Environmental Manipulation

One of the social worker's skills then, is that of preparing a patient to accept and make adequate use of his environmental resources. The following case illustrates the case work process at an environmental-manipulation level, of a RHD patient who is unable to profit by more intensive therapy, because of the deep-rooted emotional pattern of his illness.

The case is that of a 57-year-old veteran who was referred to medical social service because he was destitute and did not have friends or family within the city area who could care for him. An "investigation of the patient's social background finances, etc.," was requested. Also, the doctor felt the patient was showing too much opposition to placement under permanent domiciliary care. Following the usual pattern of RHD patients, he left home at an early age and moved from one type of employment to another. There is an indication of a strong emotional dependency upon a mother-figure, of an incompatible marriage resulting in desertion, of impetuous decisions and an altogether unhappy existence. His constant drive for activity, was halted temporarily by repeated attacks of RHD. When he realized he could no longer compete on the labour market, he turned to religious fanaticism as a means of solving his problems. He would drive himself unmercifully in phantasy as he had done in reality.

The first interview with the patient was devoted to building up a helpful relationship.

Patient appeared frightened and hostile. He said,

> "I have no plans. What I want to know is, what is all this going to cost me....It costs me forty dollars every month I am in here." Worker said she would check, but that she thought treatment was not costing him anything..., that he had a pension and was on war veterans' allowance and was thereby entitled to treatment....He said the doctor would be putting him out of the hospital soon because he talked too much. Worker said she was sure he would not be discharged until he was better. He seemed somewhat reassured.

Here we see the worker picking up the patient's ambivalent dependency-independency conflict. He is at first very demanding and accusatory as he indicates his desire to get out of the hospital. Later, as he feels the warm acceptance of the worker, he is able to express his fear of being abandoned and the underlying need for care. The worker follows up by assuring him,

> ...there was nothing to worry about. He was not going to be discharged right away, but she felt that if she came to see him and talked things over she might be able to help him in deciding what he wanted to do. The patient said he didn't want to decide in a hurry. The worker said that was not necessary, and remarked that she understood he came from Toronto and had a sister there....She wondered whether he could stay with that sister....He said ernestly, that, that is what he would like to do....He stayed with his sister when he came out of Sunnybrook hospital earlier this year. All he would have to do is look after the furnace. He would like to go back there after he was discharged, until he could stand on his own feet again....The worker asked if he would like us to write to his sister....He said he would like that very much.

The patient had previously been told by the doctor in charge of the case, that he could be transferred to one of the convalescent centres for permanent residence if he so desired. This direct appeal to the patient's dependency needs, met with much opposition. The manner in which the worker explores the possibility of another resource is worth noting. She allows the patient to bring out his own plans, rather than suggest

directly that he should live with his sister. The worker then offers to help the patient in working out his problem at his own pace. Possibly she might have encouraged the patient to write his own letter, as this would have contributed to his feeling of independence. However, she at least asks his permission before contacting his sister. Too often, a well-meaning person may further antagonize such a patient, by doing things for him without his full participation in the plan. It is not uncommon to see a patient of this type, whose independent drives are so great, offer passive resistance to any plans which are thereby made for him.

Since the doctor is the head of the treatment team, the worker conferred with him about the feasibility of the patient's wishes. Because of the doctor's knowledge of the extent of the patient's physical handicap, he vetoed any plan whereby the patient would have to tend to the furnace, but felt the patient could care for himself in the home during any absence of his sister. The possibility of a nurse from the Volunteer Order of Nurses visiting him regularly, was also suggested.

A letter was then sent to the patient's sister explaining his desire to be with her and also pointing out the limitations which the doctor had suggested. The patient responded rapidly to hospital treatment following the initial interview with the worker, whereas before, he did not appear to have any desire to get well. In a later interview,

> The worker said we had written to his sister, and his face lighted up as he said, "have you heard from her...that's what I would like best - to go and stay with her".

Arrangements were finalized, and the patient's sister came to Vancouver to pick him up. Another phase of environmental manipulation was performed by the worker, as she appraised the ability of the patient's sister to meet his needs for care and also helped her to understand what these needs were. It is in this interview with the patient's sister, that some understanding of the patient's motivation to live with her, also appears. The worker makes this comment.

> She appeared a competent and responsible person, able and willing to make arrangements for her brother, and most anxious to have a chance to look after him. She gave worker the impression that she would like "to mother" her brother, but he is very independent and difficult at times.

It would seem that the patient has transferred his unconscious dependency feelings for a mother-figure on to his sister, and is able to find satisfaction for these needs here.

In summary, the case presented, is an example of a patient who could not profit by any insight into his personality difficulties. The worker is able to contribute to a more-rapid and natural recovery of the patient by manipulating the environment- i.e. finding a suitable home for him,- yet at the same time full consideration is given to the patient, in determining how this need is met. An understanding of human behaviour and an ability to meet this individual at his own level of operation, was the keynote of this success. A perfunctory placement in the convalescent home, might easily have prolonged the illness state, and proved more damaging to the patient and more expensive to the hospital in the long run. However, a solution was found which was satisfactory to all concerned.

The Use of Psychological Support and Clarification

Although the writer has suggested that for chronically ill patients affected by RHD, the more-applicable level of treatment is usually one of environmental manipulation,[1] the writer also feels, that with careful and skillful management, psychological support and clarification can be used advantageously with RHD patients. For this reason the following case illustration has been included to show what can be done under near-ideal conditions. At the time this study was being conducted, the case was still being carried actively by a social work student who had access to skilled supervision.

The patient, a 52-year-old veteran, was referred for case work because of his unsuitable home conditions. He was married and had two children, and all four of them had been living in a two-room suite which was situated on the third floor, of a dilapidated hotel, in a slum area. The doctor on the case indicated that the patient was "in an advanced state of RHD" and pointed out that his present housing was "unsuitable for patient in view of his condition".

The patient developed rheumatic fever in 1919, while serving with the Imperial forces, and was eventually discharged with RHD in 1922. He carried on reasonably well until 1935, when he began to notice that he was unable to continue the strenuous work with which he had been accustomed. He married in 1939, and during the early war years, maintained economic

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1 See pp. (42-43).

stability. However, by 1944, shortly after the birth of his second child, and at a time when financial pressures began to mount, he developed a series of recurrent attacks of RHD.

The original problem presented in the referral, was the necessity of finding adequate housing before the patient could be discharged (i.e. environmental manipulation). The aid of one of the welfare officers was enlisted, and although several arrangements were presented to the patient, it was soon obvious to the worker that if rehabilitation was to take place much case work would have to be done, not only with the patient, but with his wife as well. The patient and his family were well known to various welfare agencies in the city, and it was from these resources that the worker learned of a more important factor in the patient's illness - that of a domineering wife, who appeared to be rejecting of her husband. This was verified in subsequent contacts with the wife, although the patient was not able to criticize her when he first discussed his home situation with the worker. Case work was then directed at providing emotional support to an individual who had overwhelming "feelings of inadequacy", which centred around his inability to maintain his role as head of his household. Since the wife was the dominant factor here, it was also intended that a modification of her attitudes to her husband and his illness, would also be attempted.

The first few interviews were focussed on establishing a good relationship between the patient and the worker, so that the patient would feel free enough to discuss his personal difficulties. Only a superficial relationship resulted,

however. It was noted after 3 weeks of brief but regular contacts that,

> The patient is now willing enough to discuss his family but unwilling or unable to look at his own position in it. He feels he has been rather hard done by, as far as various government agencies are concerned, and he does not feel that there is a chance of anything improving, as far as living or economic conditions are concerned.

Following a rejection by the patient and his wife of another housing plan a week later, a consultation was held by members of the treatment team, (the doctor, welfare officer, and social worker). It was felt that the patient was not showing any progress physically, although he had been ready for discharge to a convalescent setting for some time now. The damaging influence of the patient's wife was presented to the conference by the worker, and it was decided that until such time as the wife could be more co-operative and accepting of her husband, he should be transferred to the convalescent ward (Class 6) where he would be given domiciliary care. It was agreed that the social worker would prepare the patient for this transfer. (i.e. environmental manipulation).

