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A study of the social factors and the case worker's role in the treatment of twenty patients with bronchial asthma at the Beth Isreal Hospital

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Boston University
A STUDY OF THE SOCIAL FACTORS AND THE CASE WORKER'S ROLE IN THE TREATMENT OF TWENTY PATIENTS WITH BRONCHIAL ASTHMA AT THE BETH ISRAEL HOSPITAL

A Thesis

Submitted By

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In Partial Fulfillment of Requirements for the Degree of Master of Science in Social Service

1952
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CHAPTER I

INTRODUCTION

Purpose of the Study

The medical profession, including the allergist, psychiatrist and pediatrician, are increasingly stressing the social factors which are connected with the course of asthma as well as its onset. Since it is the social worker who is especially trained to help the patient in his social situation she would seem to have a specific role in the treatment process.

The purpose of this study is to explore the social factors which are present in the children and adults with a diagnosis of bronchial asthma and to learn the role of the social worker in the treatment of these cases. The writer hopes to find out the ways in which the medical social worker can help the asthmatic patient benefit from the medical treatment he is receiving. The writer sets forth the following questions to be answered: 1) What are the reasons for referral to the social service department? 2) What are the factors in the environment which seem to be impeding treatment? 3) What methods are used by the social worker in trying to remove the obstacles? 4) To what extent is it possible to achieve these objectives?

Scope, Method of Procedure and Limitations

The twenty cases of asthmatic patients under consideration were known to the Beth Israel Hospital Social Service Department during the years 1950 and 1951. It was necessary to
cover the span of two years in order to secure a large enough number of cases for an adequate study.

It is recognized that the age span of the patients used in this study is large and that there are different factors involved in the psychological development for the various age groups; however, it is felt by the writer that this in no way interferes with the primary purpose of the study to learn the ways in which the medical social worker can render a service to the asthmatic patient.

A survey of the literature dealing with the subject under investigation will be given.

In this study social factors will include environmental and emotional aspects. Environmental factors will refer to housing, finances, employment, recreation; and emotional factors will include relationship to parents and siblings and any overt disturbance in this relationship.

A description of the agency will be given in order that the reader will have a frame of reference for the activity of the social worker.

Each case, eight children and twelve adults, will be studied with the view of obtaining the social factors which are of significance in the asthma syndrome. The family background will be reviewed.

Case presentations will be given to illustrate the significant social factors and the way in which the medical
social worker was able to help the patient. These cases will be representative of the total sample study.

This study includes a small sampling; therefore, the conclusions apply only to the cases studied and are not a valid means by which to judge all asthmatic patients and the role of the medical social worker with them.
CHAPTER II
THE SETTING

The Beth Israel Hospital is a voluntary general hospital with departments of general medicine, pediatrics, surgery, obstetrics and psychiatry, each service having its own ward beds with the exception of psychiatry. The Hospital also has an Out Patient Department. Persons are served regardless of race, creed, age, residence. Ability to pay is determined by the Admitting Officer, and the Social Service Department is not related to this procedure except for consultation if requested. Cases from out-of-city are reviewed, and it is the task of the Admitting Officer to deem if admittance is advisable based on the fact that adequate services do not exist in the local town or city.

The Social Service Department of the Beth Israel Hospital was an integral part of the blueprints. Medical social work has always been considered an important component of good medical care there. The philosophy of the Hospital is expressed in the 1949 Annual Report of the President:

From its inception, Beth Israel Hospital has given full recognition to the fact that sound medical care embraces an understanding of the patient as a person and thus includes treatment of the social and emotional factors that often serve to make or keep people sick.

The referrals to the Social Service Department come from various sources: clinics and wards in the Hospital, other
hospitals, social agencies, patients themselves. Referrals to Psychiatry from the Out Patient Department are channelled through the Social Service Department where an intake interview is handled by the social worker. If a child is referred, the psychiatrist usually works with him and the social worker with the parent, usually the mother.

As part of the medical team the social worker helps the patient to utilize the medical care offered so that optimum recovery will be achieved. This may be in the area of concrete services such as transportation, dispositional planning which includes nursing home care and convalescent home care, or it may be in the less tangible area of the patient's reaction to the illness and the steps to recovery.

As a team member the social worker interprets the patient as a social person to the other members of the medical team, for the social situation must be taken into account to insure complete medical care and treatment. The social worker also contributes her knowledge of community resources which will facilitate medical care.
CHAPTER III

THE ILLNESS

"Asthma derives from a Greek word which means 'panting'."\(^1\)

It is characterized by a type of breathing, an audible wheeze which is more pronounced on expiration. There is a sensation of tightness in the chest with slow, laborious breathing. The patient may have fever, nausea, vomiting, and very often a violent cough which may raise a sputum of mucus.\(^2\)

It is heart rending to see a patient gasping for breath, pleading for relief in his fear of suffocation and choking to death. One can understand how this would result in a feeling of helplessness on the part of the parent of the asthmatic child and the great threat it brings to the elderly adult patient who feels that death is imminent anyway.

The duration of the attack varies depending upon the individual as well as persons in his environment. If there is an emotional atmosphere of encouragement and calm where the patient can feel secure and comforted, his fears will subside and the resulting mental relaxation has its influence on the severity and duration of the attack. The emotional attitude of the parents of an asthmatic child plays an important part

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in relieving the patient's anxiety. This atmosphere of calm and encouragement is essential to the treatment of the adult patient, too, for the struggle to breathe brings fears and anxieties to him as well.

The treatment of acute attacks of asthma varies with medication taken orally or injections administered by a physician. Sometimes just a change of environment to the hospital will stop a severe attack. The confidence and encouragement supplied by the availability of medical care are often sufficient to allay fear and anxiety, thus helping the patient to become less tense and relax.

