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Social and emotional problems in the rehabilitation of cancer patients: a study of fourteen patients age forty to forty-nine with cancer of the cervix.

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SOCIAL AND EMOTIONAL PROBLEMS IN THE REHABILITATION OF CANCER PATIENTS: A STUDY OF FOURTEEN PATIENTS AGE FORTY TO FORTY-NINE WITH CANCER OF THE CERVIX

A thesis

Submitted by

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CHAPTER I

INTRODUCTION

1. Historical Background

The American Cancer Society, Massachusetts Division, granted funds to a Harvard Medical School research project to study the effects of certain types of treatment for cancer of the cervix in four hospitals, Massachusetts General, Peter Bent Brigham, Women's Free, and Pondville. The project began in June, 1954. Only patients with a diagnosis of cancer of the cervix were included in the project.

A social worker was included on the team to interview the patients to learn of their home situations, economic conditions, personal relationships, adjustments prior to illness, and possible circumstances which might interfere with medical treatment. She had both research and social service functions. All patients except the Pondville patients were interviewed by her.

The social worker provided services to enable the patients to continue treatment. She was interested in the patient's past history, particularly her handling of other stress situations in her life, to better evaluate what kind of help was needed for optimum rehabilitation of the patient. She aimed at

providing environmental modifications and emotional support. Where indicated, discussion with the family about the meaning of the illness was held.

The project's area of service was the care of the patient to obtain maximal socio-economic and emotional rehabilitation. Also, there was interest in the correlation of significant social data with medical findings.

The writer surveyed the literature written by social workers which dealt specifically with cancer. Three notable articles[1] stress the social worker's awareness of her own feelings about cancer in order to be able to establish a helpful relationship with the patient. The social worker needs to have a sound understanding of the course of medical treatment, the areas in which the patient may need help and a knowledge of community resources. As a member of the team, the social worker plays an active role in assisting the patient to carry out the medical treatment plan.

The writer surveyed other articles which were written by medical men and dealt with the emotional reactions to the diagnosis of cancer. Interest and research in this area is fairly

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[1]Ruth D. Abrams, "Social Casework with Cancer Patients," Social Casework (December, 1951), 32:425-432.
Eleanor Cockerill, "The Social Worker Looks at Cancer," The Family (February, 1937), 17:326-329.
Marion Thurman, "Some Generic and Specific Concepts in Casework with the Cancer Patient;" Paper presented at The National Conference of Social Work, 1950 (Unpublished).

recent. An article by Harry C. Solomon, M.D.[2] outlines some of the elements which must be considered in the treatment of the cancer patient. He stressed the areas in which the social worker's skills are helpful. He included study of the personality, understanding of the problems to be faced, providing support and guidance during the various stages of treatment and recovery or terminal stages and help to the patient's family when it is indicated.

A theme which was found in the writings was that the course of cancer can not be altered by the understanding of the personality and its adjustment. The understanding of the patient is needed to provide the practical services and emotional support which meet the needs present. The insights gained from the intensive study of a group of cases, reported by Abrams and Finesinger[3], stress the practical value in helping the patients deal with many of the problems which confront them although this does not alter the course of the illness.

2. Purpose

A study of a group of patients who participated in the Harvard Medical School cancer research project was undertaken to learn about their social and emotional rehabilitation problems.

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[2]Harry C. Solomon, M.D., "Psychiatric Implications of Cancer," Rocky Mountain Medical Journal, (October, 1947) 44:801-804. (Reprinted and revised.)

[3]Ruth D. Abrams and J. E. Finesinger, "Guilt Reactions in Patients with Cancer," Cancer, (May, 1953) 6:474-482.

It proposed to investigate the meaning of the illness to the patient, its effect on family relationships, the extent of return to previous life activity, and the social worker's role in the situation. Four specific questions were formulated as follows:

I. What is the meaning of the illness to the patient and how does she deal with it emotionally?

II. What is the extent of the disability and the extent of return to previous levels of activity?

III. What is the effect of the illness on the course of interpersonal relationships within the family?

IV. What is the social worker's role in the treatment of these cases?

3. Justification

A descriptive study, such as the one proposed, is a preliminary step in clarifying the social worker's role with cancer patients. The lack of research in social casework with cancer patients makes descriptive studies necessary. Research may help delineate the casework skills and methods which are particularly effective with specific illness groups and, therefore, contribute to the general knowledge of casework.

4. Selection of Cases

The group of 54 cases in the study included all the clinic and a few private patients who came to three of the hospitals, Massachusetts General, Peter Bent Brigham, and Women's Free,

during the time period of June, 1954, and April, 1955. Originally there were 58 cases in this group, but two case records could not be located and two were removed from the project because of error in diagnosis. All patients were diagnosed as having a primary cancer lesion in the cervix.

