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Individuals and families who make
frequent use of hospitalization.

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BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

INDIVIDUALS AND FAMILIES WHO MAKE
FREQUENT USE OF HOSPITALIZATION

A thesis

Submitted by

Grace Marie Hanley

(A.B., College of Our Lady of The Elms, 1953)

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

1956

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TABLE OF CONTENTS

CHAPTER	Page
I. INTRODUCTION	1
Purpose	1
Research questions	5
Research Design	5
Limitations and Scope	7
II. INDIVIDUALS WITH A CHRONIC ILLNESS	11
General Characteristics	13
Economic Support	14
Living Situation	15
Factors in Readmission	16
Use of Out-Patient Department	17
Case work rendered	18
Case Summaries	22
III. INDIVIDUALS WITH AN ILLNESS NOT OF A CHRONIC NATURE	28
General Characteristics	31
Family Relationships	32
Economic Support	33
Living Situation	33
Factors in Readmission	34
Use of the Out-Patient Department	34
Case work rendered	35
Case Summaries	35
IV. FAMILY GROUP	39
General Characteristics	41
Number of Hospitalizations	42
Economic Support	43
Living Situation	44
Types of Illnesses	46
Emotional Difficulties	47
Use of the Out-Patient Department	49
Case work rendered	49
Case Summaries	50

CHAPTER	Page
V. SUMMARY AND CONCLUSIONS	59
BIBLIOGRAPHY	70
APPENDIX	72

LIST OF TABLES

Table	Page
1. Ten Patients who Used Hospitalization Frequently, According to Age, Sex, Marital Status, Occupation, Position in Family, Primary Diagnosis, Number of Admissions, and Total Period in which Hospitalization Occurred.....	13
2. Five Patients who Used Hospitalization Frequently, According to Age, Sex, Marital Status, Occupation, Position in Family, Number of Admissions, Total Period in which Hospitalization Occurred.....	31
3. Ten Families who Used Hospitalization Frequently, According to Number in Family, Number of Individuals Hospitalized, Number of Admissions, Total Period in which Hospital- ization Occurred, Marital Status of Parents..	41

CHAPTER I

INTRODUCTION

Purpose.-- Every year approximately 15,000 patients are admitted to the Rhode Island Hospital. For many it is their first hospital admission but for others it is a familiar place. The causes for readmission, however, are no doubt many and varied. There are illnesses which medical science cannot cure and which after a period of subsidence will again become reactivated. There is also another group of patients, those individuals and families whose hospitalization is affected by emotional and social factors in the environment which lead either to an exacerbation of a particular illness or the development of varied illnesses. Just what percentage of the daily admissions in Rhode Island Hospital are composed of such patients is not known. Nor is it known how many such cases are known to Social Service. It was felt, however, within the Social Service Department that there was a certain core of families and individuals who made frequent use of hospital services as a means of satisfying their personal and familial problems. The emotional component in illness is widely accepted. Since the hospital provides medical care to the

ill, then it logically follows that many patients with emotional problems make use of hospital services. All such patients differ only slightly from those in this study for the important criterion is the number of hospital admissions.

In addition to the emotional problems precipitating illness and the concomitant hospitalization and its satisfactions, there is also a social component. This consists of environmental conditions which adversely affect the physical adjustment of the individual and create a physical atmosphere conducive to ill health. For example, rheumatic fever, which is found most frequently among the poorer social class, is aggravated by conditions such as dampness, etc. When such illnesses occur, we can perhaps speculate that from an economic point of view these people do have many problems. Such an economic status may produce other tensions in the home and consequently other problems arise, not only in this area of maintaining health but also in the area of coping with illness.

The purpose of this study is to explore the factors in the readmission of a group of patients known to Social Service in Rhode Island Hospital.

The writer could find no study of this exact nature which had previously been done. However, related literature in the field of medicine, psychology and social work was applicable and pertinent in relation to certain areas in the study.

A social worker, Janet Thornton, in 1934, utilized a study done by Harriett Bartlett in a book which Thornton entitled, The Social Component in Medical Care. Such a study was undertaken "to determine what part influences in the patient's social situation and his manner of reacting to them played in the development of ill health, in the defeat of curative measures and in the adjustment to chronic disease."¹ This was a pioneer study and it was the purpose of the author to influence others to focus on the social component in medical care.

In 1939, Dr. G. Canby Robinson of John Hopkins University, undertook a study which he published under the title of, The Patient as a Person. Robinson used some of Thornton's classifications in his study method. The purpose of Dr. Robinson's study was "to obtain further knowledge regarding the relation of adverse social conditions to illness and where this illness was found to exist, to seek ways of alleviating these conditions and the emotional disturbances they caused."²

Both of the foregoing studies dealt mainly with the individual. In 1945, Henry B. Richardson, an Associate

¹ Janet Thornton, The Social Component in Medical Care, Columbia University Press, New York, 1937, p. 5.

² G. Canby Robinson, The Patient as a Person, The Commonwealth Fund, New York, 1939, p. 15.

Professor at Cornell University Medical College and attending physician at the New York Hospital, focused a book on the family. The book was an outcome of a study of illness in families. He considered that "the time is now ripe for a coordinated attack on the problems of family adjustment in relation to the maintenance of health and treatment of illness."¹ He was aware that while the patient is a person, he is also part of a family group and is affected by the interrelationships therein. In this book, Dr. Robinson also devoted one chapter to "The family as a Unit of Illness." This was quite helpful in the treatment of the families in this study who made frequent use of hospital services.

A book greatly utilized in this study was, Dynamic Approach to Illness, written in 1949 by Frances Upham, casework supervisor at the Hospital for Joint Diseases in New York. This book was the compilation and integration of an extensive bibliography.² To illustrate the interaction of various factors -- physical, emotional, economic and social, in the etiology and treatment of illness, and the role of the social worker in extending help to patients and

¹ Henry D. Richardson, Patient's Have Families, The Commonwealth Fund, New York, 1949, p. viii.

² Frances Upham, A Dynamic Approach to Illness, A Social Worker's Guide, Family Service Association of America, New York, 1949, p. 5.

families in the myriad of interacting factors is the central theme of this book.

Other sources were used throughout this study and are indicated by footnotes within the body of the thesis.

Research questions.-- It is hoped that this study may answer the following questions:

1. Are there common factors which are found in these cases of individuals and families which make frequent use of hospitalization? For example,
 - a. Economic status
 - b. Family and interpersonal relationships
 - c. Emotional problems
 - d. Environmental inadequacies.
2. Did the social worker fail in interpreting the use of the Out-Patient Department to these clients?
3. Has poor planning upon discharge effected the further hospitalization?

Research design.--

A. Methods

This study will be based primarily upon case studies. In order to utilize and evaluate the material, it is necessary to incorporate reference data. Such reference material has been indicated previously in this chapter.

B. Sample Selection

The writer sent to each worker in the department a note

as follows: "Would you kindly submit a list of all cases, both family and individual, which you have worked with who have frequently been admitted to the hospital. This list should include all such cases from October 1952, to October 1955, and which are closed at the present time."

The worker presumably could give such listings quite easily, since each worker has copies of her monthly statistical sheets to which she could refer. In all, 65 cases were given. However, in reading these cases, the writer found 33 which were not applicable to the study, either because of prognoses or number of admissions. The absence of recorded material was noted in a few cases and was a minimal problem which could not be considered a limiting feature to this study.

The writer, for the purpose of the study, divided the cases into three groups:

1. Ten individuals who make frequent use of hospitalization, whose illness while chronic, would not necessitate readmission and whose cause for readmission is related primarily to the social or emotional conditions which affect it.
2. Five individuals who make frequent use of hospitalization, whose illness is not of a chronic nature.
3. Ten families who make frequent use of hospitalization.

After surveying the total cases submitted, fifteen fell into the first category, five in the second, and twelve in the third. It was the intention of the writer to utilize ten cases within each category. However, due to the number which were applicable to the second group, the writer had to limit this particular group to five, the total submitted. In categories one and three, the cases chosen were representative of the age and sex distribution within the entire group.

The term "frequent" as used in this study indicates more than two hospitalizations of individuals, and more than two members of the same family in the family category.

In selection of all cases, a schedule was formulated (see appendix) which asked for general characteristics of the cases studied, as well as answers to specific questions.

Limitations and scope.-- The limitations of this study are fairly evident. While it is believed that most cases of frequent hospitalizations are known to Social Service, there is no definite proof of this. We may believe perhaps, that the private patients under the care of their own physician would not be included in the study, regardless of their frequent use of hospitalization. While cards of all admissions are received in the Social Service Department, a worker does not enter into a private case unless so advised by the private physician. The worker, however, can request that she be allowed to see a private patient, but must

obtain permission from the patient's doctor. It is apparent then, in view of the fact that all are service cases, the higher economic group would be most naturally excluded.

Cases of frequent use of the Out-Patient Department are also excluded. To include them would make the study beyond proportion. The writer can, however, see the area of the Out-Patient Department alone as an excellent possible study in the future, as many of the patients who use this service seem to be lonely and find the time at Clinic an excellent time for socialization. The medical care received also offers some secondary satisfactions.

There is no comparative analysis included in this study. That is, the results of this study will not be compared with similar factors in the total population of the hospital, so that whether they are unique or even important in relation to the number of hospitalizations will not be validated beyond what is recognized from the study itself.

The sociological significance as far as local, national, or world happenings, which might increase tension at a particular time will not be considered (e.g. war, employment situation). The period of three years, however, is regarded as fairly constant and historical significance would be important only in comparing this period with another time span.

The use of case records limits the study as far as

material is concerned. It is the prerogative of each worker to record what she considers pertinent. The length of recording is also an individual preference. To some extent this limits the information available for study.

The knowledge and skill of the researcher, as well as her subjectivity, is also a limiting feature.