In those cases where a diagnosis of allergy is established, the patient is treated for it. If attacks seem to be associated with an exposure to particular agents such as food, animals, pollens, the patient is skin-tested to determine the hypersensitivity. Then the patient submits to regularly scheduled injections of vaccine. Sometimes a change of environment to a locality with different flora is necessary. However, then the question arises as to whether the physical separation from the allergen is the vital factor in the improvement, or whether the freedom from emotional stimuli in the previous environment accounts for the relief. In some cases, when the asthmatic patient is removed from the allergen, the asthmatic attacks still persist due to the fact that the emotional atmosphere has not changed.
Dr. Leon Saul suggests:

... the thesis that the emotional leads to physiological changes which either 1) imitate the allergic symptoms or 2) render the tissues more sensitive to allergens (which are the substances to which the victim is allergic) or 3) do both. Thus the choking brought on by a pollen may be intensified or relieved by the emotional state, and the choking originating in the state of emotions may become worse because of the pollen.3

At this point the writer would like to review some of the literature that deals with the discussion of the etiology of asthma. This etiology has been approached from different angles throughout history, depending upon the scientific concepts of the day. The present-day attention on the emotional component of asthma is not a new one; it actually dates back to Hippocrates who gave cognizance to the emotional component.

Until the allergic phenomena were discovered, asthma was considered primarily a nervous disease and is referred to in older medical textbooks as 'asthma nervosa'. With the advent of modern immunology, in which the phenomenon of anaphylaxis was a cornerstone, attention became focused on the allergic component, and the older view of asthma as a nervous disease came to be considered as obsolete. More recently, in the era of psychosomatic orientation, the emotional etiology of asthma was revived.4

Although the point of view of emotional etiology is supported

3 Dunbar, op. cit., p. 178.

4 Franz Alexander, Psychosomatic Medicine, Its Principles and Applications, p. 133.
by many of the investigators, some of them do not discard the influence of the allergic factor entirely. Dr. Alexander goes on to say that one should not be oblivious to the allergic factors.

Concerning the hereditary factor, Weiss and English say:

Because allergic problems are so often thought of as hereditary let us suggest that pseudo-heredity is also important and must be distinguished from true heredity. We are thinking of the . . . manner in which a child can absorb the behavior pattern of some member of the household to whom it is intimately attached and then in later life, without consciously realizing it, imitate the illness of that particular person. Because the person is a blood relative we often think of this relationship as an hereditary one when it is in truth an environmental problem dating back to the earliest days of infancy.5

Much of the literature deals with the psychological factors influencing the physiological processes which result in the asthma syndrome. Intensive studies have been carried out by Dr. Franz Alexander and Dr. T. M. French at the Chicago Institute for Psychoanalysis and is reviewed thoroughly by Weiss and English,6 and the findings are summarized below:

1) Separation from the mother was the primary emotional problem. A strong dependency relationship upon the mother was evidenced in all cases, and whenever this relationship was threatened asthmatic attacks resulted.

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5 Edward Weiss and O. Spurgeon English, Psychosomatic Medicine, p. 495.
6 Ibid.
2) There seemed to be a relationship between the asthma and crying or laughing, for in some treated cases the crying appeared as the asthmatic attacks ceased.

3) The threat of the loss of the mother's love was indicated in the fear of sexual temptation and in sibling rivalry.

4) Maternal rejection increased feelings of insecurity for the asthmatic child with resultant clinging to the mother. Many of the mothers were of the rejecting type. In order to avoid rejection many of the children were overobedient or utilized other sicknesses to gain affection.

5) Many types of personalities were found to be suffering from asthma; aggressive, ambitious, argumentative persons, daredevils, and also hypersensitive, aesthetic types.

Although these studies have been primarily with children, the conclusions are applicable to adults who, although previously free from asthma, may be predisposed to it by unresolved conflicts from childhood.

However, not always does psychic factors alone precipitate attacks of asthma. As heretofore mentioned the patient's environment may reveal substances to which he is allergic, and the removal of these irritating substances is not always simple. Other patients suffer from spontaneous attacks whenever they catch cold; thus persons living in cold, damp quarters may be subjected to frequent attacks. Limited financial resources often make it impossible for the patient to move to more desirable quarters.

"Adults previously free from asthma may have developed it following repeated bronchial infection or long-continued
exposure to mildly irritating dusts; those who work in factories are an example. 7

In summary the stimuli of asthma may be extrinsic or intrinsic.

Of the extrinsic stimuli, pollens and dust are the most common for adults, and foods (especially egg white, cereals or cow's milk) for children. The stimuli of intrinsic cases are abnormalities in the respiratory tract (such as adenoids, spurs or sinus infections), infected tracheobronchial lymph nodes and pulmonary infections. Psychogenic asthma is a well-recognized condition. 8

7 Emerson, op. cit., p. 490.
8 Ibid., p. 491.
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CHAPTER IV

CASE STUDY OF THE SOCIAL FACTORS AND THE ROLE OF THE SOCIAL WORKER WITH ASTHMATIC CHILDREN

As indicated by Table I, the cases of children used in this study can be divided into four groups in relation to the referral. One case from each group will be presented to illustrate the significant social factors in the onset and course of the asthma and to show the various ways in which the social worker was able to help the asthmatic patient. Each case is representative of the others in the group in relation to the activity of the social worker.

Case One

Donald was a six-year-old white boy, the youngest of four children ranging from nineteen years to six years.

The mother was a forty-year-old woman with complaints of pressure on the top of her head and blurred vision. She was very anxious and expressed many fears about illness and its effect on the children. These fears were apparently accentuated by her knowledge of mental illness in her husband's family as well as her own. She had strong feelings that her children would someday suffer from similar mental disturbances.

The father was a forty-year-old cloth cutter. According to patient's mother, he was unfaithful during the war years. She also felt that he had not been a real father to the children and complained that he did not take her out.

The three siblings presented medical problems which only recently had been less serious. A sister, nineteen, had strabismus as a child and this caused her to lose a year of school. A brother, fourteen, had a rheumatic heart which inhibited his physical activity. A brother, eleven,
had epilepsy for which he was receiving medical attention in another hospital. According to the mother, the seizures were under control. Due to crowded living conditions, the patient had to sleep in the bedroom with these brothers.