At first the patient seemed quite agreeable to this suggestion.

> The patient was seen daily and Class 6 (domiciliary care) discussed. He appeared to accept this quite readily and finally stated...that he and his wife probably would have separated anyway, due to what he regards as her mismanagement of any income and also because he does not particularly care for the type of company that she keeps....The patient's wife appeared quite pleased that her husband had decided to stay.

The beginning of the patient's expression of hostility towards his wife appeared here. He was still unable to see

himself as being responsible for his predicament and continued to project this blame, although now it was directed at the one person from which he has sought satisfaction for his dependent needs. As expected, he was soon unable to face the reality of his wife's rejection. His "sour grapes" defense broke down, as was evident in the record of the following two weeks.

> He (the patient) began to show concern about signing an application for Class 6. He stated he had been home for a day and that had been enough....(He was) seen almost daily in an effort to help him adjust to Class 6 care. He has been quite upset...feeling that he had been forced into it and that his wife was trying to get rid of him. He realizes that the hotel is not a suitable place for him but feels his wife will not do anything to get better accommodation for the family, unless he is able to "nag her"....An effort was made to get the patient to see the physical impossibility of his going back to his previous living quarters....(We) discussed various ways in which he himself could take the initiative in making arrangements for further accommodation, such as newspaper advertisements and personal contacts with real estate agents. It is believed the patient was helped by these discussions.

Two weeks later.

> The patient was quite cheerful - He stated that he was doing quite well now and finds he is able to get around town a lot more than he was at home....The patient now seems much happier in the Extension, and is being encouraged to take the initiative with regard to his pension application and housing problem.

In spite of efforts to work with the patient's wife, she resisted and resented any interference into her affairs. She felt compelled to continue interviews with the worker and although at one time some progress was noted, eventually she fell back into her old rejecting pattern and subtly defied any attempts to find a home which would be suitable for her husband. It was noted that from a financial point of view, at least, she was better off having her husband under hospital

care.[1]

During the following four months, little change was noted, either in the patient or his wife. Shortly after, the patient had been unable to establish a pension claim for his disability, and his unrest became noticeable once again. He was referred to the worker by the doctor, because the patient had undergone another heart attack, was very upset and was requesting discharge. Case work was again continued on a more intensive level, but at the end of four weeks, the worker had this to say.

> The patient has been extremely unhappy recently and his relationship with his wife during her visits have not been good, according to him. This has been reflected in his attitude towards treatment. However, it is felt that he would be able to look on his present condition and treatment was a more realistic viewpoint, if satisfied about the welfare of his family.

The case worker originally assigned to this case had been seeing the patient and his wife several times a week. As well, numerous consultations with team members were involved. It is little wonder, that as the caseload of the worker became too demanding of his time, a reallocation of his efforts was made. Since the patient's ability to respond to case work would not be favourable until such time as the family situation could be improved, and since the patient's wife did not show any signs of changing her attitude, the worker rightfully devoted more time to other patients who would benefit more-readily from case work services. This is a common problem in social service agencies, where the number of cases which an individual

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1 During a patient's hospitalization, usually only ten dollars is subtracted from his war veterans' allowance.

worker is required to carry, is beyond the reasonable limit in which minimum service is expected to produce maximum results. One solution to this problem, is to hire more trained staff. Where this is not possible, the good case worker, carefully determines which of the cases he is carrying, can make best use of his services in the shortest period of time. The skills of a professionally trained worker, enable him to maintain greater accuracy of the final selection.

The case was later transferred to a female student worker, who, because of the advantage of a training setting, could devote the time necessary to insure some measure of success. Through a three-month period of her intensive case work effort, there has been a gradual amelioration of the patient's condition. The whole process of establishing and maintaining a secure relationship with the patient and especially his wife, has been a difficult one, as the wife has continued to strike out against her husband.

Again, the problem of finding a suitable home where the patient might eventually return, was the long-term plan. Before this could be achieved, the immediate problem of supporting the patient and helping him accept the demands of the convalescent hospital setting so that he could respond to treatment, was intended. As his frustration mounted, the patient became more of a nuisance to hospital staff and other patients. His petty fault-finding was accepted by the worker, as she instead, gave emotional support to his increased feeling of inadequacy and helplessness. Gradually, the suppressed hostility which was being expressed through his behaviour, was

channelled by the worker as she encouraged him to express his feelings and frustrations. At first, he projected his hostility onto the department of veterans' affairs and other government officials, then to his wife, and finally, was able to admit his own responsibility for his problems. One of the earlier interviews where the patient was beginning to respond to the acceptance of the worker, points out some of his basic inner conflicts.

> The patient was in a very depressed mood - possibly as a result of his wife's long visit two days before ....He asked me anxiously if I thought his wife would find a suite for them to live in. I said I had no way of knowing and what did he think about the situation. Here, all the frustrations and hostilities connected with his long stay in the hospital, caused the patient to break down and weep helplessly....During his discussion he wished for death "to be out of his misery".... I asked him what he felt his most pressing problem was. He said it was everything combined, that he couldn't work, he hated being helpless - he was just "worried to death". He was rather incoherent much of the time, and I felt that passive acceptance of his statements, together with periodic supportive comments of acceptance, was my only recourse....At one point he said that he wished his mother were here - she would help him and wouldn't "let all this happen" to him....On the subject of his family, I tried to draw the patient out to talk of them. He had never done this with me and I sensed that it gave him some comfort to do so. He told me they had been a happy family, saying that he guessed that was why none of them had married early....I said "and you haven't been married long either". He replied, "No, I waited a long time" - pause, and then, "I only married for a home anyway - and look at me now"....As he talked of his parents and childhood in England, the patient began to be a little less tense, stopped crying and began to discuss his problems in a more "matter of fact" way.

As the worker was also able to help the patient's wife express her hostility, the wife was able to refrain from antagonizing her husband. The worker's effort at environmental manipulation for the welfare of the patient also extended

toward adjusting the hospital setting, so that realistic annoyances could be avoided. The patient had become very attached to the use of a wheel chair and when this was taken away from him by a new interne on the ward, the patient became upset. Although he used the wheel chair sparingly, this sudden loss of this symbol of security, made him afraid to venture from his bed without an impending fear that he would collapse. Also, he interpreted the removal of the chair as a further indication of his rejection by the hospital staff. At a meeting of the treatment team, the meaning of the chair to the patient was explained by the worker, and it was agreed to return this to the patient. His response was immediate and quite favourable.

Because of some minor difficulties on the ward, which were unavoidable in terms of physical setting and hospital regulations but were nevertheless a constant source of irritation to the patient, arrangements were made to have him transferred to a new ward. Following a brief period of regression until the patient became adjusted to the new setting, his response to treatment was remarkable. During this time, the worker constantly interpreted the emotional needs of the patient to the staff members of the new ward, and once again intervened on behalf of the patient when the wheel chair was again removed. More-recent interviews at the time this present study was being made, indicate the movement which has taken place over a two-month period.

> The patient was in an amiable mood when visited. He told me that he had been allowed to use a wheel chair, and had been over to the Red Cross Lodge with his wife the day before....The patient, who had been in a highly nervous state when last visited, was calm, cheerful and conversational today. I asked if

> he were using the wheel chair much, and he smiled and said it was very satisfactory, that sometimes he wheeled himself around and at other times he pushed it....The patient smiled at me and said "you helped get it for me didn't you?" I smiled back and said that the doctor had been concerned about his welfare, and had at first thought a chair might be a hindrance rather than a help to him, but that we had agreed, that at present, it would be helpful for him to have it.

A week later:

> The patient was walking around the ward with the aid of a cane when visited, displaying more energy than I have noticed heretofore. I...asked if he were feeling as well as he looked. He beamed at me and said, "Better than I look and better than I've been for some time"....I asked what he thought the reason was, and he said, "Oh everything - but most of all because I am getting my proper sleep since I moved to the new ward...." He said that he felt better and stronger than he had for over a year. Then, he added that his doctor had come to see him the other day and had indicated amazement at how much he had improved. I said that I guessed Dr...would be very pleased to see him improving, and the patient said he thought Dr...was a good doctor, and they hadn't understood each other at first. This is the first positive comment he has made to me about any member of the hospital staff.