The scope of this study includes cases written in a three-year period: October 1952 to October 1955. Hospitalization prior to October 1952, will be utilized in determining the total hospitalizations in each case.

It is the writer's opinion that not all workers used a systematic method of referral to writer, and hence the entire number of cases of this nature known to Social Service were not referred. The writer is quite confident that within the files rest many more records of families and individuals who have frequently been admitted to the hospital and who have been known to Social Service. There is, however, no way of determining the existence of such cases and consequently these "possibilities" were not a part of this study.

The limited size of the group studied may not permit far reaching generalizations to be drawn from the data.

Setting.-- This study takes place within Rhode Island Hospital, which is a voluntary, non-profit, general hospital. It was built, equipped and endowed by contributions from private citizens. "For many years it has met the health

needs of a large segment of the State's population. Rhode Island Hospital has kept pace with medical, economic and sociological advancements...advancements which have made not only the lives of individuals more complex, but also the rendering of hospital and medical care."¹

The Social Service Department, as an important part of hospital services, affords help to the patient in areas of social and emotional problems pertaining to his illness.

Since this hospital serves the community in a similar manner to a city hospital, it is actually the health center of the community; hence, patients of all economic and social groups comprise its population.

¹ Rhode Island Hospital, Ninety-First Annual Report, September 30, 1960.

CHAPTER II

INDIVIDUALS WITH A CHRONIC ILLNESS

It is important that the term "chronic illness" be defined as it is used in this study. "A chronic illness is characterized by permanent impairment of the organism with some degree of permanent disability and continuing¹ symptoms."

Medicine can seldom restore completely anatomical defects or functions of organs after they have been damaged or removed. In order, therefore, to institute rehabilitation, adjustment to the defect is important. Because of this, rehabilitation of the chronically ill person becomes a² socio-psychological problem.

Chronic disease accounts for one out of every three disabling illnesses; 58 per cent of the services rendered by physicians and three out of every four persons hospitalized; and if current trends continue, by 1980, 30 million people will be suffering from chronic disease. If we wish to maintain our present levels of service, a 20

¹ Janet Thornton, op. cit., p. 16.

² Jurgen Ruesch, Chronic Disease and Psychological Invalidism, The American Society for Research in Psychosomatic Medicine, New York, 1946, p. 4.

1

per cent increase will be needed.

With this forecast in mind, it would seem that it is important that the chronically sick person who could be cared for outside the walls of the acute general hospital, be helped to do so. We know, however, that the chronically ill continue to enter our hospitals frequently.

With an increasing awareness of the psychological and social component in illness, the caseworker in a medical setting has a service to offer the chronically ill person. Changes in the patient's functioning, diet, employment, manner of living or housing, may result from the illness. It is important, however, to be aware of the patient's level of functioning prior to this illness, as it may have a direct bearing on his adjustment to illness. "In planning care, the patient's emotional vulnerability, his ego strengths and social satisfactions and strains, should be part of the evaluation on which medical and social treatment is based."²

Both inner and outer forces often play a part in the illness. For this reason it is not enough that the person receive medical care alone. The individual needs to be helped to improve his capacity to function.

¹ George St. J. Perrott, "The Problem of Chronic Disease," Psychosomatic Medicine, 7:21, (January, 1945).

² Frances Upham, op. cit., p. 90.

Table 1. Ten Patients who Used Hospitalization Frequently, According to Age, Sex, Marital Status, Occupation, Position in Family, Primary Diagnosis, Number of Admissions, and Total Period in which Hospitalization Occurred.

CASES	AGE	^a SEX	MARITAL STATUS	OCCUPATION ^b	POSITION IN FAMILY	PRIMARY DIAGNOSIS	NUMBER OF ADMISSIONS	TOTAL PERIOD OF HOSPITALIZATION
A	76	F	W	Laundry Worker	Mother of 3 Married Children	Diabetes, Arteriosclerotic Heart Disease	4	6.8 months
B	73	F	W	Homemaker	Mother of Children. 2 Married, 1 Single	Diabetes	4	2 years, 6 months
C	66	F	S	Waitress	Adopted	Asthma	6	2 years, 5 months
D	45	M	M	Dyeing Plant	Father of 1 Single Son	Cirrhosis of liver, Alcoholism	4	1.5 years
E	57	M	Sep.	Locomotive Fireman	Father of Married Son and Daughter	Epilepsy (Grand Mal)	4	10 months
F	29	M	D	Store Clerk	Father of 2 Children	Gastritis and TB of lungs	7	7 years, 1 month
G	20	F	S later M	Salesgirl	One of two Children	Rheumatic Heart Disease	14	19 years, 4 months
H	38	F	D	Homemaker	Mother of 1 Child	Rheumatic Heart Disease	5	2 years, 11 months
I	10	M	S later M	Student	5 Siblings	Diabetes	12	17 years
J	10	F	S	Student	Illegitimate Child	Diabetes	21	4 years, 3 months

^a At time of referral
^b Prior to illness

It is the intention of the writer that Table 1 will serve as a context for the reader so that upon a cursory study, the general characteristics will present a simple, though complete, picture of the cases studied.

The age distribution is varied. Three are in old age, two in middle age, two in young adulthood, and two in the latency period of childhood. Ratio by sex is six female to four male.

Ten of the group were married at the time of the initial hospitalization; two were later married. One of these two could be classified as a child upon admittance to the hospital. Two of the cases were widowed and two divorced. One adult and one child had single status.

The incidence of diabetes in four cases is the only outstanding diagnostic trend.

The average number of hospitalizations for the group is 8.1. The majority of cases, however, fall within the lower limits of the group establishing a median of 4.5.

Economic support.-- In seven of the ten cases studied, the patient's entire means of support was received through the Department of Public Welfare. The income of two patients' was subsidized by the Department of Public Welfare to meet the cost of medical care. In one case, nursing home expense was met, and in the other, money was given to cover the dietary needs of the patient. A pattern of economic

dependency is suggested by the fact that nine cases were receiving some type of public support.

"From the National Health Survey in 1936, emerged the realization that chronic illness created poverty. Taking the population as a whole, the study revealed that 177 persons out of every thousand had a chronic illness; in the age group over 65, that ratio was 40 per cent, per thousand. The highest frequency rates of chronic illness were among persons receiving public assistance. In the 1930's, the major cause of economic dependency was unemployment; in the 1940's, chronic illness and old age became the most important cause of rising public assistance needs that are distorting the budgets of state and local communities. In 1950, chronic illness, disease, and disability have become a welfare problem which will ultimately have grave effects on the entire national economy."¹

In the category of chronic illness, we might expect to find very few whose financial situation places them in the higher income group, since none of the patients studied were private patients in the hospital. However, outside of the higher income group there are also those service cases who are self-supporting and independently meet the cost of medical care. For those completely supported by the Department of Public Welfare, health insurance plans would be eliminated. Of the entire group, in only one case was the cost of hospitalization met by medical insurance.

Living situation.-- Four of the patients in the chronic group live alone. This is important, in that it indicates a certain amount of physical isolation. It may mean too, that the patient, if unable to meet his own needs when ill, would

¹ Loula Dunn, Chronic Illness Newsletter, (July 1950).

not be in a position to receive help from others, or make his wants known. If the patient is ill and unable to cook for himself, or get out to purchase food, his diet is often inadequate. Many of the rooming houses do not have adequate cooking facilities. The latter was a contributing factor in the frequent admissions of two cases within the group.

The causes of physical isolation are many and varied. In evaluating the interpersonal relationships of these patients who live alone, they could not be considered good.

One half of the group live in their family home. In analysing these cases, however, we see that the home environment had affected to some extent the repeated hospitalizations. For example, Case X lived with his wife and teenage son. His wife worked and the patient was alone all day. This isolation was conducive to the patient's drinking, since no one was present to set controls.

Factors in readmission.-- In the case of four patients who refused nursing home care, this problem appeared to be the primary concern of the social worker, although other factors were evident. As Upham says:

"When the patient refuses to accept medical limitations and refuses or fails to use constructive measures for lessening his disability, the problem does not usually stem only from his attitudes toward his illness. The difficulty more often comes from his failure to find adequate degree of satisfaction in the total situation."¹

¹ Frances Upham, op. cit., p. 92

An inadequate non-prescribed diet was a factor in four readmissions. The excessive use of alcohol was indicated in two of these cases. Unable to assume self-care were two patients who could not regulate their diabetes.

Emotional and personality problems in eight cases appeared to be directly related to the illness and the hospitalizations:

Case C -- pre-psychotic - identification with invalid friend, creating hypochondrical tendency.

Case D -- alcoholic.

Case E -- paranoid tendencies, poor family relationships.

Case F -- alcoholic.

Case G -- use of illness to satisfy deep emotional problems and a means of escape from poor home environment.

Case H -- attempted suicide, use of illness as a means of escape.

Case I -- suicidal in 1945, many emotional problems satisfied through illness and hospitalizations.

Case J -- problems regarding illegitimacy and relationships satisfied through illness, diabetes.

Use of the Out-Patient Department.-- Of the cases in the chronic group, all patients made use of the Out-Patient department. There is, however, one case (E) where there is

no indication in the case record of whether the patient attended clinic, although he had been advised to do so.

Case work rendered. -- Casework is defined as:

"Specific processes through which an expert service is rendered to develop within the individual his fullest capacity for self maintenance and at the same time to assist him in establishing for himself an environment which will be as favorable as may be to his powers and limitations."¹

The casework process was carried on in each case in this study. The casework methods utilized, however, are those used by Florence Hollis, i.e.