This is the environment in which Donald lived until six months prior to the social service contact at the Beth Israel Hospital. Upon the medical recommendation of another hospital, the patient had been placed in a foster home as it was felt by them that placement was indicated because of the large psychological factor in the patient's asthmatic condition.

According to a report from that hospital, the patient had eczema at the age of one. At the age of two a diagnosis of bronchitis was made, and at the age of three a tonsillectomy was performed. When he was four, the diagnosis of asthma was made.

During his stay in the foster home, the patient had only minor attacks of asthma. When living at home his attacks occurred during the night most of the time; however, there were attacks during the day, too, especially when he was reprimanded by siblings or parents.

The social service record from the other hospital described both parents as overprotective. Also, at the time the patient's mother was pregnant with him, she tried many time to have a miscarriage. There was marital conflict at that time.

The referral to the Social Service Department at the Beth Israel Hospital came from a community agency for the purpose of medical-social evaluation and review of the asthmatic condition with the thought in mind of aiding in future planning for the patient. The mother was desirous of having him home again in spite of the improvement while he was away from home.

Due to a severe attack of asthma, the patient was hospitalized for observation and study during which psychiatric consultation was
brought in. It was decided that the patient should return to his own home after a preparatory period. However, on discharge, the patient refused to return to the foster home, and the agency allowed the patient to return to his home directly from the hospital.

During the hospitalization, the social worker visited the patient on the ward. She also saw the patient's mother, giving her reassurance regarding the medical recommendations.

When the patient returned to the Out Patient Department for treatment, the mother sought the worker regarding the treatment and also to discuss family problems. The patient's father was unable to work due to an injured hand, and the family was receiving financial assistance from a community agency.

Generally, the patient's medical condition improved much. There was also a development on the part of the mother of some security in making use of the medical resources at the hospital and the ability to respond more positively to the casework offered by the community agency. The mother was able to maintain an adjustment free of the symptoms which she had demonstrated earlier.

In this case the little boy was striving for his mother's love and sensed that he could only get gratification when he was sick and needed special attention as did the other siblings. Through illness he was able to compete with his sister and brothers in securing some of the mother's attention and love.

In the relationship with the mother, the medical social worker offered her understanding and psychological support as well as to encourage her to use the casework service of the community agency which could help the mother with many of the problems in the family situation which were overwhelming the
patient's mother.

During the visits to the Out Patient Department, the mother was helped with some of her anxiety regarding the doctor's recommendations.

It is evident that placement of the child aroused guilt feelings in the mother because she rejected the child. These feelings had to be handled by the social worker as well as the community agency social worker who was active with the patient's mother.

In this case the medical social worker participated in a case conference with the community agency to determine and clarify agency function.

Here the social worker is not only engaged in cooperative casework with another agency but also participating in the team of the physician and psychiatrist in order to insure optimum treatment for the patient.

Although there was considerable improvement in the boy's condition at the time he was placed away from home, he still was unable to express his emotions upon his return home in any other way than in his physical symptom. However, as the maternal attitude changed somewhat so that tension upon the child was relieved, there was some improvement in the attacks of asthma toward the latter part of the contact with the social worker.
Case Two

John was an eleven-year-old white boy who had a younger sister six years old.

The onset of his asthma was at the age of three. He was also wetting and soiling at the same time, becoming dry shortly after the first asthmatic attack. He continued soiling into the fourth year for which his mother made "four-cornered" pants for him.

His mother had difficulty in managing him as he was disobedient and aggressive. During the contact with social service he showed increasing aggressiveness, hitting his sister, in contrast to his previous pattern of docility.

The mother was a thirty-six-year-old woman who rejected the patient, identifying him with his passive father. She was maritally unhappy and stated that her husband did not show her the same affection as did other men. She believed that the patient inherited his emotional disposition from his father because he, too, did not show her any affection. She called the patient by his full first name whereas she had an affectionate nickname for patient's sister. She also stated that patient's restless sleep and attacks of asthma at night did not bother her as her husband got up to give him his pills.

Although the information was scanty, the impression was that mother had been a rejected child.

The father was a forty-year-old passive, ineffectual person who was allergic to flour and had to leave his job as a baker. His job adjustment had been poor, and throughout the contact with social service he was not stabilized in any employment. Thus, the financial situation was a marginal one.

The referral to the Beth Israel Social Service Department came from the patient's mother who requested placement of the patient in the
western part of the country until his asthma was better.

In a psychiatric evaluation the patient's drawings showed him to have tremendous hostility toward his rejecting mother. Temporary improvement in his asthmatic condition caused the postponement of placement plans, for his mother seemed to be more accepting of the patient as a result of the release of her feelings in the relationship with both the medical social worker and the social worker in the community agency.

Later, the patient was placed in a foster home when the frequency of asthmatic attacks in his own home necessitated hospitalization often. While in the foster home the patient was under psychiatric treatment. During that time there was a progression from the patient's early preoccupation with single, fierce, threatening men and animals to peaceful, colorful scenes. However, there were still threatening objects in the background of the pictures he drew. The frequency of the asthmatic attacks decreased coincidentally with this progression.

The parents removed the patient from the foster home claiming that the living conditions were unsatisfactory. Actually they were not. Although the patient was not having any asthma at the foster home, he was torn between his wish to return home and to remain in the foster home. The patient tended to be in status asthmaticus almost continuously after the return home.

The mother finally requested help again, making it clear that removal of the patient from the foster home was the father's determination. She wished placement of the patient in another climate and felt that she was becoming exhausted from constant care of the patient. When the placement was medically approved, the patient was seen by the psychiatrist for preparation for the placement in another section of the country. The mother was offered support from the social worker as she was fraught with ambivalence regarding the
plan although she had initiated it.

The community agency assisted with transportation costs, clothing needs, and it also assumed the responsibility of intensive casework with the mother during the patient's absence.

In this case the patient was also striving for the mother's love and felt her rejection, for in free associating with pictures he said that he saw in one picture a mother who loved the younger girl, but he was not sure that the mother loved the boy.

The social worker was helpful in emphasizing the placement as a medical plan so that the mother's guilt feelings were relieved somewhat.