Although the worker had been giving mainly psychological support, clarification of the doctor's interest in the patient was given and was acceptable to him at this time. Note that the worker did not interpret the unconscious aspects of this conflict, (i.e., conflict with authority), but instead worked within the conscious framework of the patient's thought processes.

The worker's comments on the patient's progress is a good indication of the movement which has taken place.

> Relief of environmental pressures have caused this patient to feel that the hospital team is working for his welfare, with a consequent improvement in his relationship with his doctor and the nursing staff. In addition, his relationship with

> the worker appears to be deeper than heretofore, and he has been able to express more of his hostility towards his wife and his anxiety regarding his children....I felt in this interview, that the relationship was developing to the point where the patient could not only express some of his hostility towards his wife, but could accept help in gaining insight into his own behaviour. He seemed very receptive to comments concerning his attitude towards the marital situation.

There is still much case work to be done before the patient and his wife can ever come together in their own home. Because of his deteriorated physical condition and the difficulty of finding a suitable home within their financial means, this may never take place. The value of the social worker as a member of the treatment team has been shown however, in the gradual physical improvement of the patient, which went hand in hand with the alleviation of his emotional stress. Their is little doubt that skillful use has been made of the case work techniques of psychological support and clarification, in bringing about some beneficial environmental changes for the patient.

The material of this chapter indicates how the social worker, as a member of the hospital treatment team, can utilize his professional case work skill to alleviate the social and emotional problems of the patient with RHD. Throughout this and preceding chapters, reference has been made to the way RHD patients are affected by the members of their families. How these patients in turn affect their families, and how the social worker operates to reduce these further stresses and strains, will be discussed in the following area of presentation.

CHAPTER 4

FAMILY IMPLICATIONS

Previously, in discussing adequate care for the RHD patient's illness, stress has been placed on the treatment of his social and emotional problems. Since the patient's family performs a vital role in the creation and prolongation of his difficulties, the social worker must treat the members of this family, as well as the patient. By gaining some relief from their own social and emotional stresses and strains, they are then better able to aid the patient in his recovery.

The social worker in a hospital setting, although sensitive to the need for case work services to families of RHD patients, as a rule, has a limited role to play in the performance of these services. Specialized agencies such as family welfare, children's aid, public welfare, etc., which have been specifically created to alleviate the social and emotional problems existing within that broad area known as the community, are better equiped to meet the varying needs of family members. In this sense, the medical[1] social worker is not only a member of the hospital team, but is also part of the social welfare team within the community. Just as he is expected to treat the varying aspects of physical illness, he is also aware of the specialized skills of particular welfare agencies to alleviate specific social and emotional problems which can

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1 The social worker in a hospital setting.

occur. Just as a co-ordination of the efforts of the treatment team in the hospital is necessary, similar co-ordination of all the community welfare services is also vital. The medical social worker, then, can call upon and is called upon by other social agencies to act jointly in promoting the welfare of patients and their families.

Although it has been possible to formulate one general personal and social profile into which most RHD patients fit, it has not been possible from the results of this study, to draft a similar type of profile for members of the patient's family. The reason for this, is felt to be due to the more-varied individual differences which are characteristic of any family constellation. Very general areas of similarity will be pointed out where possible, but as a rule, each family member must be evaluated on an individual basis and treatment planned accordingly.

The Effect on Parents and Siblings

At least one case reveals the complicating effect which a dominating mother can have on her son's welfare. A 28-year-old single veteran was referred by his doctor to medical social service for aid with his domestic and financial problems. The referral indicated that the patient's father was dead, and that although the patient was the second of four siblings, he was the sole financial supporter of his mother. He worried considerably about this, and complained that the only future he saw for himself, was the unhappy one of having to maintain her for the rest of his life.

When first seen by the worker, the patient expressed willingness to discuss his problem and work towards some solution, however, the patient's mother refused to accept help, maintaining, "they would work out their problems on their own". The mother was described by the worker as being a "domineering unhappy neurotic woman", who incidentally, also suffered from RHD. The patient fluctuated between willingness to accept help and erratic hostile behaviour, depending upon the frustration which his demanding mother created for him. At one time, it was noted that he was able to oppose everyone except her. Her demands revolved around a request for an additional pension for her son's disability which would provide for her as well, despite the fact that she was already receiving financial assistance elsewhere.

Part of her income, a widow's pension, was being paid by the department of veterans' affairs. Her husband, although eventually dying from a heart ailment, developed neurasthenia during his service in the first world war, and was pensioned for this. The worker noted that there was a striking similarity between the neurotic symptoms of which the father complained and those which the patient also developed. The patient had so identified himself with his father, that he had, in effect, assumed his father's role with the mother. She encouraged this unhealthy relationship and thereby directly affected the course of her son's illness. Through her demands that he alone be financially responsible for her, despite the fact that she had three other children who might share this responsibility, her neurotic attachment to her son became evident. Meanwhile, his

illness and his resulting pension, provided the source of financial security to which she had long been accustomed.

Since she consistently defied all offers of case work and psychiatric aid, it was not possible to help her son. A psychiatric report on the patient four months later, pointed out that no real improvement had taken place in his RHD condition. His tense, restless and emotional state was felt to be the contributing factor in his inability to recover. Specifically, it was stated that "his mother was the disturbing influence". As long as she was unable to recognize the detrimental effect her demands were having on the patient, the treatment team felt that the conflict created by his dependency upon her and his inability to break away, would continue to affect the prolongation and exacerbation of his illness.

This case also hints at the effect which this patient's illness created on his siblings. There is evidence of much ill-feeling, and it is expected that a great deal of this was aroused by the over-attention which the mother may have given to the patient in preference to her other children.

Other cases did not reveal so striking a relationship between family members as this one. Since the remainder of the selected cases were of older married veterans, little comment appeared about parents and siblings except to express how the <u>patient felt</u> towards them. The fact that RHD was acquired usually after the patients left home, and only in rare cases returned to their parents, accounts in part for this lack of information.

Only one other record contained sufficient information

which would bring out sibling relationships, and this has already been discussed more fully elsewhere.[1] Of importance here, was the stronger bond which was formed between a patient and his sister as a result of his illness. Her desire "to mother" him, was achieved at a time when her brother was finally prepared to accept her hospitality.

The Effect On Marriage Partners

Depending upon the expectations which wives of RHD patients seek in their marriage, a variety of responses to their husband's illness can develop. On the whole, frustration and resentment appeared to be the more common responses in at least 14 out of the twenty cases containing such information. Although data as to the cause of their unhappiness, does not appear consistently enough to indicate statistical comparisons, it was noted that many complained of financial inadequacy and the resulting poverty-stricken conditions with which they were forced to contend. Several specifically stated they were tired of having to assume responsibility for home management, children, etc., that sexual relationships were poor and that they no longer could continue to live "as man and wife, but rather as nurse and patient". Although many complained about environmental conditions, a few of them appeared quite content to care for their husband - in fact their marriage seemed to be held together by the changing situation of illness.

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1 See pp. (45-48), in Chapter 3.

Case Examples of Marital Difficulties

(1) Sexual Incompatibility - One wife became increasingly concerned about her 35-year-old husband's attitude and state of mind, because of his prolonged hospitalizations. At first she gave the impression she was sincerely interested in his welfare, as she tended to spoil and overprotect him. Arrangements were made for her by the social worker, to talk with the patient's doctor, and she was then given reassurance about her husband's condition. When she returned again and again with similar fears, some case work was given to resolve her difficulties. She began to complain that her husband was going crazy - that he accused her of running around with other men. During the course of her treatment it was revealed that she had lived in common-law relationship with her husband, prior to obtaining a divorce from her first husband. She complained of poor sexual relationships and expressed considerable feelings of guilt around this. In this sense, her accusations against her husband, appeared to be projections of her own unconscious desires.