Environmental modification - "Steps taken by caseworker to change the environment in the client's favor by the worker's direct action."²

Psychological support - "Emphasis not on development of understanding by client, but rather on re-enforcing his ego strengths through guidance and release of tension, and through reassurance."³

Clarification - "The dominant note in clarification is understanding. Understanding by the client of himself, his environment and for the people with whom he is associated. It is directed toward increasing the ego's ability to see

¹ Gordon Hamilton, The Theory and Practice of Social Casework, Columbia University Press, New York, 1954, p. 27.

² Cora Kasius, editor, New Directions in Social Work, Harper, New York, 1954, p. 413.

³ Ibid., p. 416.

external realities more clearly and to understand the client's own emotions, attitudes and behavior."¹

Insight development - "help client to an awareness of his strong projection of his inner needs and his subjective responses upon the outer world. Current and past emotions must be relived in a therapeutic atmosphere in order that some of the affect may be discharged and in order that irrationalities may be brought so clearly to the surface that they can be recognized at first in the safety of the treatment situation and later in real life."²

Environmental manipulation was utilized in nine cases, psychological support in eight, and clarification in two cases.

It is important to note that no insight development was utilized. The writer feels that such findings will be consistent throughout the study, as insight therapy can only be used in cases where understanding is carried to a deeper level and where the caseworker has access to an analytically trained psychiatrist for regular consultation on the case. Such service is not generally available to the workers in the hospital.

Case analyses.-- The age factor in illness seems important to the writer, and since for the purpose of better

¹ Ibid., p. 419.

² Ibid., p. 422.

understanding, categorizing is necessary, the chronic cases are divided into four age groups - old age, middle years, young adulthood and childhood.

Old Age Group

"The emotional problems of elderly people like all other psychic problems, are problems of adaptation."¹ Man does not find himself in old age a completely different and distinct person, for he has brought to his senescence all the previous experiences of his life. His adjustment to old age will be very much dependent upon his adjustment in other periods of his life. Citelson states that, "The more rigid the character adaptation has been, the more open will tend to be the signs of anxiety and insecurity, as manifested by sensitiveness, irritability and querulousness, compensatory self assertiveness and stubbornness, the hypochondriasis."² Therefore, when dealing with illness in the aged person, it is necessary to understand what illness means to the aged as a group, while cognizant of the fact that each individual will react according to his own personality and needs. Every blow of illness threatens the security of the elderly person. "This insecurity tends to produce either over-compensatory reactions which burden the failing organism still more, or

¹ Maxwell Citelson, "The Emotional Problems of Elderly People," Geriatrics, 3, (May-June, 1948), p. 135.

² Ibid., p. 140.

invalid reactions which enforce the claim of the person for the care and attention which he has felt himself to be in danger of losing."¹

It is important to realize this inability of the aged to adapt when medical social workers attempt environmental manipulation during the process of discharge planning.

"There is a psychological homestatis as well as a physiological one and the results are especially disastrous when it is thrown out of equilibrium. Any alteration in the conditioned adjustment of the senescent should be made cautiously and gradually."²

All three persons over 65 lived alone in one room. Two out of the three refused nursing-home care when recommended. The writer feels, from information recorded, that perhaps too much emphasis was placed on the medical need for nursing-home care, rather than on helping the patient understand what the change would entail, preparing the patient for the new type of living, and allowing the patient to express negative feelings regarding the change, while helping him to accept it. This type of casework presupposes helping the patient to accept the illness, its limitations and allowances, for unless the patient accepts the illness, he

¹ Ibid., p. 145.

² Edward Allen, "Psychological Orientation in Geriatrics," Geriatrics, (May-June, 1948), p. 58.

he will be unable to accept satisfactory care based on needs created by the illness. Psychological support was offered in two out of the three cases. The writer feels more might have been accomplished had the casework been focused as described above.

In Case A the patient had only a fair relationship with her children, preferring to live alone. The best relationship was had with an asthmatic son who was unable to help his mother financially.

Case B had a poor relationship with her sister, who had refused to give the patient insulin injections. The patient's relationship toward her children could be considered only fair since she found living in her daughter's home difficult and the daughter found the mother's presence equally upsetting. The patient continued to ignore her dietary regime, which resulted in her leaving the daughter's home and returning to the hospital. This was an indication that she wished to use the hospital as a source of removal from her daughter.

Case C had a rather dependent relationship with an emotionally disturbed sister. The patient herself required frequent hospitalizations which were in some way caused by a pre-psychotic identification with an invalid friend. The identification created a hypochondriacal attitude in the patient.

Case C also indicates the need for thorough casework with the elderly patient upon first admittance to the hospital. Prior to admission to Rhode Island Hospital, this patient had five admissions to another private hospital. Within a three-year period the patient had five admissions to Rhode Island Hospital. From the first admission to the last, the casework help extended was in the area of discharge planning, helping both the patient and her sister to accept nursing home care. The patient had four unsuccessful nursing home placements and finally returned to live with her sister. While the worker understood that the emotional component in this illness lay partially in the patient's relationship with her sister, the patient was not helped to effect a separation. Not until the last admission was a psychiatric consultation considered and the patient was found to be pre-psychotic as indicated previously.

From this information it is noted that all three

patients' emotional adjustment prior to this period in life could not be considered good. It can be speculated that the chronic illness and refusal to accept recommended care outside the hospital setting, helps to offer the patient a means of satisfaction of his emotional needs.

Middle age and young adult group

The writer has combined the years of middle age and young adulthood. It is evident that this span envelops a wide age range. However, there appears to be few relevant problems directly related to the age factor in either middle age or the young adult group. Generally, the young adult might possibly be in the marriageable age, or in the early years of married life, when chronic illness would be threatening. The psychological and emotional make-up of the individual would be important factors. The problems of the patients in the young adult group in this study seem to have their origin in generally poor adjustment and are not necessarily related to the time the illness first developed.

In two of this group of five patients, alcoholism is a problem as both a causal factor in precipitating the illness and the repeated hospital admissions.

Case F, a patient with tuberculosis and acute gastritis, is one illustration. The patient refused to accept the medical recommendation imposed by his illness. In addition, he retreated to alcohol as a means of solution of his problems. He had utilized this means of escape prior to his diagnosis of tuberculosis, however this problem increased his need to

escape reality. This man had made a poor life adjustment. He was one of a family of five children and his father was also an alcoholic. The patient was separated from his wife and two children. His only apparent satisfactory relationship was with a sister who died of tuberculosis in 1947. This man's pattern of living consisted in residing in rooming houses and eating in restaurants, while supported by the Department of Public Welfare. Due to medical urgency, the casework focus was in attempting to help the patient agree to sanitarium care with nursing home care as an alternative. The patient refused at first, but finally consented to a nursing home arrangement in 1948, where he remained only a short while, finally being discharged due to excessive drinking. In 1950, upon admittance, a neurologist diagnosed the patient as aphasic with gastro-neurosis, but felt he was not a good candidate for psychotherapy. A sheltered environment was recommended in 1953, with medical supervision through clinics. Four or five hours of work per day was suggested. This patient's problems were psychological in nature and deeply rooted in his personality pattern and life adjustment. While sanitarium care would have solved the medical aspect and prevented frequent hospitalizations, the psychological needs remained unmet and we could anticipate a return to the original symptoms upon discharge.

Case D indicated another chronic alcoholic whose inability to refrain from drinking aggravated his cirrhotic condition. Social Service initiated referral to the Division of Alcoholism, helped both patient and his wife to express feelings of hostility, and referred them to the Department of Public Welfare for supplementary assistance. In neither Case D nor F, was the alcoholism handled directly by worker.

Case E, the patient was a former alcoholic. However, upon treatment at The State Hospital For Mental Disease, he was helped and has not been drinking for 15 years. The alcoholism, however, was the factor that created his separation from his family. The patient returned to his room because of failure to accept boarding home care. A neurological consultation in January 1955, found the patient not psychotic, only epileptic. The patient had a very dependent relationship with a friend, the patient exhibited paranoid tendencies toward everyone else and a relationship could not be established with the social worker. Social Service worked through the friend, offering support and an attempt at environmental manipulation. Upon admission in March 1955, due to the patient's peculiar hospital behavior, a neurologist found the patient to be suffering from a post-epileptic syndrome, and The State Hospital for Mental Disease

was recommended. Plans for commitment were initiated by Social Service, but the landlady took the patient home. Later, however, the patient was admitted through the community to the State Hospital.

Cases G and H are similar in their diagnosis, rheumatic heart disease. Both patients had deep emotional problems which were factors in their inability to recover.

Case G used the hospital as a means of satisfying her dependency needs. She had a lifelong pattern of maladjustment which was known to the hospital since 1945, when she had a therapeutic abortion for an illegitimate pregnancy. In 1946, Social Service felt that the patient was in need of psychiatric help after a suicide attempt. The Social Service focus during the entire history of hospitalization for this patient had been one of support, attempt to help the patient adjust to illness, environmental manipulation in the way of nursing home placement, service to relatives in helping them to understand patient's illness. Social Service assumed a very active role in helping this patient as the psychiatrist felt, due to limited intellectual capacity, weak ego and inadequate motivation, she was a poor candidate for psychotherapy.

Case H is another emotionally disturbed person who utilized her illness as a means of escape from problems she was unable to control. Her marital adjustment was poor, ending in divorce. Her only child, eleven years of age, presented behavior problems with which the patient could not cope. Her constant anxiety state created tension which aggravated the condition of her heart. In August 1955, she attempted suicide by barbiturate intoxication and left the hospital against advice. Social Service attempted to help this woman accept nursing home care. She did accept, but soon left. Upon a neurological consultation, the woman was considered tense and nervous, inordinately irritable due to domestic difficulties and it was felt that she might be an early involuntional. Social Service helped this woman to voluntarily commit herself to the State Hospital for Mental Disease in 1955, for help with her emotional problems. She was found at this time not psychotic.