Here again the social worker was active in cooperative casework with the community agency who was responsible for the financial assistance. The worker was also active in sharing with the allergist what she knew of the social situation, helping him to obtain a clearer picture of the family constellation and the emotional problems in order that the best plan could be considered for the patient. The social worker also contributed her knowledge of resources for placement of the patient.

Case Three

Jean was a ten-year-old white girl who was referred to the Psychiatry Department because of multiple somatic complaints in addition to her asthma. She was also emotionally withdrawn and unable to make friends easily. She
preferred to stay at home on her bed, listening to the radio, surrounded by her books and other things to amuse herself. Although she was an excellent student in school, receiving A's in most of the subjects, she did not like to go to school and used her somatic complaints as a device to remain at home.

Her sister, five years younger than she, was described as a sweet, obedient, and independent child, who was the favorite of both parents, especially the father who would let her sit on his lap whereas he would tell patient to go away.

The father, a forty-year-old man, was a house painter who had been unemployed for over a year a year about four years ago following an attack of coronary thrombosis. Shortly after, the patient began to complain of joint pains.

The mother, a thirty-six-year-old woman, was an attractive, intelligent person who showed little warmth in her attitude. She talked about her many disappointments with her father dying about six years ago. She was very close to him. A baby born about ten weeks after his death also died of congenital heart disease. Although the patient had been prepared for the baby's arrival, she never said anything to her mother about its death until some time later when in an angry mood she exclaimed that she was glad the baby had died. She had previously been told by her maternal grandmother that she must not say anything to her mother about the baby's death at the time it occurred.

The patient had had many colds followed by asthma at the age of two; however, it was only slight. After a tonsillectomy at the age of four the patient had severe asthmatic attacks which subsided when she was about five, and at the time of the period of this study she only had an occasional attack of asthma. The attacks seemed to be precipitated by the failure to get her own way. Also, whenever she was invited to spend the night away from home, she would develop an attack of asthma which would subside soon after the opportunity for leaving home was over.
The patient was very aggressive to both parents, "talking" back to her father and having outbursts of temper with her mother who frankly admitted that at times she thought she hated the patient.

While the psychiatrist saw the patient, the social worker had interviews with the mother.

Here again, the threat of losing the mother's love was most significant, and this was evident in sibling rivalry and maternal rejection.

It is apparent that the mother had underlying conflicts and the social worker was helping to ease the resultant tension. The emotional climate of the worker-mother relationship became the milieu of treatment resulting in a somewhat modified maternal attitude toward the patient. At the end of the period used in this study this case was still active.

Case Four

James was a twelve-year-old white boy who was the fourth of five children, ranging in age from twenty years to ten years. He had had asthma since the age of two and a half at approximately the time that his younger brother was born. However, the parents related it to the fact that the family spent the summer at the beach, and they felt that the damp climate had something to do with the onset of the asthma.

The patient had had irregular treatment for his condition which was somewhat disabling in that the patient missed considerable time from school.

Although all the siblings, all boys, were care-free, the patient was described by his parents as a "worrier". He assumed the responsibility
of picking up his sibling's possessions when they were careless about them. The patient was a passive boy who showed little hostility, and according to the mother he was a "good" child who never got into fights. He seemed to find it necessary to belittle the other siblings in order to raise his own status. He also seemed to identify with his mother in controlling others, and this was particularly so with his two brothers, ages fourteen and ten. When he accompanied them to the movies he insisted on carrying the money and would scold them if they were not good.

The mother was a thirty-six-year-old overprotective, rigid woman who would not permit the boys to participate in leisure activities without adult supervision and did not consider her nineteen-year-old son old enough to supervise. She was very ambitious socially and would not permit the boys to attend the local community center. She stressed that she wanted her sons in good company and was seeking to move from the neighborhood to a better one so that the children would meet worthwhile people.

She procrastinated in getting medical care for the patient until an emergency occurred. She attributed his asthma to his inability to fight his emotions. She also displayed other confused impressions as she talked about his weak ego, strong conscience and strong will so that he had to do everything correctly.

She was rejecting of her marital situation as well as her children when she at one point indicated that she had no choice in having the children and really would have preferred to have had none. Her comments about her husband were always negative, and she talked about marrying him out of sympathy. She had been married previously and remarked that she wished she had remained a widow instead of remarrying. At one point she brought out her hostility by saying that she wished she had never met the patient's father whom she felt came from "inferior stock" whereas her first husband's family was related to the professional class. She blamed her husband for the patient's asthma.
She felt the patient had inherited the asthma from his father's family although actually no one of the relatives did have asthma.

The father, a thirty-six-year-old man, was more positive in his attitude toward the patient. He planned activities for the family. During the patient’s hospitalization he brought the patient a chess game when he discovered the patient had learned to play. He then had the patient teach him. He displayed much sympathy toward his wife one time when accompanied the patient to the clinic alone. He supported her in her overprotection of the boys, saying that he did not blame her for she had so many children to look after.

The patient had four brothers, three of whom were older than he, two of whom were step-brothers. According to the mother, they sympathized with the patient because of his asthma, and they did not resent his authoritative attitude or his sarcasm.

The patient was referred to the Social Service Department of the Hospital from the ward for help in arranging follow-up medical care as the parents had previously been refused clinic admission on the grounds that the father's income was sufficient to warrant private medical care.

After a review of the situation, the Admitting Office accepted the patient for medical care due to the long-time care needed with frequent clinic visits necessary.

During the social service contact the mother withdrew some of her controls she was exerting over the patient's activities, and this did result in a decrease in his asthmatic attacks.

The social worker was not active in the financial situation per se; however, she enabled the parents to express their feelings about it and encouraged them to bring their situation to the Admitting Office. In the relationship with the mother, the
social worker aimed to help the mother withdraw some of her controls over the patient, and this did result in a decrease in his asthmatic attacks. In giving vent to some of her hostility against her husband, the mother was able to ease up on her restrictions on the boys as a result of having someone interested in her.