She responded briefly to supportive therapy, although no attempt was made to give her insight into her basic conflict. This was sufficient to make an improvement in her husband's condition and he was eventually discharged. However, once at home, their marital incompatibility upset the patient, and in a short time he returned to the hospital, where he died. As expected, the wife's guilt feelings mounted and she continued to return to the hospital for help with her problem. Because of the deep-seated appearance of her emotional conflict, attempts were made to refer her for psychiatric treatment, but this was

consistently refused by her. The worker summed up this difficulty with:

> No help could be given her because of her need "not to understand".

(2) Immaturity Versus Dependency - A second example, is that of a young veteran who married an equally young and immature girl, shortly after he enlisted in the service. He was subsequently posted overseas, developed rheumatic fever and was discharged in 1942, - two years after his enlistment. Repeated hospitalizations since then, were mainly attributed to serious conflicts with his wife.

His was a wife who married for the romance and excitement she craved. Being even more dependent and immature than her husband, from the very beginning she refused to accept her role as a responsible wife. While the patient was overseas, she satisfied her needs through the attention other service men gave her, and managed to dissapate the savings which her husband sent her for safekeeping. While the patient was hospitalized during the early years of their marriage, she would abandon her two children to go "bowling and dancing". The patient insisted at this time that he encouraged her to enjoy herself, but it was felt he was really unable to oppose her.

Following his third hospitalization in January 1948, the family situation completely erupted. By this time, there were five children to care for. However, it was not until November 1948 and three hospitalizations later, that the case was referred to medical social service, The patient complained of his wife's irresponsibility with their finances, and suspected she

was running around with other men. Contacts with her through the public welfare agency in her community, revealed the extent of her irresponsibility. At first, the situation was eased somewhat by the fear which the wife encountered at the intrusion of the public welfare worker. Two weeks later, the patient's wife left him to live with another man, and stated at this time that she would divorce her husband. Her father in the meantime, arrived from Saskatchewan and had taken the children with him. Shortly afterwards, the patient's wife changed her mind and decided to return to her parents' home in Saskatchewan. Following a concentrated co-operative effort by case workers in the hospital and in Saskatchewan, the patient and his wife were reconciled. The patient responded to hospital treatment and after help was given in establishing a home for them, he also returned to Saskatchewan.

No sooner had reconciliation taken place, when it was learned that the patient returned to the hospital and was seeking a separation because of his wife's continued irresponsible behaviour. Again social service brought them together, but four months later, the situation became unbearable for him. He was transferred back to Shaughnessy hospital shortly afterwards.

At the time this study was made, the patient was separated from his wife, but continued to support his family from an adequate pension for his 100 per cent disability. She appeared quite happy with this arrangement, since she was living with her parents and they assumed the major share of care for the children. Her husband's illness has created for her the financial security which has been most important to her. It has

also meant frustration in terms of her desire for romance and excitement, however, it is reasonable to expect she will continue to seek satisfaction for these needs from other men.

The Effect on Children

The children whose parents are afflicted with chronic illnesses, are, unfortunately, the ones who suffer most in the long run. It is from their early experiences in the home that personality patterns emerge, and it is here that a normal child develops a feeling of security and well-being. Since it is expected that both parents must be reasonably well-adjusted, physically, as well as emotionally, if they are to contribute to the welfare of their children, it is not unnatural, therefore, to expect much turmoil and instability in children whose parents are so wrapped up in their own personality conflicts, that they can offer little to the dependent needs of others.

The detrimental effect which a father's absence creates on either a son or daughter, is a subject which has been given a great deal of attention by child psychiatrists and others interested in child welfare.[1] Since a father with RHD is repeatedly entering hospital for several months at a time, his periodic absence from the home, creates an unstable atmosphere for his children. When he is at home, his illness usually demands the overattention of his wife. Because of his need for rest and quiet, the children are forced to restrict their natural exhuberence. At the same time, it is not uncommon to

1 A more detailed account of this is given in, English and Pearson, Emotional Problems of Living, pp. 91-97.

find parents displacing frustrated feelings which illness has created for both of them, onto their children at the slightest provocation. Physical deprivation, which usually accompanies reduced incomes of RHD patients, also affects their children. Inadequate clothing, diet and shelter, make them easy preys to illness and disease. Finally, where foster home placements are necessary, in cases where both parents are unable to provide care, i.e. through illness or marital strife, the traumatic experience of separation provides for their children the climax for a totally unfortunate beginning in life.[1]

Recognition of these dangers by government and private organizations, has led to the development of vast child welfare programs to alleviate these conditions. Some mention has already been made of the community resources which the medical social worker uses in this regard.[2] As a rule, direct contact with these children by the medical social worker is avoided, and instead, co-ordination of the services of those agencies best equiped and trained to work with children, is attempted.

Case Examples of the Effect on Children

The first case, is one that has been described before.[3] Here, both parents would regularly go into hospital, so that foster home care for their 6-year-old child was needed.

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1 Gordon Hamilton, Theory and Practice of Social Case Work, pp. 281-83, points out the problems encountered in "The Separation Experience".

2 See p. (43), in Chapter 3.

3 See pp. (21-24), in Chapter 2.

Collateral contacts with the city social service and the children's aid society (C.A.S.), revealed that financial aid, as well as foster home care, had been given in the past. C.A.S. were also concerned about the effect of the mother's mental illness on the child.

Where possible, children are placed in the care of relatives in preference to strange foster homes, as the effect of separation is not so great when a familiar person is present. Consequently, C.A.S. arranged to place the child with the patient's mother-in-law. However, the patient was unable to accept this plan, as he resented his mother-in-law for her many interferences into his marriage. With the help of the medical social worker, the patient was able to give up some of the more-unreasonable conceptions of his mother-in-law, in view of the advantages her care could offer his child.

Following the birth of a second child, the patient again entered hospital. Shortly afterwards, his wife began to show signs of another mental breakdown. The patient was ready for discharge as his wife was admitted to the mental hospital, and, in a state of panic, he demanded that C.A.S. place his children immediately. A day later, he changed his mind and decided to care for the children himself. A few days later, housekeeping services were obtained through C.A.S., after the medical social worker encouraged him to utilize their services.

When last heard from, both parents were at home with their children. On the whole, the oldest child has seen very little of either parent, and was showing instability as a result of her unhappy experiences of separation from them. The second

child has little to look forward to, since it was expected that both parents would shortly return to the hospital. The possibility of removing the children to a permanent foster home, where more consistent care could be given, was being considered.

Another case example which has also been presented before,[1] indicates similar problems. Here five children were the victims of inconsistent and immature parents - the father either being in the army or the hospital most of the time, and the mother abandoning them on several occasions. It is not known what was done for the children except that child welfare agencies have been involved, and presumably have provided some substitute care.

It is doubtful how much can be done for children who are already so severely damaged emotionally. Two other cases indicate the possible result of such neglect of children, as both of these reveal difficulties with juvenile court authorities.

Case Work With Families

One of the few areas in which the medical social worker can be called upon to provide direct case work services to a member of a patient's family, is in helping parents and marriage partners to understand how illness affects the mental outlook of a patient, and also in gaining some assistance with their own difficulties which the patient's illness has created for them. The writer has suggested that as a rule, the particular community agencies specializing in the specific service needed e.g. the

1 See pp. (65 - 67).

family welfare bureau, would be called upon to aid the medical social worker with this latter task. In reality, this is not always possible. Since this study concerns itself with the male adult RHD patient, the wife of a patient may show a willingness to discuss her problems with the medical social worker, under the guise of providing information which will help the hospital team to treat her husband, but too often she will resist any referral to another agency. Because we are still living in an age when to ask for help with social and emotional problems implies a stigma, the wife may need much preparation by the medical wocial worker before she can feel free to go elsewhere to secure help with her own problems. The case referred to on p. (64) is a good example of this resistance.