Childhood group

Two of the ten patients in the chronic group are ten

years of age. In discussing the emotional factors in chronic illness in children, it appears important to discuss what a chronic illness can mean to a child and how it can affect his development. The child's first hospitalization can be a very threatening experience as he is separated from his parents and siblings and his physical activity is limited. Age is a meaningful factor, as the time the separation from parents occurs, is significant. "The various periods of development all have their particular characteristics and special points of vulnerability. Senn states:

"The emotional response of a sick child to convalescence depends on (1) his physical and emotional status at the onset of the illness. This, of course, depends on his previous growth experiences and his relationship with parents and siblings. (2) The type, severity and duration of his illness and the length of convalescence. (3) The meaning of illness to him, (a threat or a punishment, arousing fear, guilt, or defiance). (4) His relationship with the doctor and nurse, which may aid his recovery if warm and reassuring."

The writer would also like to include two more factors: how the family accepts the child's illness, and the satisfaction of the child's needs through illness.

Case I illustrates a ten-year old boy with diabetes. The home was the center of family friction and the mother took little responsibility for watching the child's dietary needs. The child, however, seized upon illness as his means of securing attention. Both he and his mother became

I J. M. Milton Senn, Child, U.S. Children's Bureau, (August 1945), p. 24.

preoccupied with the daily test for diabetes. The child used his illness as a means of escape from school. When things at home became intolerable and the sibling rivalry acute, he came into the hospital for satisfaction of his dependency needs. In working with Case I, the social worker was quite active. The worker provided free insulin, consulted with the Department of Public Welfare regarding money for the patient's diet, offered clarification to the patient and his mother regarding the meaning of his illness, and the limitations imposed. The social worker assumed a supportive role in helping the family accept this illness. In addition, upon discovery of further help needed, the social worker contacted a protective agency in order to secure removal of the child from the emotionally upsetting environment. The child was not removed as neglect could not be proven.

Case J, with the same diagnosis, diabetes, was also a frequent hospital admission. This child, a girl, used the illness as a means of satisfying her conflict in relation to her mother as she was an illegitimate child under the care of an aunt and uncle. She did not regulate her diabetes. The social worker utilized environmental manipulation by referring the child to the convalescent unit of the hospital. While there, she responded. Due, however, to her complete acceptance of the hospital regime, she was overlooked and time and service were extended to less docile and more overtly disturbed children. Her problems flared up upon discharge and she was frequently admitted to the hospital.

CHAPTER III

INDIVIDUALS WITH ILLNESS NOT OF A CHRONIC NATURE

The meaning of illness differs for various persons. Some find sickness frustrating and anxiety provoking, others find it a source of satisfaction. Incapacity often elicits special consideration from others; the ill person becomes the object of concern and the focus of attention, from which he may derive some pleasure. The ill person may enjoy this regression and take delight in the satisfaction of his dependency needs. Physical symptoms may be the result as well as the cause of emotional disturbances. Thus, it is important in both diagnosis and treatment that the patients' emotional reaction be understood.¹ "It is necessary to distinguish between attitudes resulting from illness and those precipitating it, or more exactly to be aware of the interaction of physical and emotional factors in the etiology and treatment of disease syndromes."²

An individual in whose illness the emotional component looms large, will not achieve health until he has made a more satisfactory life adjustment. Not having achieved health, he

¹ Frances Upham, Op. cit., p. 16.

² Ibid.

will continue to seek medical care in the hope that the secondary satisfactions received will alleviate the anxiety. "The individual with a relatively weak ego may find an escape from his anxieties in the less demanding situation that illness provides."¹

For many years the relationship between the psyche and the soma has been known. The need for treating the total person has been recognized. Margolis states, "We know that in most instances, illness is both functional and organic and that the symptoms presented are in reality an expression of the interaction of the two, although the somatic component may predominate in one case and the psyche in another."²

In this study, the term "psychosomatic illness" means that the illness may have an emotional causation, i.e., that the psychological factors within the individual have created a bodily reaction which is a product of changes in endocrine or neurological balance and/or that the individual receives secondary gains through the body symptomatology. The symptoms represent fear or anxiety within the individual and serve as a means of handling these problems. The latter is

¹ Ibid.

² H.M. Margolis, "Psychosomatic Approach to Medical Diagnosis and Treatment," Journal of Social Casework, (December 1946), p. 292.

often referred to as a "flight into illness." It is important to understand that "no one consciously enjoys being ill. The psychoneurotic reaction to the life situations and illness is in essence a reaction to some conflict, fear or strategy of living motivated largely by unconscious psychologic processes of which the individual himself is totally unaware."¹

Illness as an expression of inner tensions is often the only or the best solution the patient can achieve at the particular moment. The organism uses it as a means of establishing some balance between tensions and satisfactions.² This illness becomes a defensive reaction to help the individual maintain his equilibrium. This type of defense mechanism, however, is used by a person with little degree of emotional security.³ Illness brings with it regression and likewise dependency. In the relatively emotionally healthy persons such reactions are of a temporary nature because the patient receives more satisfactions from the activities of daily life.

The social component is another important factor in this study. The patient must live in society and adjust to his

¹ Ibid., p. 294.

² Frances Upham, op. cit., p. 18.

³ Flanders Dunbar, Mind and Body: Psychosomatic Medicine, Random House, New York, 1947, p. 30.

environment. He has to cope with the pressures involved in maintaining an adequate living, housing, diet, etc. When problems arise in the area of subsistence, this added pressure affects his emotional and physical life. In the total adjustment of the individual lies the social worker's concern. Since, however, other members of the team may be interested in other aspects of the person, it is the social worker who should be aware of the social component in medical care.

Table 2. Five Patients who Used Hospitalization Frequently, According to Age, Sex, Marital Status, Occupation, Position in Family, Number of Admissions, Total Period in Which Hospitalization Occurred.

	^a AGE	SEX	MARITAL STATUS	OCCUPATION	^b POSITION IN FAMILY	NUMBER OF AD- MISSIONS	TOTAL PERIOD OF HOSPITALIZATION
A	66	F	W	House- wife	Mother of 2 Children	5	3 years
B	37	F	W	Book- keeper	No Child- ren	5	2 years
C	29	F	D	Unknown	Mother of 2 Children	7	5 months
D	15	F	S	Student	Oldest of 2 Children	3	1 year
E	8	M	S	Student	Second Child	5	11 years

^a At time of referral

^b Prior to illness

As indicated in Table 2, frequent hospitalizations of

patients without a chronic illness occur irrespective of age, as many age groups are represented in equal proportion. This factor correlates with the age distribution in the chronic group.

The sex ratio may indicate a trend as four of the group are females. However, the writer could find no other study where the sex ratio played an important factor in this regard. The sex incidence has been known to be important in the type of illness developed, but not in the area of the ratio of males to females.

In regard to marital status it is found that two were widowed, one divorced, and two single.

In estimating the number of hospitalizations, results showed that both the average and the median equalled five. This approximated the median of 4.5 established by the chronic group.

Family Relationships.--- The family relationships of the five cases under study is interesting. In Case A, the patient's only living relatives were cousins who lived out of state. Her husband was murdered in 1935. These cousins rallied to the patient in her need, although they seemed to have had little previous contact with her.

In Case B, the patient's husband, older than she, was dead. She had no children and was estranged from her own family.

The patient in Case C was divorced from her husband. She lived with her two young children.

The parents of the patient in Case D were separated and the patient lived with her mother and one sister. The mother suffered a nervous breakdown one year prior to the patient's symptomatology.

In Case E, the patient lived with his father, mother and siblings. The mother was emotionally tense and the father suffered from ulcers. There was considerable sibling rivalry which gives us a picture of a family with a good deal of emotional conflict.

The family relationships, then, in this entire group, with the exception of Case A, could be considered weak, and consequently dependency needs could not be met through the family members.

Economic support.-- Four cases in this group received support from the Department of Public Welfare. Case A owned property on which she, with the aid of the social worker, was able to secure a lien so that she would become eligible for aid from the Department of Public Welfare. One case (B) was self supporting. This patient lived on her savings and planned to return to work when these were depleted.

In this group, as in that subject to chronic illness, we can see a pattern of dependency on public funds.

Living situation. -- Three patients lived with their

families, while two lived alone. The physical aspect of their living arrangements did not seem to be pertinent to readmission.

Factors in readmission.-- In all of the cases, emotional problems were factors in readmission. In two of the cases (A and B), inadequate diet was a factor, and upon admission nutritional anemia was found. Recommended care was refused by both these patients who would not accept nursing home arrangements.

The psychiatric and emotional problems of the patients in this group were as follows:

Case A -- pre-psychotic with paranoid tendencies.

Case B -- independence-dependence conflict, uses hospital to satisfy dependency needs.

Case C -- emotional problems regarding marriage and marital act, frequent admissions on Gynecological Service.

Case D -- sibling rivalry, adjustment reaction to adolescence, desired attention secured through illness.

Case E -- emotionally disturbed child, "second child" conflict, escape into illness.

Use of the Out-Patient Department.-- All of the patients in this particular group made use of the Out-Patient Department.

Case work rendered.-- Environmental manipulation was used in four cases and clarification in two, while psychological support was utilized in all cases.

Summary and analyses of cases.-- Emotional problems were important factors in the readmissions, therefore it appears necessary to emphasize this aspect particularly.

Case A. The cause of this patient's repeated hospitalizations was admittedly due to psychiatric problems. There were also definite environmental barriers toward achieving and maintaining satisfactory health. The patient lived in her own home, made unliveable by fire. She slept on an unheated porch and failed to supply herself with an adequate diet. Upon second admission, she was seen by the psychiatrist, but not diagnosed as psychotic. She was placed several times in nursing homes but refused to stay. Upon her third admission she was discharged to relatives out of state. She remained for a time with them, and again required hospitalization in another state. Three months later, she appeared at Rhode Island Hospital's accident room. She was examined by two psychiatrists and admitted to the State Hospital for Mental Disease, with a diagnosis of toxic psychosis.