The patient’s condition did improve somewhat, but upon the transfer of the case to another worker the mother was unable to establish a relationship with the new worker and at the time was inaccessible to casework help.

* * * *

An analysis of the eight cases of children studied shows that the onset of the asthma seemed to be related to an emotional stimulus. The onset occurred during the first six years of life in all the cases and in five of the cases between the ages of two and a half and three. In three of the cases the onset occurred at the time of the birth of a sibling when the child may have felt threatened with the separation or estrangement from the mother. In one of these cases the onset came at the time the family moved, and although the parents were convinced that the environmental factor of the presence of a particular allergen was responsible, it seemed that the emotional component was particularly significant, too. In one case the onset of the asthma began when the child started to school and the mother began to work at the same time. In two
of the cases the mother of the patient recalled the onset of the asthma as immediately following a respiratory upset. In most of the cases the children had had pneumonia, whooping cough or bronchitis before the onset of the asthma.

Since all children have a fear of losing their mother's love, this fear is strengthened if the expression of sexual needs is forbidden or punished. If the mother rejects the child's genital interest, the fear of the loss of the mother's love by yielding to the temptation is influential in creating the threat of psychological separation from the mother. This was evident in the case of one boy for whom psychiatric treatment revealed a conflict involving the sexual area, and the casework treatment was aimed toward helping the mother acquire a healthier attitude toward sex. Although the patient had been symptom free for almost a year, there was an exacerbation of the symptoms after the sister's delivery of an illegitimate baby.

The fear of losing the mother's love either through physical or emotional separation was an outstanding emotional factor in five of the eight cases. In one case in particular, whenever the child was invited to spend the night with a friend she had an attack of asthma. In another case, each time the mother planned to leave the home for an evening of sociability the child developed an attack of asthma.

In one case the attacks subsided so quickly that the
allergist felt that this was not due to the injections but rather to the satisfaction felt by the patient in having his mother alone in the clinic. The illness was used as a form of competition with the siblings and served as a means of getting attention.

In two of the cases the children reacted to parental friction with an attack of asthma.

In three of the cases the patient had an asthmatic attack following an outburst of anger. In other cases the children were unable to give expression to their aggressive impulses. Three children were dependent, sensitive, passive, and when one of these children was helped by the psychiatrist to express his aggressive impulses, the intensity of the asthmatic attacks decreased.

Three of the patients had their attacks primarily at night.

Most of the children had other somatic complaints or behavior problems which reflected inner conflict feelings which could not be expressed openly. One was obese, one was enuretic, another had compulsive traits in dressing and eating, and one had stuttering associated with the onset of the asthma. Two patients had temper tantrums. Three had complaints of stomach or joint pains.

All the children showed a sensitivity to some allergen and were being treated in the Allergy Clinic. In many cases
these injections were gradually decreased as the parent-child relationships improved.

Some of the children used the asthma to secure the mother's attention. Some resorted to sociably unaccepted ways of doing this. One patient made demands upon her mother for bedside care to the point of depriving her mother of her night's rest until the mother became exhausted.

In all the eight cases maternal rejection was an important factor. In three of the cases the rejection was frank and undisguised. The mother verbalized that she hated the patient at times. In another case the mother had planned for the patient's adoption during her pregnancy; however, when he was born she could not go through with the plan. In all cases the mothers spoke more favorably of the other siblings, and in some instances marked favoritism was shown. The only way the patient could compete with the siblings was through illness. In all the cases maternal overprotection was prevalent as the mother overcompensated for her rejection of the child. In one case the mother would not allow the patient to walk to school and prepared special meals for him although this was not medically indicated. She also prohibited his participation in sports.

In two of the cases the mothers were very ambitious in economical standards; one mother worked in order to provide music and dancing for the patient and sibling. Other mothers
had high standards of behavior and school achievement, and when the patient could not meet these standards he found refuge in the asthma.

Three of the mothers could not allow the patients to remain in the foster homes where there had been decided improvement. Guilt feelings over the rejection of the child became an obstacle in the treatment.

In all but one of the cases, the father was a passive figure leaving the managing of the household, the disciplining of the children and all matters pertaining to the upbringing of the children to the mother. Parental relationships were unsatisfactory in all cases although there was not always open conflict.

In five of the cases the mothers had overt personality problems or psychosomatic illnesses. This, of course, was not conducive to a wholesome emotional atmosphere.

Although in six of the eight cases there was financial insecurity with the families receiving assistance from private or public agencies from time to time, this did not play a significant role in the asthma per se. The financial situation may have aggravated the existing parental conflict and added to the environmental pressures which in some of the cases completely overwhelmed the mothers.

It is evident that in order to be of maximum help the social worker must have a thorough knowledge and understanding
of the illness with its emotional component if she is to appropriately and successfully help with the environmental factors.

A further analysis of the data collected from a study of the eight cases of children used in this study reveals how the social worker was able to help the asthmatic patients and the methods used by the worker in trying to remove the factors in the environment which were impeding treatment.

As previously indicated Table I shows that the cases can be divided into four groups in relation to the referral which involved similar treatment methods for the cases in each of the particular groups.

Group I included two patients whose families were known to a family agency which was actively engaged in casework. These two cases were referred by the community agency for medical-social evaluation with the thought in mind of placement of the child. Here we find the social worker at the hospital engaged in cooperative casework with another agency as well as participating in the team of physician and psychiatrist in order to insure optimum treatment for the patients.

In each of these cases the treatment goals and methods of the medical social worker were aimed at helping the mothers to be more giving, more permissive, less controlling. By accepting the mother in each case, offering her support and understanding in her problems, the maternal attitudes were
changed somewhat so that tension upon the child was relieved. The two children were seen by the psychiatrist for evaluation in order that recommendations could be given to the community agency.

With these patients as with others, the social worker was in contact with the physician in the Allergy Clinic and was able to help him obtain a clearer picture of the family constellation, the emotional problems, the environmental factors receiving attention through the family agency.

The social worker was also able to help reduce the anxieties of the child and his parent regarding the various tests that have to be given to determine the hypersensitivity.