An Illustration of Case Work With a Patient's Wife

The writer encountered much difficulty in presenting a fair example of the kind of case work which can and is usually given here. In some of the case records, it is apparent that considerable case work had been given to patients' wives and good results achieved in terms of the patient's health. However, in only one case is there sufficient recording to indicate the case work process used, but this case was still in progress at the time this study was made. This case has already been presented in Chapter 3, in relation to the social work which can be offered to patients with RHD.[1]

Mention was made of the detrimental influence this patient's

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1 See pp. (49 - 58), in Chapter 3.

wife had on his ability and motivation to get well. The first worker on the case was unable to bring about a noticeable change in her attitude but subsequent contact with the second worker, who had more time to spend with her, helped her to express much of her hostility which had previously been directed towards her husband. A more-detailed picture of this second worker's efforts is, therefore, being presented at this time. It should be noted that although case work with wives of RHD patients is on an environmental manipulative level in relation to the patient's treatment, all four levels may be used with the wife in bringing about this environmental change.

In an early interview, where the worker is attempting to establish a friendly accepting relationship with the wife, encouragement is given to her which would allow her to express her feelings about her husband's condition.

> I asked, "how do you think your husband is, Mrs...?" She replied, after a pause, "Well, I know he'll never be any better and he's likely to die at any time. I faced that long ago". I asked her if she thought he should give up the idea of ever leaving the hospital and she said very forcefully, "Well I haven't really said this before, but I think he is better off staying where he is, and I think he knows it most of the time"....I said it was quite a problem to have a husband who was unable, through no fault of his own, to fulfil any of the functions of a husband. She replied, "My God! That's sure a true statement". I said that one certainly wouldn't blame a person for feeling some resentment at the way things were, and she told me she "got pretty fed up at times".

Although the worker does not agree with the wife's conception of her husband's illness, she does not criticize the wife's defence. Instead, she indicates that she can understand that it has been difficult for the wife as well as her husband. This helps to create a feeling of acceptance and gradually the

wife is able to bring out her true feelings.

Later, as the worker senses that the wife feels more secure, the worker is then able to help her face the truth.

> I said, "You really don't want Mr...at home, do you", and she replied, "No I don't, but for God's sake don't tell him". I said that it was not our policy to repeat conversations with the husband or wife to one another, and that our conversation would be respected as confidential.

At first the wife is threatened by the abruptness of her disclosure; but, once again, she is given the necessary reassurance which would allow her to discuss her frustrations freely. At this point she begins to reveal her fears influenced by her past relationships with other social workers. She refers to people who "pry into other people's business", and although she does not mention the worker specifically, this is picked up by the worker and an interpretation of the role of social work is given to the wife.

> I said that while it might appear that way to her, that prying into other people's affairs had no place in <u>our</u> work and that our purpose was to give people a chance to talk over any of the things that might be bothering them - with the idea of giving any help we could. We did not want to <u>tell</u> her what to do; we appreciated the fact that people are able to make their own decisions, but talking about them beforehand often makes the path to be followed clearer.

The wife accepts this, and then pours forth her many frustrations at having to assume the role which is normally carried by a husband, but which his illness has changed. Like her husband, who is also a dependent personality, she is unable to assume any responsibility for her difficulties and projects the hostility which this frustration creates within her, onto her husband and everything connected with him. One by one, she

brings forth much resentment towards the various staff members treating her husband, and indicates that she does not hesitate to make her hostility known to them. Without attempting to interpret her behaviour to her, the worker encourages the wife to bring her future complaints directly to the worker. By the worker channelling the wife's hostility onto herself, the hospital staff is thereby saved much needless argument with a woman who is aggressive and wishes to make trouble.

The worker's appraisal of the wife, gives a good indication of her motivation.

> I felt two reasons for this hostility towards the staff. (1) It is an attempt to assuage the guilt feelings around her rejection of her husband and (2) an attention - getting device by which a dominant woman, resenting the fact that she has no status other than that offered to a "veteran's" wife, (no status in being the wife of a man you have rejected), seeks this status in a negativistic way be trying to dominate in the hospital situation.

This early diagnosis is later born out, and it becomes clear that the wife is jealous of the attention which everyone has been giving her husband in the hospital, while she has had to carry the load of maintaining a family alone.

> She said he was a "spoiled brat" and he expected her to spoil him the way his own mother had. I asked if she had always thought this was so, or just since he had been in the hospital. She said, in a tone of disgust, that he had always been that way.... "I don't mind looking after him, but I sure don't spoil him. She continued with a long dissertation concerning her husband's need to get used to having all these people "waiting on him" and to get used to the kind of food he was going to get at home.

The worker then plans to offer supportive case work to the wife, so that she can gain some measure of self-worth. By making her also feel important, it is expected that she will

have less need to reject her husband. A later interview points out this problem and indicates how the worker is able to handle it.

> I asked Mrs...how she thought her husband was feeling, and she said reluctantly, "I feel that he is much better since he has been moved". I said that I thought so too, and apparently the doctor believed this to be true as well. I thought Mrs...resented this improvement, because she said quickly, "Well it won't last I can tell you that". I smiled and said, "You said that so emphatically, that you must have some strong feeling about it". She paused, and then said vehemently, "Well I don't want my husband, or anyone else, thinking he can come home as soon as I get a house". At this point she glared at me and looked very upset. I said that this was one of the things I had wanted to discuss with her. I said I realized that she was making a serious effort to find new living accommodations, while at the same time worrying about all the adjustments which would have to be made by each member of the family. I said that I could understand that her life would be different with her husband home, that they would have to get used to each other again....Mrs...looked relieved, and said she...had thought of these things, and it bothered her. I said that I hoped that when she found a house, Mr... would take the transition in stages - first a weekend at a time at home, with gradual increases of time spent there, until they could see how things were working out. She said she was glad I thought this way too, because she was afraid the minute she got a house, everyone would think he should go right home. I said that the hospital treatment team was concerned not only with the patient, but with his adjustment at home, and was therefore interested in the whole family.

Following the worker's supportive understanding of the wife's conflict and clarification of the treatment team's interest in her, as well as her husband, clarification is extended to an interpretation of the husband's feelings about his lengthy hospitalization.

> She said, "Well he seems to have the crazy idea that he can move right home and everything will be cosy". I said that such an idea would seem "crazy" to those of us who were active, healthy, people and living our normal lives, but to a patient who has spent about two years in hospital, it was natural to think he would be going home to the same situa-

> tion he had left. I pointed out that she could help her husband by planning with him....

The wife's resistance to change is accepted and understood by the worker and gradually other household problems, such as control over finances, care of the children etc., are faced. The worker encourages the patient's wife to discuss all these problems with her husband, while he is still in the hospital. It should be mentioned, that these areas of conflict were also discussed with the patient, and he was also encouraged to talk with his wife. In this way the greater part of the tension between husband and wife, is released in the accepting atmosphere of a worker-client relationship.

It is in connection with this problem of home finding, that the worker brings out one of the basic principles of case work - that of encouraging the client to make his own decisions. As they return from an inspection of a prospective apartment, the patient's wife asks the worker to decide whether or not she (the wife) should take this suite.

> I explained again that it was not my function adding that I was sure she didn't want me to make up her mind for her, although I hope she knew that I wanted to be of help if I could.

At this time all the frustrations of early experiences with social workers and social agencies is expressed, and as the worker encourages her to bring out this hostility, without criticizing her, she helps the wife to understand the cause of this feeling.

> I said, "this sort of thing bothers you doesn't it Mrs...because we've talked about it before, although you've never told me why you dislike social workers". She paused, and told me how she had hated the woman who had "butted in" about her

children. I said you were perhaps a little afraid at the time and reacted by being angry? She paused and said finally that she guessed she had been "sort of scared". I said that when we are frightened, we often don't show that we are, but hide our fear by getting angry at someone - often a different person than the one who had made us afraid.

Although progress has been very slow, there has been some positive indication that the wife has changed since first seen by the worker. On the whole, she has responded to the feeling of acceptance which the worker has given, and together with the changing attitude of the husband towards her, she has been able to modify her demands upon him. As has been pointed out before,[1] it is doubtful whether complete reconciliation in their own home, will every become a reality. The patient's physical condition is too serious to ever allow this for any length of time, but at least the emotional tension which formerly existed between husband and wife has lessened considerably, and the patient has experienced benefit from this. The hospital staff, who were formerly annoyed by a hostile wife, have also received benefit through the efforts of the social worker on their behalf.