Social Service helped the client to accept financial aid from the Department of Public Welfare and also made several arrangements for nursing home care. The social worker offered psychological support to the woman and also extended supportive help to the relatives, who would find living with such a disturbed woman rather difficult. The social worker utilized clarification in helping the woman to understand the need for change and the environmental and attitudinal components which were factors in her illness.

Dunbar has aptly written of the "beloved symptom." She indicates that there are two types of patients to whom this applies: the patient who cherishes his ailment as a means of avoiding an evil which he regards as even greater, and the patient who has grown fond of a symptom because it brings him

the love and attention which has been denied him.¹ Case B presents a perfect example of the second type.

Case B. This patient, a woman, at the age of twenty-nine, married a man much older than herself. This man apparently served as a father figure for the patient. He offered her the attention and security she desired and he apparently was the only person from whom she could obtain this love and protection. The husband died a few years ago and the patient, having been estranged from her family, found herself alone. The dependency pattern she had established created great conflict now that she was alone. She sought protection and attention through illness and seized upon the hospital as a source of gratification. The patient manifests her dependency needs also by a certain amount of recourse to alcohol and by not feeding herself properly.

Upon termination of each hospitalization, the patient would resist discharge. After one hospitalization, the patient was placed in a nursing home, but left after a short stay. She refused such care thereafter. Such planning had been advised to offer a protective environment to the patient.

Interestingly, after the third admission in 1952, a student was assigned to the case. This student had regular contacts with the woman and offered to the patient sufficient psychological support to free her from the need of securing attention through hospitalization. The student left, however, and another worker did not carry on such regular contact. Soon after this, the woman was again hospitalized and there was evidence that she was using alcohol for satisfaction more and more. The positive effects of the supportive help of the student caseworker can be seen, however, the relationship was not transferred to the new worker for unknown reasons.

Case D is another example of a patient who uses illness and the concomitant hospitalizations as a means of obtaining satisfactions.

Case D. This adolescent girl made frequent use of the

¹ Flanders Dunbar, op. cit., p. 29.

Out-Patient Department in 1952, and was seen in nearly every clinic. She was under psychiatric treatment on an out-patient basis. This girl would spend long hours around the clinic with minor complaints and often feigning illness. She had been known to injure herself in order to secure medical care. Finally, she latched on to hospitalization. Each time discharge became more difficult for her to accept and in her last hospitalization she threw herself from her bed in order to cause injury. She refused discharge and finally was seen on the ward by the psychiatrist, who diagnosed her difficulty as an adjustment reaction to adolescence. She was referred to the psychiatric unit at Chapin Hospital. On previous psychiatric evaluation in 1952, the patient was not considered psychotic but there was a question of her being hebephrenic.

Casework was first extended to this girl on an out-patient basis. When her problems manifested themselves in such a bizarre way, psychiatric help was indicated. The social worker then utilized psychological support as a means of helping the girl to accept treatment. The worker also interviewed the mother who was herself a disturbed person. During hospitalization, only a minimum of contact was extended to the girl in the area of psychological support. There was much indication that this patient was using illness as a means of securing the attention which had been deprived her through emotional neglect. Sibling rivalry was also a contributing factor in this girl's problem.

The patient who cherishes his ailment as a means of avoiding an evil which he regards as even greater, is represented by the following two cases.

Case 3. This case involves an emotionally disturbed boy who was reacting to a poor emotional environment in the home. Many of his problems centered around a "second child" conflict. The patient was admitted several times with different complaints and diagnoses. In 1946, he was hit by a car and since that time has had several seizures. It is quite evident that this child was using the illness to escape the home environment, which to him was a greater evil.

The social worker arranged for the child's transfer to the convalescent unit and offered him a supportive relationship. Although the social worker also worked with the mother, the mother refused to accept the emotional component

in the child's illness.

Case C. This patient was admitted many times on the Gynecological Service of the hospital, beginning with a pregnancy in 1952. In 1953, she was admitted with a diagnosis of anxiety neurosis, and in 1954, hospitalization was necessitated due to an overdose of barbituate. On this admission, she spoke in relation to her husband as "hating to have him attack me, beat me and rape me." She is, however, divorced from her husband. There was no evidence in the record of whether or not she had any contact with him. She had no satisfactory interpersonal relationships with family or friends.

Until the admission on 4-17-54, the casework service involved only planning for the children during the mother's hospitalization. On the fourth admission it was felt that the woman had deep psychiatric problems in relation to marriage and the marital act. On the fifth admission, twelve days later, the patient was referred to the Neurological Clinic upon discharge. Whether or not the patient availed herself of this help was not indicated in the record. There was no evidence of the social worker helping her to accept such a referral.

CHAPTER IV

THE FAMILY GROUP

The term "family" has many meanings. It can mean all who possess the same name, or those who are related within a certain degree of kindred. In this study, the term "family" relates specifically to the husband, wife, and children. If there has been more than one marriage, the children of each are also included.

"Family imbalance is, of course, a result of many factors. Current reality problems, as well as immature or neurotic attitudes can set off a series of reactions and counter-reactions. Whatever the nature of a particular overt difficulty, illness, or other symptoms of family disturbance, early attention should be given to the inevitable resulting chain of reaction."¹

Since this imbalance which results in illness can cause hospitalization of many individuals within the family unit, it is important that the family as a unit be included within this study.

Another aspect which is worthy of consideration is the vulnerability of certain persons to the illness. This

¹ Frances Upham, op. cit., p. 23.

vulnerability is related to the individual's constitution which has some basis in the heredity pattern of the family. It is this hereditary aspect which underlies the doctor's taking a family history on each case. However, it is necessary to also consider a person's susceptibility to illness or infection due to the fact that both his physical and emotional state is conducive to the receipt of a disease agent. "The predisposition of infection has a psychological as well as a physical aspect. It is a characteristic of the total person or constitution for which the theories of heredity have offered a very meagre explanation."¹

There are other factors which also give rise to illness within a family. Environmental conditions can create lowered resistance to disease. (Poor housing, inadequate food, unsanitary living conditions). To such conditions, the whole family is exposed.

The welfare of the family depends not only on its individual members, but on its capacity to maintain a stable equilibrium, both internally and in relation to its environment. Family life then is a compelling influence in the origin and perpetuation of illness. The children of today are the parents of tomorrow. Thus, when we help a family to attain a better equilibrium, we are making a large

¹ Henry D. Richardson, op. cit., p. 65.

investment.

Table 3. Ten Families who Used Hospitalization Frequently, According to Number in Family, Number of Individuals Hospitalized, Number of Admissions, Total Period in which Hospitalization Occurred, Marital Status of Parents

CASES	NUMBER IN FAMILY	NUMBER OF INDIVIDUALS HOSPITALIZED	NUMBER OF ADMISSIONS	TOTAL PERIOD OF HOSPITALIZATION	MARITAL STATUS OF PARENTS
A	7	3	7	6 years	M
B	9	3	5	4 years	M
C	6	3	4	1 year	M
D	6	2	3	1 year	M
E	4	3	3	3 years	M
F	6	3	27	6 years	SMP
G	9	3	3	2 years	M
H	6	3	14	9 years	SMP
I	9	3	16	7 years	SMP
J	9	4	17	3 years	M

The number of individuals in each family, as illustrated in Table 3, indicated that all families could be considered above the national average. In the total population of the United States, 57.7 per cent of the families have less than four members. Less than five per

cent of the families in the nation have seven or more¹ members. It is important to note, however, that this number often included the children of more than one marriage. Such a situation existed in cases A,F,I,J. One mother was married four times, one three, one twice, and the second marriage of another was a common-law relationship.

Number of hospitalizations.-- Since one individual within the family group could cause a rise in the total number of hospitalizations indicated in Table 3, further elaboration of the data appears necessary.

Case A -- One child had four admissions, another child and the mother each had one admission.

Case B -- One child had three admissions, another child and the mother each had one admission.

Case C -- The father had three admissions, two children each had one admission. It is significant that all admissions occurred during a one year period.

Case D -- One child had two admissions and another one admission.

Case E -- The mother had two admissions, one child had five admissions and another, one admission.

1 United States Bureau of the Census, Statistical Abstract of The United States, 1955, Washington, D.C., 1955, p. 51.

Case F -- The father had twelve admissions, one child had ten admissions, one child, three, and another had one admission.

Case G -- One child had three admissions, two children each had one admission.

Case H -- One child had six admissions, one child had four, another child had two and the mother and two children each had one admission.

Case I -- One child had eight admissions, one child had three admissions, another child had two and the mother and two children each had one admission.

Case J -- One child had ten admissions, two children and the mother each had two admissions and one child had one admission.

In relation to the number of hospitalizations, the family group established an average of 10.6 and a median of 7.5.

Economic support.-- In seven cases the family is supported by the Department of Public Welfare. In four of these cases the Department of Public Welfare assumes entire financial responsibility. In three cases the family receives only partial support from the public agency. Again, in this group as in the chronic group and those individuals without a chronic illness, we see a pattern of

economic dependency upon public funds.

In Case A, one of the children receives Old Age and Survivors Insurance as her father's dependent. The remainder of the support is provided through the program of Aid to Dependent Children.

In Case C, the father's earnings cannot cover hospital expenses. Thus, all hospital expenses above and beyond those paid by medical insurance are paid by the Department of Public Welfare.

In Case H, the family is supported by income from the father who is separated from his family. This income is inadequate to meet the needs of the family.

By the term adequate, the writer means that the income is fully satisfactory to meet the demands of the family for the necessities of daily living, (adequate living quarters, sufficient food, heat and clothing). In addition, the writer includes in this definition, the availability of the father's income to the family. None of the families within this group studied could be considered adequately supported through the father's income.