In Group II there were two patients whose mothers requested help in locating facilities in the western part of the country. The social worker was active with the mother in each case to help her with her feelings regarding the placement of the patient. Although both mothers had made the initial request for placement, each was very ambivalent when the plan was approved medically. The social worker was helpful in emphasizing the placement as a medical plan so that the mother's guilt feelings were relieved somewhat.

Here again, the social worker was active in cooperative casework with the family agency which was responsible for assistance with transportation costs, clothing needs, and the community agency assumed the responsibility of intensive
casework with the mother during the patient's absence.

Both the mother and child had to be prepared for the placement which to the child is often the irrevocable proof of rejection. One must determine if the child can really be helped by the separation and placement. The worker had to accentuate the temporary phase of it in both cases.

In Group III there were two patients who were referred to Psychiatry from the Allergy Clinic because of additional somatic complaints or behavior problems. Here the social worker was part of the team of psychiatrist and psychologist. The social worker established a relationship with the mother while the child was seen by the psychiatrist. In this relationship the social worker is a valuable instrument in the therapeutic process. In the two cases the social worker offered the mother understanding, acceptance and support in her problems. The emotional climate of the worker-mother relationship became the milieu of the treatment resulting in somewhat modified maternal attitudes toward the patient. These two cases are still in treatment.

In Group IV there were two patients referred by the doctors, one from the ward and one from the clinic, for help in facilitating medical care. In one case there was a request for an investigation of environmental factors which seemed to be contributing to the patient's apparent inability to benefit from treatment. The social worker's role was that of a
warm, accepting person giving the mother, who was overwhelmed by environmental problems, understanding and support. The worker arranged for the patient to have a bed for himself, to obtain toys to provide an outlet for his aggressive tendencies and arranged for the patient to attend classes at one of the settlement houses.

In the other case the parents had previously been refused care in the Out Patient Department due to the father's adequate income; however, later the patient was accepted for clinic service. Although the social worker was not active in the financial situation, she enabled the parents to express their feelings. Since there was a tendency on the part of the mother to delay in seeking medical attention until an emergency, the social worker, in the course of the relationship, aimed to help the mother accept the need for consistent medical care. The worker also helped the mother to withdraw some of her controls she was exerting over the patient's activities. In this case, too, the mother was overwhelmed by environmental pressures in bringing up five boys. Through her relationship with the social worker, she got some relief of her tension and hostility regarding her situation.
<table>
<thead>
<tr>
<th>Case No.</th>
<th>Reason for Referral</th>
<th>Source of Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Vocational Rehabilitation</td>
<td>Ward Doctor</td>
</tr>
<tr>
<td>2</td>
<td>Dispositional Planning*</td>
<td>Ward Doctor</td>
</tr>
<tr>
<td>3</td>
<td>Medical-Social Evaluation</td>
<td>Community Agency</td>
</tr>
<tr>
<td>4</td>
<td>Medical-Social Evaluation</td>
<td>Community Agency</td>
</tr>
<tr>
<td>5</td>
<td>Dispositional Planning</td>
<td>Ward Doctor</td>
</tr>
<tr>
<td>6</td>
<td>Investigation of Home Situation for Factors Influencing Asthma</td>
<td>Ward Doctor</td>
</tr>
<tr>
<td>7</td>
<td>Dispositional Planning</td>
<td>Ward Doctor</td>
</tr>
<tr>
<td>8</td>
<td>Dispositional Planning</td>
<td>Ward Doctor</td>
</tr>
<tr>
<td>9</td>
<td>Dispositional Planning</td>
<td>Ward Doctor</td>
</tr>
<tr>
<td>10</td>
<td>Dispositional Planning</td>
<td>Ward Doctor</td>
</tr>
<tr>
<td>11</td>
<td>Vocational Rehabilitation</td>
<td>Ward Doctor</td>
</tr>
<tr>
<td>12</td>
<td>Dispositional Planning</td>
<td>Ward Doctor</td>
</tr>
</tbody>
</table>

*Refers to nursing home and convalescent home care, transportation, financial assistance.
CHAPTER V

CASE STUDY OF THE SOCIAL FACTORS AND THE ROLE OF THE SOCIAL WORKER WITH ASTHMATIC ADULTS

As indicated by Table II the cases of adults used in this study can be divided into three groups in relation to the referral. One case from each group will be presented to illustrate the significant social factors in the asthma and to show the ways in which the social worker was able to help the asthmatic adult patient.

Case One

Mr. S. was a thirty-three-year-old New American who had his first attack of asthma in early infancy. The attacks continued until he was about ten years old after which he had none until he was twenty-eight. About that time he remarried upon the persuasion of his friends. He had married at the age of eighteen, but his wife died during the war. He fell in love with another woman who rejected him.

In Europe he was a teacher, but since his arrival in this country he had worked in a factory. When his attacks became more severe, he took sick leave, saying that he was too exhausted to work and also felt that working aggravated his condition. However, the doctor indicated that on a physical basis there was no reason for the patient’s remaining out of work.

The family was receiving assistance from a community agency. This agency reported that the patient was passive and restrained in contrast to his demanding wife. He resented and rebelled against having to do housework which his wife insisted upon his doing. Although he gave vent to these rebellious feelings in the relationship with the agency worker, he could not object to his wife’s demands at home.
He had a four-year-old son with whom his relationship was good. He was not overprotective with the child as was his wife.

Although the patient acknowledged the relationship of his asthmatic attacks "to times when things were not going well", he refused psychiatric help, insisting that the asthma was due to the climate. He indicated that he was going to seek employment in another part of the country where he thought the climate would be more favorable for his health.

There was insufficient material to yield any conclusions regarding the family constellation of the patient's early life and the onset of his asthma at that time.

The social worker's chief role was furnishing the community agency with the medical recommendations which were that patient could resume his job and that there was a large emotional component in the asthma.

**Case Two**

Mr. T. was a fifty-three-year-old widower who lived alone in a single room. His mother lived in a home for the aged, and one sister lived in the western part of the country.

The patient was referred to the Social Service Department by the doctor on the ward, for it was considered that the patient's job as a newsboy was detrimental to his health. His many colds precipitated frequent asthmatic attacks.