The purpose of this area of presentation has been to point out the far-reaching effects which a patient's illness can produce on others. Because of the varying inner and outer needs which individuals in a family constellation seek to satisfy as they interact with one another, and the barriers which illness of one of the members creates in the search for

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1 See p. (58) in Chapter 3.

ultimate satisfaction of these basic desires, the role of social workers in the community becomes clearer. Ways in which the medical social worker seeks to combat these resulting difficulties, as a member of this vast community team, have been suggested. Too much emphasis cannot be given to the interdependent relationship which must exist, not only between members of the hospital team but also between the various community agencies interested in the well-being of its citizens, if the individual efforts of these valuable resources are to achieve maximum results. The following section will attempt to bring together the conclusions which this study has to offer in making such results possible.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study has been to explore the social and emotional backgrounds of male adult patients affected by rheumatic heart disease, in order to determine the following relationships:

(1) The connection - if any - between a patient's social and personal background and his susceptibility to rheumatic heart disease.

(2) The relationship between emotional disturbances and the course (onset, convalescence, and later recurrence) of rheumatic heart disease.

(3) The specific social and emotional factors which affect the patient with rheumatic heart disease.

(4) The role of the social worker - as a member of the treatment team - in alleviating these environmental and personal pressures.

Two main factors have influenced the validity of the findings, (1) the cases selected for this study, and (2) the available social and personal information concerning the patients selected. Because only those patients which were referred for medical social service at Shaughnessy hospital were used, approximately three-quarters of all the RHD patients admitted during a four-year period, (1947-1951), were excluded. Medical records available on each patient, did not contain sufficient social and personal information to make a more-complete study of all RHD patients admitted to the hospital

possible. Although medical social service records included such information, even these in many instances, did not possess sufficient material from which to draw valid conclusions. Despite supplementation of these records by material obtained from other sources,[1] it was still not possible to obtain enough information about RHD patients - especially their early social and personal histories.

Although only records of veterans with RHD have been examined, the findings of this study are, in the main, applicable to all patients affected by RHD. The most outstanding finding, not only in terms of hospital treatment, but in the broader aspect of community responsibility, has been the relationship between the increasing economic difficulties which beset the RHD patient and his extensive physical and personal inadequacies. As a rule, the RHD patient entering a veterans' hospital, does not suffer the added burden of hospital debt as does the average citizen. On the contrary, there are times when the veteran is far better off financially, e.g. increased pension grants, rehabilitation programmes, etc. Therefore, it is reasonable to expect that economic difficulties present as great, if not a much greater handicap to all RHD patients.

Despite the resources within the department of veterans' affairs, the RHD patients examined in this study have not been able to make effective use of the environmental aid offered to them. Part of the answer to this enigma lies in the area of incomplete or inadequate resources, but what seems to be of

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1 See pp. (13-14) in Chapter 1.

equal importance, is the personality defect within the RHD patient, that does not allow him to make full use of this aid. Although information surrounding personality formation of the RHD patient is very sparse, there is sufficient evidence of similarity in all the cases examined, to indicate there is an interrelationship between personal adaptability, social pressure and eventually, physical deterioration.

In all cases, it was seen that the RHD patient's preparation for adulthood and the responsibilities which accompany this stage of development, was mainly inadequate. It is difficult to say whether his education was limited because of solely personal or social pressures. Similarily his choice of a physically-strenuous vocation would appear to be the result of a number of interrelated factors. It is significant, however, that there has been little permanency of employment or development of skills. The exercise of manual labour is the only common factor in his choice of employment.

It has been suggested that the personality of the RHD patient has been founded upon insecure relationships. Somewhere in his development, he has "learned" that in order to gain approval, he must constantly drive himself. In our competitive society, where the physically-superior athlete is given high honours, it is not strange to equate acceptance by others with a show of physical prowess. It has also been suggested, that despite this need to exert his independence, the RHD patient has never really resolved his earlier dependency feelings upon his parents and later upon parent substitutes. This constant "unconscious" mental conflict, therefore exerts itself "psychoso-

matically" upon his physical condition, so that by driving himself physically, he achieves satisfaction for both his dependency and independency needs. He gains approval for his martyr role as well as dependent care which his resulting illness affords. In this way, he is able to resolve his conflict so that it is now acceptable to his conscious self.

This pattern of reaction is evident in all phases of the RHD patient's adult life experiences. Not only in his choice of and ability to maintain suitable employment is this noticeable, but, what is equally important, in his marital adjustments as well. It has been shown how many of the RHD patients have attempted to seek a haven of dependent emotional security in their marriage, but because their wives have not been able to play the mother-role as was expected of them, more, rather than less, social personal and physical turmoil has resulted for these patients. What is then observable, is a vicious, never-ending cycle of social and emotional problems which appear to precipitate repeated attacks of RHD. As the RHD patient becomes frustrated by his inability to maintain a former level of existence, he becomes more susceptible to reinfection. By becoming ill, his environmental problems increase, he becomes more frustrated, and his ability to respond to treatment is impaired. If and when he does recover, he returns to an emotionally-charged atmosphere which has not improved during his absence. His physical condition is further impaired, and the pattern repeats itself - perhaps until such time as death takes over.

However, the problems which have surrounded the illness do not stop here. The interrelationship of family members and the

effect which the breadwinner, suffering from RHD, has had on them, remains. If divorce or separation has not ended the marriage long before this, and children born to this union have not grown sufficiently to fend for themselves, the family continues to bear the brunt of the ever-increasing financial burden which illness has created. Because they have been forced to live under poverty-stricken conditions, the roots for further social and physical disorganization have struck deep. Because illness has interfered with the satisfactions normally sought in marriage, personal disintegration in the wife has reached a high peak, but perhaps it is the children of this marriage that suffer the most. Since many children have been denied the basic security of a happy normal home, their personalities have already been so severely damaged that they are ill-equiped to face the mature demands of later life.

The role of the social worker has been presented as that member of the hospital treatment team, who is specifically trained to cope with these social and emotional problems affecting patients with RHD, as well as other forms of illness. Four types of therapeutic processess, (1) environmental manipulation, (2) psychological support, (3) clarification, and (4) insight have been introduced as basic forms of differential case work treatment. Because of the deep-seated nature of the personality conflict of the RHD patient and the permanent dependency situation which accompanies the physical limitation of a chronic illness, the writer has suggested that the major contribution of the social worker, lies in the area of environmental manipulation. However, in order to help this patient

make the best use of the resources which are available, the value of psychological support and clarification has been indicated.

As part of the social worker's job of social amelioration, his work with the patient's family has also been presented. Most common, is the interpretive work which must be done with the patients' wives, for it is this intimate relationship of marriage which has been so seriously damaged by illness.

Because the greatest area of social pressure affecting the emotional well-being of the patient and his family stems from sources within the community, it has been suggested that the burden of responsibility is largely a community one. In the broader sense, the medical social worker has also been presented as a member of the community treatment team, as well as the hospital staff.

The social worker, therefore, has a role to play with RHD patients in a hospital setting. Specifically, this is:

(1) To work together with other members of the treatment team, to bring about the best possible treatment measures for the good of the patient.

(2) To determine what emotional pressures are affecting the patient's response to medical care - both from "outside", and within the hospital.

(3) To utilize all the available resources which will ameliorate the conditions creating these emotional pressures, so that the patient can better respond to medical treatment. This includes the use of both environmental and psychological aids.

(4) To work with the community welfare team in the performance of their task to bring about the best possible atmosphere for the mental and physical well-being of the citizens within that community.

Recommendations

Treatment for RHD patients is of long-term duration. Because of the chronic nature and the extended convalescent period of RHD, adequate social service to these patients must be on a continuous basis. This involves then, the continuous and co-ordinated effort of both the medical and community social workers. The former group is required to offer treatment while the patient is in hospital, but it is the latter group's responsibility to provide adequate preparation and follow-up services to insure that hospital treatment will be and has been of utmost benefit to the patient. If it is accepted that people who suffer from RHD have the right to receive physical, mental and social treatment just as any other member of society, then the need for more-adequate service, is self-evident.