Living situation.-- Overcrowding existed in six cases. Dirty and unkempt conditions were evident in six cases. Inadequate heating facilities were noted in seven cases. In all but one case, (H), more than one inadequacy in the living situation existed simultaneously. An illustration of each

type of inadequacy will perhaps offer a clearer picture of the existing conditions.

Overcrowding:

In 1950, Case F, consisting of the mother and seven children, were living in a one room furnished apartment. The mother was advised to move by the Department of Public Welfare, but was slow to do so. However, by 1953, the family was living in five rooms and finally, through the help of Social Service at the hospital, moved to the housing project.

Dirty and unkempt conditions:

Case B is illustrative of this particular situation. The home, as described by the worker who visited, consisted of five rooms. Both the furnishings and the children were extremely dirty. The family did not wish to change their pattern of living.

Inadequate heating:

Since this situation appeared to be the only inadequacy in the living situation of Case H, perhaps this family would serve as a good illustration. This family lived in a five room tenement on the second floor of a two family house. The home was neat and clean and well ventilated. Two coal stoves served as the source of heat. They were, however, unable to compensate for the extreme dampness of the home. Due to this dampness, the children were subject to frequent upper respiratory infections. The family was helped to

secure an apartment in the housing project through the social worker at the hospital.

Extreme unsanitary conditions:

In Case D, the father, mother and four children lived in a three room tenement. There were no refrigeration nor bath facilities. Flies and cockroaches ran rampant and the backyard was filled with garbage. The children were malnourished. The mother threw the clothes away when they became dirty. This case was brought into Juvenile Court on a neglect charge.

Types of illnesses.-- The writer noted that in five cases rheumatic fever or some question of it was evident. The incidence of rheumatic fever in these families was as follows: two children affected in cases B,G,H,I; one child affected in Case F.

There is a dispute among authorities in regard to just what degree heredity plays in the occurrence of rheumatic fever. The prevailing opinion appears to be that susceptibility to this illness can be inherited. Therefore, in families where there has been a case of rheumatic fever, the chance for an individual acquiring it is three times greater than in a family where there is no rheumatic fever.¹

¹ Herbert Yanraes, Rheumatic Fever - Childhood's Greatest Enemy, Public Affairs Pamphlet Number 126, American Council on Rheumatic Fever of the American Heart Association, p. 5.

This, of course, could be due to other circumstances, and leads into the second contributory factor, the living conditions. "Many rheumatic fever cases are found among the well-to-do people but ... poverty, malnutrition, and unhygienic surroundings furnish the most favorable human soil for the development of this infection."¹

All these cases were known to the Rheumatic Fever Program of the state of Rhode Island, which assumed financial responsibility for hospitalization and follow-up care.

Upper respiratory infections occurred in six of the ten families under study, (A,D,E,F,H,J). Malnutrition occurred in three cases, (A,D,F). Gynecological difficulties were the cause of hospital admissions in six of the ten families. Other illnesses were present in the group, but the above were found in the greatest incidence.

Although chronic illness appeared in this group, no members of the families studied were used in the section relating to the chronic group in this study.

Emotional difficulties.-- Some outstanding emotional problem existed in every family. Marital problems per se existed in seven cases, while marital problems leading to divorce or separation were found in four cases. Parents

¹ Ibid., p. 9.

with psychological disturbances totaled eight. Rejecting parents were noted in five cases. As might be expected, there was a correlation between rejecting parents and the manifestation of psychological disturbances of the children.

If the family group is the center of tension, we can perhaps expect illness to develop among its members. It is often quite difficult to determine whether the living conditions precipitate the emotional problems, or whether the living conditions are the result of the emotional problems (depression, absence of motivation, etc.). Perhaps the answer is on an individual basis. It is known that "emotional disturbances form the element of illness next in importance to organic disease and are closely related to the social and personal status of the patient."¹ Another relationship between the physical and emotional aspects of illness is found in the patient's "flight into illness" as described in previous chapters.

"A family, as well as an individual, establishes a balance. For a satisfactory balance a synchronization of needs and satisfactions of all family members must be achieved; each member should contribute to the strength of the others and each should derive satisfaction from the interplay of giving and receiving."²

When anxiety is increased by traumatic experiences,

¹ G. Canby Robinson, op. cit., p. 4.

² Frances Upham, op. cit., p. 22.

tension mounts and satisfaction diminishes. The solution of this anxiety is dependent upon each individual. However, "a siege of illness in a family is as likely to be a result of disturbances in the family balance as of communicable disease germs."¹ Therefore, the interacting forces in the family become an important factor in the illness of the various individuals in the family group.

Use of the Out-Patient Department.-- All of the families in this group made use of the Out-Patient Department with the exception of Case D, where the use of clinic services for the children was recommended, but the parents failed to comply. These parents medically neglected their children and consequently rejected all medical services.

Case work rendered.-- Environmental manipulation was utilized in each case. This relates particularly to the poor housing situation and the social worker's role in helping the family secure more adequate living arrangements by initiating referral to a housing project in three cases. Other means of environmental manipulation included referrals to other agencies and the placement of children in the convalescent unit of the hospital for nursing care. The latter service was extended to eight of the ten cases, (A, B, C, E, G, H, I, J).

¹ Ibid

Psychological support accompanied environmental manipulation in all cases. This is understandable, since the caseworker would not have just a superficial contact with the family whose admissions to the hospital were frequent.

The case work method of clarification was utilized by the social worker in only three of the ten cases, (A, D, H). In Case A, the casework was in the area of helping the child to see the relationship between the illness and her need for security. Such clarification was also used with the parents. In Case D, the social worker attempted to help the parents see the relationship between the neglect and the illness. In Case H, clarification was attempted regarding the relationship between the mother's rejection of the boy and his illness, and the relationship between the physical environmental conditions and the illnesses of the other children.

Case Summaries.--

Case A. This family was composed of the father, mother, and five children. The father was the mother's fourth husband the father of three of the children. One of these three was a child by a previous marriage of the father. The parents in this family were separated. The mother lived with the five children in a crowded, damp tenement consisting of four rooms. Between 1947 and 1949, the oldest child, then about twelve years of age, was admitted to the hospital four times with different complaints. The last two admissions proved negative in regard to physical diagnoses. At that time, the psychiatrist saw the child and indicated that she was an insecure child who was attempting to achieve security through illness. The child was admitted to Crawford Allen Memorial, and casework services were rendered for psychological support and clarification.

The family as a unit continued to use the hospital for

various complaints of its individual members. All members made continued use of the Out-Patient Department. Finally, in 1953, the mother decided she could no longer cope with the responsibilities of the care of her family. She requested that they be committed to state care. This the mother accomplished with casework help around the area of what this separation would mean. Before accepting the children, the Juvenile Court Judge again made the mother aware of what she was doing and she acknowledged she could not care for them any longer.

Case B. The family consisted of both parents and seven children. The father, a college graduate, lost his job as an interviewer for an employment agency, due to alcoholism. He obtained a job as a bartender; however, his income went into the purchase of liquor. The mother was employed part time. The home conditions were crowded and dirty, evidencing a lack of interest and care. The children were not properly cared for. The parents, however, enjoyed their living pattern and had no desire to change. The mother complained of the father's drinking habit and a referral to the Division of Alcoholism and other agencies which could offer such services was made by Rhode Island Hospital Social Service. The couple refused to follow through. Two of the children suffered from rheumatic fever and rheumatic heart disease. Both were placed at Crawford Allen Memorial for Convalescent care. The family refused to accept any help from Social Service, hence the social worker utilized environmental manipulation alone, removing the children from the poor physical environment of the home for convalescent care. The underlying emotional problems of the father, which resulted in alcoholism, was not explored. The mother apparently received some satisfaction from the relationship with her husband and was resistant to change the status quo.

Case C. Six children live with their parents, and although the family does have poor living standards, a warm family relationship exists within the group. The father is a mechanic, earning \$50 per week. One of the children suffered from cerebral palsy. His IQ was 60. The social worker offered psychological support to the family in their acceptance of this child. This boy was placed by the social worker in Crawford Allen Memorial. A warm relationship was offered to him by the social worker and other staff members. The child soon became more outgoing and he was able to accomplish more things by himself. The mother was dull and it was difficult for her to perceive the needs of this child.

Although the family inter-relationships were considered

good, the writer feels that some of the needs of these children were unmet. The older boy had exhibited some delinquent behavior and was known to the police department, and a girl of 17 was illegitimately pregnant. Social Service extended help to this girl by referring her to an agency which could offer her help in planning for the needs of herself and her child. The area of casework extended to this family consisted chiefly of environmental manipulation and psychological support.

Case D. A family consisting of father, mother, and four children is an example of chronic neglect which was brought to the attention of Rhode Island Hospital Social Service Department, when one of the children, one year of age, was admitted to the hospital on 1-3-54, with burns on the left leg and thigh, blepharitis (inflammation of the eye lids), malnutrition and hernia. The father told the doctors that the child had developed a sore from a diaper rash. The doctors, however, said that there definitely had been a burn which was not treated. The child remained in the hospital a long time and upon discharge he met the standards of normal growth and development. Readmittance to the hospital, however, on 6-2-54, revealed the child suffered from dehydration and weight loss. Another child had been admitted previously with bronchopneumonia. The family lived in a three room tenement which was dirty and dingy. There was no refrigeration, no bathroom and garbage was piled in the backyard. The home was cold and drafty and the refuge for many flies and cockroaches. None of the children were weaned from the bottle nor toilet trained, although the oldest was five years of age. The mother threw the children's clothes away when they became dirty. The problems which appeared evident were (1) poor housing, (2) medical neglect, (3) inability of parents to provide proper care of the children.