Since the patient was known to various agencies for the blind, the social worker was in constant contact with them in arranging vocational rehabilitation and financial assistance for the patient.
The patient could not follow through on a plan to sell his newsstand, and as a result of a respiratory infection he was hospitalized on one occasion and seen in the Emergency Ward on several others.

At the time of the social worker's activity in this case, it was felt that the patient was not ready to accept the limits that had been set up for him by medical recommendations.

Here was a patient who had a great need to maintain his independence. The social worker had to recognize her limitations set by the patient's inability to use her. She could not be discouraged by the lack of movement towards the patient's acceptance of his own limitations and need for a protected environment. The worker avoided an authoritative role, trying to give him a feeling of as much independence as possible even though he had to accept some help.

Case Three

Mrs. B was a seventy-year-old woman who had been separated from her husband about twenty years. She and her two single daughters lived with a married daughter, son-in-law, and three grandchildren.

The youngest daughter, age thirty-eight, was being followed by a family agency who was helping her to emancipate herself from the family.

Another daughter, age thirty-nine, had ulcerative colitis and was being followed by psychiatry.

The oldest daughter, age forty-three, assumed the responsibility of the patient's care and indicated a desire to be rid of the worry.
The patient was hospitalized on several occasions, and although the doctor's recommended chronic hospital care, the patient could not accept this and preferred to be discharged to her daughter's home even though she knew that she would be much more comfortable away from home.

Although the social worker tried to help the patient to accept chronic hospital care, she remained adamant about returning to her daughter's home. During the period of dispositional planning, both of the patient's daughters were in contact with the social worker. They described how nervous she made them, her constant demands for attention and their inability to meet all of them.

In this case it is evident that the problem of medical care involved not only the patient but extended to the entire family circle. In this respect the social worker had a dual role in understanding and accepting the difficult patient-parent and at the same time showing understanding and sympathy with the adult child of the patient.

There was no information to give a picture of the onset of the asthma and the patient's early life; however, there is evidence of marital conflict as well as disturbed parent-child relationships which may have been an important factor in the asthmatic attacks.

* * *

An analysis of the twelve cases of adults shows that only two of the cases yielded any specific information as to the onset of the asthma although in most cases the illness had
been of long-standing. In one of the cases the onset of the asthma dated back to experiences in the concentration camps during World War II. Each patient had lost his family in the persecutions.

In studying the twelve cases of adult patients, there was insufficient material to yield any conclusions regarding the family constellation of the patient's early life; however, there was a glimpse of the present family situation. In seven of the twelve cases there was overt interpersonal conflict, and in three other cases there were indications of discord. In one of the latter cases, the husband was passive, apparently devoted to the patient, taking care of her during her asthmatic attacks; however, he was beginning to break down and was developing ulcers, was unable to continue in his own tailoring business and had to apply for old age assistance. In another case, the patient, a fifty-three-year-old unmarried man, lived with his mother, and although there was no indication of friction he did not speak of her and could not be encouraged to do so.

In the adult group there was not as obvious a relationship between the emotional component and the attack of asthma as was evident in the group of children. The attacks, for the most part, seemed to be precipitated by environmental factors such as damp and cold housing, colds or other respiratory illness, working conditions.
In nine of the twelve cases the patients had other chronic illnesses such as heart disease, cardiovascular disease, arthritis, or some handicap such as failing vision, which all present serious reality problems as well as engender feelings of helplessness and frustration.

Seven of the twelve patients were in the age group over sixty-five years of age, and this group has usually reached its peak of productivity, lost the companionship of a spouse or relatives, has seen offspring transfer their affections elsewhere. One or more of these factors was evidenced in these seven cases; thus the sense of being useful and being loved was threatened. In view of this, the immediate relief a patient receives upon admission to the hospital need no longer be explained only in terms of the removal from the unsatisfactory physical environment, but also in terms of the emotional need that is fulfilled by attention and care that is received from the hospital personnel. In one case this was very obvious; the patient received relief from placebo injections of water.

Eight of the twelve patients were receiving some form of financial assistance, and one was in the process of establishing her citizenship so that she could apply for old age assistance. Two of the male patients needed help in a more realistic solution of financial problems, for they preferred to remain in job situations which were contraindicated medically.
A further analysis of the three groups according to referral and activity of the social worker shows that in Group I there were seven patients whose referrals came from the doctors on the ward or in the clinic. These referrals requested such practical services as dispositional planning which included transportation, nursing home or convalescent home care. Even in helping with these practical needs the emotional element had to be understood and handled by the social worker. Patients oft times have to be helped to overcome resistance to seeking financial assistance. In one case during dispositional planning, a warm, supportive relationship was established toward helping the patient take steps toward a more comfortable and realistic solution of financial problems as he refused to apply for assistance.

In two of the cases in this group the social worker had contact with the adult child of the aged patient, helping these children in their frustration regarding the care of the elderly patient.

In Group II there were three patients whose referrals also came from the doctors. Two of the patients needed help in vocational rehabilitation. Even in this simple situation the social worker had to exercise diagnostic skill, for in individualizing the patient she must evaluate the patient's capacity to use the help, the fine balance between his dependent needs. In the other case the social worker investigated
the home situation and learned that the emotional element was significant in the patient's attacks. The worker was able to help the patient with her guilt feelings regarding her role as a mother to a young daughter who had just been married in spite of the objection of the patient and her husband. All three patients in this group were fifty to fifty-nine years of age.

In Group III there were two patients, one thirty-three years old and another thirty-eight years old, both referred by a community agency for medical-social evaluation. These two patients were New Americans. The social worker evaluated each case and furnished the community agency with the medical recommendations as well as her impressions as to what the illness meant to the patient. One patient was able to see that her attacks were usually associated with nervous tension.

* * * *

As revealed through the case studies the ages of the patients, both children and adults, ranged from six to over sixty-five as shown in Table III.