Staff Requirements

As has been pointed out,[1] the general practice of social workers who are carrying a heavy case load, is to select the greatest number of patients who can benefit from the least amount of the worker's time. It is the chronically-ill patient who usually must be sacrificed when this necessary procedure is carried out. There is a need for more social workers to cover

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1 See pp. (53-54) in Chapter 3.

this gap in treatment services. A case load of thirty to forty chronically-ill patients at any one time, is probably the maximum that can be expected to receive full benefit of case work services by one worker.

Again, because of the time involved, there is a need for sufficient highly-skilled social workers who can make the best use of the time allotted to each patient. There is a great difference between the untrained social worker who merely "visits", and the one who has had at least two years of professional training, as well as lengthy medical social work experience. The professional social worker, is the type of person who, not only possesses an innate capacity for "helping others to help themselves", but who has also, through training, added an objective awareness to his understanding of human behaviour.

The plea for experience in medical social work is founded upon the complexities which social work in a medical situation create. The ability to work with other treatment-team members calls for added skill and knowledge. The medical social worker's function is to help interpret to other team members, the meaning behind the patient's reaction to illness. Because of his greater awareness of the social situation beyond the hospital setting and his understanding of human behaviour, the medical social worker is in a natural position to perform this liason work with other members of the treatment team who are not ordinarily concerned with the social and emotional aspects of illness,but are more directly interested in the specific medical task for which they have been trained. As always, the ultimate focus is on the patient-as-a-whole, not just the patient.

Resource Requirements

Apart from the physical equipment, such as adequate office space, clerical staff, telephones, etc., which permit the social worker to carry out his job without unnecessary restrictions, there are specific service requirements for the welfare of RHD patients which must supplement case work treatment. It has been pointed out that a veterans' hospital, such as the one where this study has been made, has numerous valuable resources at its disposal.[1] In considering the social problems which are most frequently encountered by RHD patients, the value of financial aid for patients and their families at a time when hospitalization is creating the most serious financial burden, cannot be overlooked. Too, the convalescent homes, (George Durby Health and Occupational Centre, Hycroft), fill a need which the usual convalescence in overcrowded, damp, poorly-constructed, cold homes of RHD patients, does not provide. The possible use of nursing homes specifically designed to meet the emotional as well as physical needs of the RHD patient, requires further investigation. Opportunity for retraining through correspondence courses etc., and aid in finding employment which is in keeping with the physical limitations, is and should be, also available. Temporary use of a sheltered workshop which is designed to bolster the confidence of physically inferior patients, is another area which needs further exploration.

Retraining aids serve the dual purpose of not only making it possible for the RHD patient to maintain his role as

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1 See pp. (43-44) in Chapter 3.

breadwinner, but what is equally important, provides him with a much-needed form of diversion to counteract his natural tendency to brood over himself during the long months of his "restful", yet "restless" convalescence. This does not obviate the need for other forms of occupational therapy. The possible use of group work with RHD patients, as a part of treatment, is another area which still needs much more exploration.[1]

Unfortunately, these services are not available for all chronically disabled RHD patients. For those who are not eligible for maximum veteran benefits, the existing services of the community have been used. In any event, there is a serious gap in both resources. The patient affected by RHD is expected to function within the limitations of the society in which he lives, as well as within his physical limitations. The use made of retraining programmes, employment services, financial support, etc., is only valuable in comparison to the availability of these resources within the community. Realistically, it is not always possible to find suitable employment described as light work, etc., or low-cost, though adequate housing.

For this reason, it is necessary to re-examine our standards of financial aid. How much better equiped, emotionally as well as financially, is the one hundred per cent disabled veteran who receives sufficient income to meet the economic

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1 Celia R. Moss describes some interesting experiences on this subject of group work in a medical setting, in her article, "Integrating Case Work and Recreation in a Military Hospital", Journal of S.C.W., Dec. 1946, pp. 307-313.

need of himself and his family. Consider however, the patient who sees debts mounting up in front of him, with inadequate means at his disposal to counter-balance them. Is it any wonder that many are forced to abandon the wise counselling of doctors and return to physically strenuous employment which is available, long before it is safe for them to do any type of work? Is it any wonder that many delay medical treatment until their physical condition becomes critical? Is it not also possible that many consciously or unconsciously seek to prolong their hospital stay, because it is the only solution they can visualize to an ever-widening circle of financial debt?

There is a strong case for recognizing the added burden which chronic illness places on the RHD patient. Since much of the emotional strain affecting the course of his illness surrounds his financial inadequacy and its resulting social disorder, there is a need for a more-adequate re-allocation of welfare budgets which will compensate for the RHD patients' and their families' unequal struggle for survival. It is evident that the cost to society is far greater when a breadwinner is undergoing hospital treatment, than if he can be maintained in his own home. Also, the value which his resulting emotional well-being creates in terms of the effect he has on his family, cannot be overestimated. An atmosphere for stable personality growth of an RHD patient's children, provides greater assurance that as these children grow up, they will be better-equiped to cope with the demands, and contribute to the needs, of society.

The Need for More Research

More research is needed along similar lines of this study

with other groups of adult male RHD patients. As this study has concerned itself mainly with the veteran RHD patients, there is a danger of drawing conclusions which are not applicable to the general population. A control group which is more representative of the young male adult population could be selected for a research project which would involve the co-ordinated activities of several interested disciplines. Since the availability of background information, feelings towards illness etc., has been lacking in the records used for this study, it is felt that a controlled research project could overcome this difficulty, and more-accurate statistical comparisons could be made. Too, more-effective measurements of the relationship between emotional and physical responses should result, by the comparisons which each discipline can make, as specific treatment measures are introduced.

Related research projects are also needed. As a possible suggestion, there is a need for a closer examination of the possibilities for greater co-ordination of the efforts of the treatment team, both in and out of the hospital setting. The advantages and disadvantages affecting the granting of pensions (i.e. pensionitis), is another area for further study. Specific research projects on other forms of chronic illness such as rheumatoid arthritis, diabetes, etc., are also needed. In connection with this latter project, the formation of a standardized method of approach would prove invaluable in terms of statistical comparisons.

Adequate Use of Recording

Since the major difficulty affecting the findings of this

study involves the unavailability of complete medical social service records of the patients selected, some change in the future plan of recording is suggested. In view of the large case loads and shortage of medical social service staff, which existed at the time this study was being conducted, recognition is given to the limited time which the social workers have been able to devote to recording. These recommendations concerning the more-adequate use of recording, are being presented in terms of ideal working conditions which include the necessary time for such recording.

Because of the unique use to which medical social service records are put,[1] provision should be made for two kinds of files. The first would be similar to the type of recording now in use - namely, a brief report on the significant facts surrounding the social and emotional problems of the patient and the corresponding case work treatment used to counteract these problems. The second set of recording should be a more-detailed account of the significant factors surrounding the patient's illness, on an interview by interview basis.

Whereas the first record would be placed on the central file, the second one would be retained for the exclusive use of

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1 All departments of D.V.A. are requested to file individual reports in a common file, so that complete information of all services rendered to the veteran is readily available. The disadvantage of this for medical social service, is that records must be written, not only for future use by social workers, but for other treatment team members who have little interest in detailed reports of the process of social work as such. For this reason, as a rule, medical social service reports usually indicate briefly, what has happened - not necessarily how and why a change has taken place.

the medical social service staff. There is value in this latter set of records not only for future research purposes but also for supervision and teaching of case work staff. Skills in case work used to relieve the patient's problems, would thereby be improved. Because of the extra time involved for such recording, provision should be made for clerical staff to handle this load.

The use of very full (process) recording is, of course, the most valuable method of obtaining research material. Since this is very time-consuming, it is not suggested as a practical method for the average case load. Changes in the chronically-ill patient are rarely sudden, and much repetition of material is unnecessarily recorded. However, this recommendation does not obviate the use of process recording where the specific function of the research project is designed to bring out techniques of case work treatment. There is room for much improvement in case work treatment with the chronically-ill patient.