There was some marital difficulty, the nature of which was not indicated in the record. The mother was limited in intelligence. Casework help was extended to this family at first in the area of psychological support and clarification, however the family refused such services. In the interim between hospitalization at Rhode Island Hospital, the same two children were seen in clinic at another hospital and a diagnosis of malnutrition was made.

The doctors at Rhode Island Hospital indicated that there was definite medical neglect. In view of the parents inability to cooperate, a referral was made to the protective agency. The case was brought into Juvenile Court. The judge ordered the case continued for a time with supervision

provided by the protective agency. Rhode Island Hospital Social Service worked with this agency on a consultative basis.

Case E. This was the smallest family in the group studied, consisting of the parents and two children. The father was diagnosed in 1952 as psychoneurotic by the Mental Hygiene Services. His neurosis was of a hysterical type, characterized by conversion symptoms and anxiety. He had been referred to the Mental Hygiene Services of the State by Rhode Island Hospital, psychiatric clinic, since this man was dissatisfied with his psychiatrist at Rhode Island Hospital.

The father's neurotic condition necessitated his discharge from his job, and thus the family was supported by aid to Dependent Children.

The mother was in the period of menopause. She was admitted to the hospital twice with gynecological difficulties and once with psychosomatic dizziness. Both sons were admitted repeatedly with upper respiratory difficulties. In 1953, they were admitted to Crawford Allen Memorial, because of secondary anemia (cause unknown) and repeated upper respiratory infections, low grade fever and ear difficulties. All members of the family, including the father, made frequent use of the hospital Out-Patient Department.

The mother was born and raised in Canada, and she had great difficulty in speaking the English language as she came from a French family. This woman was isolated from her relatives and had made no social contacts in Rhode Island. The father was extremely irritable and dominating, creating much tension in the home. The mother, perhaps in her identification with her husband and lacking other emotional outlets, developed many psychogenic complaints.

Social Service offered the mother psychological support in the area of her husband's illness. Attempts were also made by the social worker to help the woman join some church group. This woman appeared to establish a great relationship with a French-speaking nurse in the Out-Patient Department. This relationship was utilized in helping the woman to gain some satisfaction from social relationships. The nurse occasionally took this mother for a ride and introduced her to friends who also spoke French.

The doctors felt that the frequent respiratory infections suffered by the boys were due to dampness in the home. The home was neat and clean, however the dampness was not

controlled by the heating system. Social Service helped the parents to make application to the Housing Project and the family was accepted.

The writer feels that there may have been more than environmental difficulties creating these illnesses. After all, both parents utilized illness as a satisfaction of needs - perhaps the children were escaping from their father through hospitalization. The mother too, was overprotective of the children, they may have received such satisfaction from illness that they needed this in order to satisfy their needs, which were unmet due in this case to the father's neurosis. This case is an excellent example of how one person within the family can create disequilibrium, affecting every member of the family group.

Case F. This family group is complicated by the three marriages of the mother. This woman had four children by her first husband, now all over thirty and living away from home. The immediate family is composed of the children of the second and third marriages and one child out of wedlock. The first husband died, the mother is separated from her second and third husbands and the family is supported by Aid to Dependent Children.

The mother, of low grade intelligence, is a poor household manager. The family came to the attention of Rhode Island Hospital Social Service in 1944, when the oldest child, age ten, was admitted to the hospital for reapplication of a cast to his broken leg. Adequate care had not been given to the boy and his cast had been broken in some way. The mother said that she had been boarding this child and his sister, but someone had initiated a story that the children were over-worked and consequently the mother took them home only because of pressure placed upon her and not because she believed the story.

The family has always resided in very poor neighborhoods and in extremely crowded and unsanitary conditions. The Department of Public Welfare frequently recommended moving, but the mother was always slow to do so.

This woman had two admissions to the hospital for gynecological difficulties and one admittance on Neurological Service, with a diagnosis of hysteria. This latter admission followed an eviction from her home. Each time the mother was hospitalized, the children were placed in a children's home.

The mother was considered to be a maladjusted promiscuous

woman who was unable to cope with the reality situation. The family was known to nine community agencies.

This woman's last husband was an alcoholic. He was frequently admitted to the hospital with chronic alcoholism and barbiturate poisoning. In addition, he spent some time at a sanitarium for this alcoholism. Each time he was admitted to the hospital, his wife would visit him. She considered him as "another child."

One of the children was admitted to the hospital with rheumatic fever. Another child had ten admissions with a diagnosis of pneumonia. The doctors attributed this to the child's allergy to oil fumes. Change in the living situation was indicated.

Social Service helped the mother to make application for the housing project. She was not eligible, however, due to her marital situation. She therefore legally divorced her husband and moved into the housing project. Case work with this family was mainly on a superficial level, making the necessary referrals, when indicated.

Case G. Seven children and both parents composed this family group. The family relationship appeared to be good on the surface. However, the family was known to 15 community agencies. One child was a behavior problem. He was seen at a child guidance clinic and diagnosed as psychopathic personality. The mother was also seen at this time and there was a question whether she also was a psychopath.

Three of the children suffered from rheumatic fever and of these three, two were placed at Crawford Allen Memorial for convalescent care. One in 1948, and the other in 1955.

The oldest girl, who was considered promiscuous, had a severe cardiac condition but was not considered a candidate for surgery. She ran away with a boy and accused her father of incestuous behavior.

During hospitalization at Crawford Allen, the children were offered case work help, mostly in the area of psychological support, this service was also offered to the parents. Since the family was more or less a so-called "chronic" social agency case, as it was known to thirteen agencies, little could be done in remedying the situation in the hospital setting. The problems were of a deep emotional basis and did not seem amenable to casework help.

Case H. This family consisted of the mother and six children. The father was separated from the mother; however he did contribute to the family's support, although he had very little interest in them. The separation was based on an agreement, rather than through legal action.

The family lived in a damp home. Prior to separation there had been a great deal of marital discord. Due partly to the dampness of the home, the children suffered from laryngitis and frequent colds. One child had rheumatic fever and was referred to Crawford Allen Memorial, due to his physical overactivity and chorea. In the neutral setting of Crawford Allen Memorial, through the attention given him by the staff, the child recovered from chorea and made a satisfactory adjustment. It was felt by Social Service that the mother rejected this child.

Another child was transferred to a children's home because of malnutrition and anemia. One other child was admitted to Crawford Allen Memorial, due to four admissions within one year with colds.

Another child totaled six admissions with a diagnosis of tonsillitis and laryngitis, however, this was within a longer period. Casework help was extended to this mother in the area of referral to the housing project. She was not eligible, however, due to her marital status. She was referred by Social Service to Family Service for help in her marital adjustment and relationship with her children, in addition to securing better housing. Attempt was made by Social Service to help this mother with her rejection of the boy, and the relationship between the environment and the illness of the children.

Case I. This family consisted of the mother and five children by her first marriage and two children by her second marriage. The parents are separated, however, the father returns periodically to visit the mother, and since their separation, the mother became pregnant during one of these visits. The mother was seen in Neurological Clinic at the hospital and was diagnosed as a reactive depressive. The father is nine years the mother's junior in age. The cause of separation was due to the husband's use of marijuana.

After the mother was diagnosed as a reactive depressive with marked anxiety, it was felt that she could not benefit from psychotherapy.

Three of the children had questionable rheumatic fever at different times and were placed at Crawford Allen Memorial for convalescent care. One child was seen in Neurological Clinic in 1950, and his condition was diagnosed as mental retardation, hypertension, repressed chronic aggression and chronic anxiety state.

The worker's role with this family consisted in making arrangements for summer camp for the children and casework with the children while at Crawford Allen Memorial. No casework was extended to the mother due to the fact that she was unable to accept help. The mother, however, was able to make an improvement in her living condition in 1954, which greatly aided the physical condition of the children. With such an anxious and disturbed parent, the children will no doubt receive satisfaction of needs in some way and perhaps have to revert to illness to do so.

Case J. The family group in this case is composed of the father, mother and seven children. One of these children was born of the mother's first marriage. The mother and father were never legally married but have a common law relationship. The home is dirty and damp with the bathroom located in the basement. The mother's relationship with the children is warm and loving. Two of the children were admitted to Crawford Allen Memorial for convalescence after hospitalization. Their diagnosis was acute glomerulonephritis (a type of kidney disease). The mother was admitted twice, once with cholecystitis (inflammation of gall bladder), and once with gynecological difficulties.

The most frequent admittance to the hospital, however, was the youngest child, a boy. This child had ten admissions to the hospital for upper respiratory infections. He also spent some time in a Boston hospital for treatment of a congenital heart condition.

The main difficulty in regard to the cause of hospitalization in this case appears to be environmental. However, one would feel that perhaps there is some emotional difficulty involved in the mother's heterosexual relationship and hence we cannot exclude the emotional component. Further substantiation of an emotional difficulty lies in the fact that the mother was refused admittance to the housing project on the basis of larceny and adultery. Neither of these are explored in the record. Too, this family was known to ten community agencies, indicating perhaps greater social problems than evident in the recording.

Social Service attempted to help this woman obtain better living conditions for her family, however, the application for the housing project was unaccepted due to reasons as stated above. Psychological support was extended to this woman in helping her with the congenital illness of her child, necessitating good medical care.

The social and emotional components in illness can be readily seen in this group of ten families under study. The social worker, in order to perform a satisfactory service has to deal with both inner and outer factors in treatment of the patient. If the environmental condition is the result of emotional problems, the caseworker through environmental manipulation is removing only a symptom and another will soon rise up to replace it. When, however, the health of the individuals in the family is threatened, it sometimes becomes necessary to help the patient adjust the environmental problem. This should always be done with psychological support and referral to another agency, if the patient's need indicates he could receive help from another source. Such casework was indicated in this study.