Table IV shows the areas in which the social worker was active with all the patients. This summarizes the social worker's activity as shown from the data presented in this and the preceding chapter.
### TABLE III

**AGE RANGE OF ALL PATIENTS**

<table>
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<th>Age</th>
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<tr>
<td>10-15</td>
<td>3</td>
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<tr>
<td>16-</td>
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<tr>
<td>30-39</td>
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</tr>
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<td>40-49</td>
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<tr>
<td>50-59</td>
<td>3</td>
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<tr>
<td>60 plus</td>
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<tr>
<td><strong>Total</strong></td>
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</tbody>
</table>

### TABLE IV

**SUMMARY OF AREAS OF SOCIAL WORKER'S ACTIVITY**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Children</th>
<th>Adults</th>
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</thead>
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<tr>
<td>Placement</td>
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<tr>
<td>Parental Attitudes</td>
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</tr>
<tr>
<td>Vocational Rehabilitation</td>
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<td>2</td>
</tr>
<tr>
<td>Dispositional Planning*</td>
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</tr>
<tr>
<td>Recreation</td>
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</tr>
<tr>
<td>Carrying Out Medical Recommendations</td>
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<tr>
<td>Preparation for Treatment in Clinic</td>
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<td>Interpretation to Community Agency</td>
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<td>3</td>
</tr>
<tr>
<td>Home Conditions</td>
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<td>Children of Adult Patients</td>
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</tr>
<tr>
<td>Finances</td>
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*Nursing home care, convalescent home care, transportation.*
CHAPTER VI
SUMMARY AND CONCLUSIONS

The purpose of this study was to explore the social factors which were present in the children and adults with a diagnosis of bronchial asthma. It was also undertaken to learn the role of the social worker in the treatment process and the ways in which she can be of help to the asthmatic patient.

The writer studied eight cases of children and twelve cases of adults who had been known to the Beth Israel Hospital Social Service Department during the years 1950 and 1951. It was recognized that the age span of the patients used in this study was great and that there were different factors involved in the psychological development of these various age groups.

The patients ranged from the age of six to eighty. The children were between the ages of six and twelve with one patient sixteen years of age. Of the adult patients two were between thirty and forty, three were in their early fifties and seven were over sixty-five.

A description of the agency from which the case records were selected was given.

A review of the literature that deals with asthma was presented.

The onset of the asthma in the children occurred exclusively in the first six years of life, and in five of the cases it was evidenced between the ages of two and a half and
three years of age.

Any threat in the mother-child relationship was the most significant factor in the occurrence of the asthma. Sibling rivalry was a threat in many cases so that the patient used the asthma as a form of competition with the sibling, as a protection and attention-seeking device in seeking the mother's love. In all cases maternal rejection was significant. The mother spoke more favorably of another sibling and showed marked favoritism. In two cases the rejection was frank and undisguised. Maternal overprotection was evidenced in all the cases.

In all but one of the cases the father was a passive figure leaving the management of the household to the mother. Parental relationships were unsatisfactory although there was not always open conflict.

Five of the mothers had overt personality disturbances or somatic complaints.

Most of the children had other somatic problems or behavior manifestations which reflected inner conflict feelings which could not be expressed openly.

With the adult group of patients, there was interpersonal conflict in the present family situation in seven of the twelve cases.

In nine of the twelve cases the patients also had other chronic illnesses such as heart disease, cardiovascular
disease, arthritis or some handicap which present reality problems as well as engender feelings of helplessness.

In eight of the adult cases the patients were receiving financial assistance, and in two of the cases the male patients were engaged in occupations contraindicated medically so that they needed help to adjust to the limitations imposed by the illness.

In some of the cases used in this study, the social worker was active in cooperative planning with other community agencies.

Since the emotional component is of such significance in the asthma syndrome, the social worker must be aware of this in order to render a more adequate casework service to the patient in the area of environmental and social factors that are either blocking medical treatment or needing modification for maximum therapeutic results.

Her understanding of the underlying conflict will enable her to evaluate the limitations of her role and the need for psychiatric referral. The social worker who has a greater opportunity to observe the patient has the responsibility of sharing her impressions with the doctor so that he can make the referral to psychiatry.

As is true in all casework, the relationship is the basic tool in working with the asthmatic child and his parent or the asthmatic adult. Whether in the area of concrete services or
in the area of the less tangible services, this relationship is paramount.

When placement was the plan, the social worker used this relationship to give the mother a chance to relieve her guilt feelings regarding her rejection of the child.

Although with the adult patient the social worker was active in concrete, practical help such as transportation nursing home and convalescent home care, or referral to a community agency or resource, she used the relationship to offer the patient understanding, support, acceptance and an opportunity to express his feelings.

In two of the cases the social worker had contact with the adult children of the aged patient, helping these children in their frustration regarding the care of the patient.

The major activity of the social worker with the children was in helping the mother to relieve tensions and pressures on the child due to maternal attitudes. With the adults the major activity was in the area of concrete services.

As evidenced in this study, the medical social worker's practice of social casework is based on generic casework. With this sound foundation she must also develop special skills to function more adequately in the setting of the hospital.

In working with a multidisciplined setting the social worker must have clear diagnostic thinking and the ability to clarify what she is doing and her impressions with the other
members of the team. In the cases used in this study, the worker was always in touch with the doctor, sharing her impressions in the conferences to help the doctor become aware of the need for psychiatric evaluation or treatment. In working with the team concept, the social worker must be aware of the responsibilities of the others on the team so that she can best fit her contribution into the total care of the patient.

The social worker is one of a group and must have an ability for group planning and sharing. This was especially true in the cases used in this study, for in many instances she was active in the team of allergist, psychiatrist and social worker.

From this study it is evident to the writer that the medical social worker has a definite contribution to make to the treatment of the asthmatic patient. Whether it be in the area of specific help such as nursing home care, transportation, referral to appropriate community agencies or whether it be with the less tangible such as alleviation of anxieties, supportive help, understanding and acceptance, the asthmatic patient benefits from the service of the medical social worker.

Approved:

Richard K. Conant
Dean
BIBLIOGRAPHY

BOOKS


PERIODICALS