Prevention

The best remedy for any chronic illness is of course, one of prevention. As with treatment, there are two aspects for consideration (1) the responsibility of the community towards prevention, and (2) the responsibility of the hospital.

RHD is a social responsibility, therefore, the major role of prevention lies within the community. Since "poverty breeds disease", more adequate social measures are needed to remove this source of infection. Slum areas, etc., need to be replaced by living conditions more conducive to the physical well-being of its inhabitants. Although this study does not attempt to

verify theoretical assumptions of emotional factors contributing to the development of RHD, the importance of mental pressures cannot be overlooked in any prevention programme. For this reason, adequate health measures will include both physical and mental health education, especially during early childhood years where the onset of RHD is so prevalent. The use of social services as a part of the programme, is vital.

More specifically, the hospital's role in prevention, from a social work point of view, is that of early diagnosis and referral to medical social service as soon as it is apparent that there are social and emotional problems affecting the course of the patient's illness. On the basis of this study, it is felt that there is a strong possibility that many other RHD patients treated in this and other hospitals, have not been referred to a medical social worker when such service might have been required by the patient. For example, two records of RHD patients have been selected at random from approximately seventy-five patients who were never seen by a medical social worker at any time while they were undergoing veteran hospital treatment.

The first case is that of a 25-year-old veteran who suffered with RHD since his first attack of rheumatic fever in 1942. He died six years later, after fourteen readmissions. This patient presented the usual pattern of sporadic, strenuous employment, and although he received some training as a jewellery repairman while undergoing hospital treatment, he was never able to support himself again. In 1947 it was noted that he was married, and that he was having difficulty finding living accomodations. A few months later, it was noted that he entered

hospital immediately after a child was born to his wife. There are suggestions in the record of financial difficulties, as well as possible friction with his wife.

The second case is that of a 63-year-old veteran who has been continuously ill since World War 1. Since 1919 he has averaged more than one admittance per month to the hospital. It is known that his wife deserted him in 1947 and that he has had continual financial problems. Although he has been informed of the limitations of his cardiac ailment, he constantly denies this and continues to work at strenuous employment. It was felt that although this patient attempted to very "independent in expression", he was basically emotionally dependent and quite immature. As an example of his self-destructive behaviour, it was noted that he once fell from a wagon while he was working on a farm, and fractured his left arm. A short time later he removed his cast "because it hampered his movements".

If social work services are to be most effective, referrals must be made as early as possible by the doctor in charge of treatment. In view of the findings of this study, there would also appear to be a case for an automatic referral to medical social service of all RHD patients. Since there are RHD patients, who, because of their quiet manner do not openly express their emotional problems to hospital staff, it is important that they not be overlooked. The patient who cannot express his difficulties, suffers much more mental strain and subsequent psychosomatic discomfort, than the one who can "release" his feeling more readily. As a future research project in prevention, a comparison could be made between the progress of RHD

patients who were referred to medical social service on admission to hospital, and those whose referrals were delayed until such time as their social and personal problems appeared to the hospital staff to be of sufficient magnitude to warrant social work services.

APPENDIX A

MEDICAL ASPECTS OF RHEUMATIC HEART DISEASE[1]

Definition: The various inflammatory changes in the heart which arise in rheumatic fever, together with the valvular deformities and other scars that remain, constitute rheumatic heart disease. This term is now used to indicate that the individual has or has had rheumatic fever, even though it has not been clinically evident.

Classification: Two classifications, active and inactive are most commonly used with RHD. The former is used to designate that a rheumatic infection is present in one or all of the structures of the heart. The latter indicates the infection has ceased but healed lesions remain. These lesions are usually valvular deformities resulting from a previous inflammation.

Another grouping includes four classifications, (1) fulminating - occurring during the initial attack of rheumatic fever, (2) recurrent active - intervening intervals of quiescence, (3) chronic active - inflammation persisting over periods of months or years, and (4) chronic inactive - where the disease exists for years without signs or symptoms of a rheumatic infection, yet healed structural lesions are present.

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1 Extracted from Russel L. Cecil, "Rheumatic Heart Disease," Textbook of Medicine, pp. 1185 - 1192.

ETIOLOGY AND MORBID ANATOMY

Cause: Although 20 to 30 per cent do not show existence of rheumatic fever, it is believed that this disease is the cause of RHD.

Development and Mode of Onset: Rheumatic fever - An infection in the form of polyarthritis, muscle and joint pains, chorea and carditis, is the characteristic mode of onset in over 85 per cent of rheumatic fever patients under ten years of age. After age forty, approximately 20 per cent of the patients are so affected.

Rheumatic heart disease - approximately one-third of the children developing RHD give evidence of polyarthritis first, another third have carditis and chorea. Young adults usually have polyarthritis, whereas older people usually have only signs of valvular lesions.

Type of Infection: During adolescence and early maturity, carditis is seen more frequently as a single manifestation.

Symptomatology: Onset of Active RHD - Usually an inflammation of the myocardium and valves - less commonly of the pericardium. Subsequent course - In children, the course of inflammation may last from several months to several years - sometimes it may never completely subside.

Disappearance of the clinical signs does not mean that the inflammatory process is inactive. Further damage can result by ill-advised, premature physical activity. Recurrent periods of active RHD result in progressive damage to the heart,

heart failure, and death, if adequate rest and similar measures are not enforced.

Onset of Inactive RHD

Not all rheumatic fever turns into RHD of a permanent nature. Approximately one-half of rheumatic fever patients from ages twenty to fourty do not get RHD. Subsequent course - Symptom free unless complications supervene (e.g. congestive heart failure), it is possible to remain symptom free for ten to twelve years, then develop cardiac insufficiency, followed by congestive heart failure.

Complications - More commonly found in the inactive group -

(1) Cardiac insufficiency - This is probably the most common complication. Within three or four years after the symptoms of cardiac insufficiency, e.g. fatigue and dyspnea, first appear, approximately 50 per cent of the patients die in spite of treatment.

(2) Heart failure - When the symptoms of cardiac insufficiency are so easily induced that the patient becomes distressed on slight exertion or even while at rest, heart failure is said to exist. Heart failure usually appears about two years after the first signs of cardiac insufficiency are in evidence. About 80 per cent of the RHD patients suffer at least one attack of heart failure.

(3) Embolism - The source of emboli is usually from a thrombus in one of the auricles or auricular appendages. Pulminary infarction is probably the most common embolic manifestation of RHD.

(4) Arrhythmia - The most common irregularity of rhythm affecting the RHD patient, is auricular fibrillation. Approximately fifty per cent of the rheumatic cardiac patients are so affected. Arrhythmia is most commonly found in the fourth decade. About 75 per cent die within three years after the onset of this complication.

(5) Bacterial endocarditis - Approximately six to ten per cent of the RHD patients die from this - the majority from a subacute type of infection.

Incidence: Sex - Ordinarily equal numbers of males and females are affected by RHD.

Race - This is still an unknown factor, although it is common to find higher incidences among such racial groups as Negroes in parts of U.S.A., where environmental pressures have forced these people into infectious areas.

Climate - RHD is most commonly found in the temperate zones, particularly in the northwestern areas of U.S.A. and the British Isles.

Prognosis - Life expectance is short. About 50 per cent live nine years, 25 per cent longer than 17 years, and only 10 per cent longer than thirty years.

Treatment - Treatment of inactive phase is directed mainly towards complications which may arise.

Convalescence - The rate of recovery is roughly proportional to the length and severity of the illness. The patient is usually kept in bed for two or three weeks, until free from fever and

other signs of infection. Following this, is a period where the patient is allowed to sit in a chair in gradually increasing amounts, so that he can sit for four or five hours a day without undue fatigue or reawakening of the infection. Then, he is permitted to walk at first only a few steps. Stair climbing is not permitted until walking comes easy to the patient. Where possible, it is recommended that the patient be moved to a southern climate. In any event, cold, damp environments conducive to the creation of re-infection, should be avoided.

Recent experiments have been conducted with children who are susceptible to streptococcal infections. During the winter months, small doses of sulfanamides have been given to them, and this treatment has resulted in a lower incidence of re-infection than patients who were not given such treatment.

APPENDIX B

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