Social workers can often see disequilibrium developing between the internal and external environment when many members of a family present physical symptomatology. Therefore, the importance of working with the family as a unit is evident.

CHAPTER V

SUMMARY AND CONCLUSIONS

The purpose of this study was to explore the factors in the frequent hospitalizations of certain individuals and family groups.

Sample selection.-- The writer sent to each worker in the department a note as follows: "Would you kindly submit a list of all cases, both family and individual, which you have worked with and who have frequently been admitted to the hospital. This list should include all such cases from October 1952, to October 1955, and which are closed at the present time."

From the 65 cases submitted, 32 were found to be applicable to this study. The writer divided the cases into three categories:

1. Ten individuals who make frequent use of hospitalization, whose illness while not chronic, would not necessitate readmission and whose cause for readmission is related primarily to the social or emotional conditions which affect it.
2. Five individuals who make frequent use of hospitalization, whose illness is not of a chronic

nature.

3. Ten families who make frequent use of hospitalization.

Although the writer intended to use ten cases in each category, only five of the total 32 fell into the second category. Fifteen cases fell into the first category and 12 into the third. From categories one and three, the ten cases selected from each were representative of the sex and age distribution of the total number, within both the individual and family categories.

Method.-- The method utilized in this study was primarily based on case studies.

Limitations.-- Since private cases are not necessarily known to Social Service, their absence from this study may eliminate the higher economic group.

The patients who make frequent use of the Out-Patient Department are excluded, since to include them would make the study beyond proportion. This group would, however, comprise excellent material for a future study.

The writer makes no comparative analysis of the group studied with the total population of the hospital. There is no consideration given to external sociological happenings within the time span studied.

Case records limit the study as the recording determines the amount of information available. The

knowledge and skill of the researcher as well as her subjectivity is also a limiting feature.

The scope of this study includes cases within a three year period: October 1952 to October 1955. The hospitalizations prior to October 1952 will be utilized in determining the total hospitalizations in each case.

The general questions proposed at the outset of this study were:

1. Are there certain characteristics which are found in these cases of individuals and family groups who make frequent use of hospitalization? For example,
 - a. Economic status
 - b. Family and interpersonal relationships
 - c. Emotional problems
 - d. Environmental inadequacies.
2. Did the social worker fail in interpreting the use of the Out-Patient Department to these clients?
3. Has poor planning upon discharge affected the further hospitalizations?

The three groups were treated in three different chapters within the main body of the thesis.

From the case records studied, the following answers to the research questions were obtained:

1. a. Economic support

Of the twenty-five cases under study, twenty cases, or 80 per cent of the group received some support from the Department of Public Welfare. In only two cases could the economic support be considered adequate. No cases of adequate support were found in the family group studied. Such figures indicate that the group presents a picture of economic dependency.

b. Family and interpersonal relationships

The family and interpersonal relationships of the patients in the group studied could not be considered good. Viewing only marital difficulties leading to divorce or separation, we find that separation or divorce existed in nine cases, or 36 per cent of the group.

Other indications of weak family and interpersonal relationships were sibling rivalry, inability to live with relatives, other marital problems.

Considering, therefore, the group as a whole, the satisfaction of needs through family and interpersonal relationships was not accomplished.

c. Emotional problems

Emotional problems were noted in twenty-three cases, or 92 per cent of the group. The degree of the emotional difficulty ranged from mild neurotic

disturbances, through more severe psycho-neurosis. In one case the patient was eventually found to be pre-psychotic and in one case the patient was transferred to the State Hospital for Mental Disease. Both these latter cases were found in the chronic group and the diagnosis was made by psychiatrists.

Emotional factors were important elements in each group. However, in the second group, composed of individuals who do not have a chronic illness, the emotional component was the primary factor in the readmittance to the hospital, and was found in 100 per cent of the group. These individuals were using the hospital as a satisfaction of their needs or as a means of escape from an unhappy situation.

d. Environmental inadequacies

In this category, the writer also included rooming houses where the physical condition per se were adequate, however, they did not meet the needs of the particular patient, e.g., the absence of cooking facilities, requiring the patient to eat in restaurants.

Environmental inadequacies were apparent in eighteen of the twenty-five cases.

In the family group they were found in 100 per cent

of the cases and were important factors in the illnesses developed by family members.

From the above data it would appear that economic dependency, emotional difficulties, and environmental inadequacies are important factors in the use of hospitalization by the particular group studied.

2. Of the entire twenty-five cases in this study, the Out-Patient Department was utilized by twenty-three cases, or 92 per cent of the entire group. In the two remaining cases, the situation was as follows: In one case there was no indication in the record of whether the patient came to clinic, although he had been advised to do so. In the other case, the parents were advised to bring the child to clinic, but following their pattern of medical neglect, refused to do so.

Considering the above information, the social worker did not fail to interpret the use of the Out-Patient Department to the client, and consequently this explanation for the frequent use of hospitalization can be ruled out regarding the cases in this study. Particularly in the second group, the patients utilized the Out-Patient Department frequently, availing themselves of the service of as many clinics as possible.

3. In the area of poor discharge planning, the writer

found that in only one case could the social worker be held responsible for poor planning. In four cases in the chronic group, however, it was notable that the patients themselves refused the recommended care, and consequently this was an important factor in their readmittance to the hospital.

The writer felt that in working with these patients in the chronic group, that more help could have been extended in the area of helping them to accept their illness, for unless this was done the change in living, necessitated by the illness, could not be accepted by the patient.

It can be concluded then, that emotional factors seemed to be the important influence in creating the frequent admissions to the hospital. Environmental conditions were nevertheless very important also in the family group, and less important in the other groups studied. It is very difficult to separate the emotional and social component in illness as one very often precipitates the other.

The family as a unit of illness, seemed to occur frequently in the group of patients who make frequent use of hospitalization. In order to give a picture of the type of conditions which might be related to frequent hospitalizations, the writer thought that the family should not be excluded. Since family records are kept in the Social Service Department

of Rhode Island Hospital, the family as a unit could readily be included in this study.

In the family group, the writer noted the significance of the physically poor environmental conditions of the home which were related to the illnesses of the family members. The physical conditions of the home were not attributed to the hospitalizations of any of the patients in the category of individuals without a chronic illness. In the group of individuals with a chronic illness, the physical condition of the home as a factor in the readmissions, was related to the lack of facilities for the patient's needs, rather than to the generally poor living conditions.

The diagnoses of the members in the family group may also be significantly related to the poor living conditions, as rheumatic fever, upper respiratory infections, and malnutrition, were found in the greatest incidence.

When many members of one family make use of the hospital, we might speculate that the case worker would become more quickly suspicious of a precipitating factor in the home environment, and then draw the family into the picture. This was notable in the cases studied as the worker made a home visit in each case. However, home visits were made also in work with individuals with and without a chronic illness, when such seemed advisable.

Emotional problems were as evident in the family group

as in the other groups studied. The frequent hospitalizations of the family members were no doubt also related to these emotional problems.

It is necessary for us to view the whole man and to understand the complex elements involved in his life; it is equally important, however, to determine what proportion the various elements play in the total picture. Alleviation of the social conditions may produce satisfactory results in one case and not in another. Thus, we can see that it is vital for the social worker to be able to diagnosis the problem properly.

Economy is an element in medical care. This economy extends into finances, service, and facilities. Considering the financial aspect, it should be noted that the cost of medical care within the hospital is expensive. In this particular study, the writer notes the number of patients whose cost of medical care is being met by the Department of Public Welfare. Yet the state reimburses the hospital for only a portion of the entire cost of services rendered. Thus, we can see the expense to the community and to the hospital involved in every hospital admission of the patients in this study.

Service and facilities are also factors in the picture of economy. The number of doctors, nurses and social workers and others available in the hospital is not abundant.

Economical use of the services of these professional persons is a necessity. Beds should be available to those who need them. Consequently, the social worker should be aware of the value to the entire hospital of helping these patients to secure satisfactions and maintain themselves outside of the hospital setting.

A third factor is human resources. Every individual has a place in the society and each can contribute in some way to the general progress. Persons who have become unproductive due to illness should be helped to return to a productive status within their capacity. The writer sees far-reaching consequences of incapacity when poverty affects the entire living situation of the family. Emotional problems of the individual members are then created by the environment.

Rehabilitation of a physical, social and emotional nature should be the goal of the hospital staff in working with these patients.

Since the social and emotional factors are outstanding in their influence, the social worker's role assumes considerable importance. If the emotional problem is of a considerably deep psychological nature, then perhaps the social worker could make a proper referral to psychiatric services within the hospital itself, or in the community. If the problem is such that it can properly be handled by

casework treatment, then it appears that it is the social worker who has major responsibility for patients who make frequent use of hospitalization.

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APPENDIX

SCHEDULE

General Information

1. Age
2. Sex
3. Marital Status
4. Employment Status (Occupation prior to illness)
5. Financial Status
6. Family Constellation
7. Place In Family

Information Regarding Hospitalization

1. Number of Admissions
2. Dates of Admissions
3. Diagnosis
4. Prognosis
 - a. Acute
 - b. Chronic
 - c. No Organic Disease

Social Factors

1. Environmental Problems
 - a. Subsistence
 1. Financial Status
 - a. Assistance from Public Relief Program
 - b. Weekly Earnings
 - c. Other Sources

2. Housing

- a. Live Alone
- b. Family Home
- c. Adequate
- d. Inadequate

3. Diet4. Lack of CareEmotional Problems

- 1. Faulty Personal Habits which Influence Health Status
- 2. Inability to Adjust to Illness
- 3. Poor Family Relationships
- 4. Poor Interpersonal Relationships
- 5. Neurotic Tendencies
- 6. Other Emotional Problems

Case Work Treatment

- 1. Environmental Manipulation
- 2. Psychological Support
- 3. Clarification
- 4. Insight Development