Four medical social work students, Mrs. Rita Kaplan, Miss Savanah Mitchell, Miss Eileen McNulty, and the writer participated in the study of this patient group.[4] The patient group was comparatively evenly distributed in terms of age. The students participating in the study elected to use this natural distribution because it provided an opportunity to isolate the age factor. It was felt that each age group had certain problems peculiar to it and that a division by age would be valuable in relation to the formulated research questions. The writer studied the fourteen cases in the forty to forty-nine age group. Miss Mitchell studied the thirteen patients in the thirty to thirty-nine age group; Mrs. Kaplan studied the thirteen in the fifty-to fifty-nine age group; and Miss McNulty studied the fourteen in the sixty to seventy-nine age group. The patient group was followed from the beginning of treatment through the third and sixth month check-ups.

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[4]These three theses completed at Boston University in 1956 all have the same major title as this study, with sub-titles as follows: Miss Savanah Mitchell, "A Study of Thirteen Patients Age Thirty to Thirty-nine With Cancer of the Cervix"; Mrs. Rita Kaplan, "A Study of Thirteen Patients Age Fifty to Fifty-nine With Cancer of the Cervix"; Miss Eileen McNulty, "A Study of Fourteen Patients Age Sixty to Seventy-nine with Cancer of the Cervix."

5. Method

Social service records, which contained the interviews with the patient and the family and a description of the services rendered, were available. Research medical records with pertinent past medical history, a running account of the course of treatment, and some social information were also used. The cancer project began to use, but later abandoned, a detailed social service form, which would have been useful had it been present in more cases. (An adaptation of this form is being instituted; however, it was not present in many cases.) Consultation was available with Mrs. Abrams and Mrs. Krush, who replaced Mrs. Abrams as the social worker in May, 1955, for information which was not clearly stated in the records.

6. Limitations of the Study

The total project population was representative of the patients who attended the clinic; however, it did not provide a representative sample of any larger segment of the population. The writer's study covered a six-month period; therefore, the findings are limited. In a six-month study, the extent of the patient's socio-economic and emotional rehabilitation is not too great. Indications and changes which have occurred can be presented. The project had one social worker at a time, which meant that the patients were seen by both social workers or one social worker, depending upon the date of referral to the project. Wherein the material desired was the same, the differences

in approach by the individual social worker were present. The patients, however, were seen by only one or two social workers and not by several social workers. This meant that the patients were not confronted by several different approaches. Consultation with the two social workers was used for verification and clarification of facts which were not in the record or were not clear. At times, consultation relied on the memory of the social worker. The three hospitals provided different settings, personnel and experiences for the patients, and the effects of these can not be singled out for inclusion in the study. The social workers' approach was also affected by the three settings, and these factors can not be included. The factors which influenced the patients, i.e., support from friends, relatives, other professional staff, religious faith, could not be isolated and studied. The research project has continued contact for follow-up and check-up care of the patients because of the illness. It was felt that interviews with the patient group would increase anxiety about their condition.

CHAPTER II

CHARACTERISTICS OF THE PATIENT GROUP

In this chapter the characteristics of the patient group at the time of referral are presented. This includes information about vital statistics, economic circumstances, living arrangements, and number of children born to the patients.

1. Age

The distribution of ages within the forty to forty-nine age group is contained in Table 1. The mean age of the group was 45.5.

Table 1. Age Distribution of the Patients

Age	Number of Patients
49	1
48	1
47	4
46	2
45	1
44	2
43	2
42	-
41	1
Total	14

2. Race and Nationality

In the group, eleven patients were white and three patients were negro. Twelve patients were born in America. Two

patients were born in European countries and one of these had a serious language handicap.

3. Religion

Six patients were Catholic; four were Protestant, and no religion was recorded for four patients. In view of other studies[1] of cancer of the cervix, it was interesting to note no Jewish women were included in the research project. The hospitals included in the project were not ones frequented by Jewish women as there is a Jewish hospital clinic in the city.

4. Marital Status

In Table 2 is shown the marital status of the group.

Table 2. Marital Status of the Patients

Marital Status	Number of Patients
Married	8
Widowed	3
Separated	3
Total	14

The social and medical records indicated there was a variety of marital patterns within the group. Nine patients had had one

[1] James H. Stevenson, M.D. and William J. Grace, M.D., "Life Stress and Cancer of the Cervix," Psychosomatic Medicine (July-August, 1954) 16:287-293.

marriage. Of these, five patients were living with their husbands and one patient had been deserted by her husband ten years ago. Four patients had had two marriages. Two of these patients were living with their second husbands and two were separated from their second husbands. One patient had had three marriages. The first one had ended in divorce, the second had ended with her husband's death, and she was with her third husband.

5. Education

Table 3 shows the level of education achieved by the patient group.

Table 3. Educational Achievements of the Patients

Years of School	Number of Patients
8 or less	5
9 through high school	5
unknown	4
Total	14

6. Economic Status

In Table 4 is contained the estimated weekly income in the families of the patients and the number of people supported. Eight of the patients were supporting themselves and/or families or supplementing the earnings of the other wage earner(s). Case 1 received Public Assistance and held a part-time job. Case 4 received a contribution from her husband, and Case 13 received Survivor's Benefits and Veteran's Pension.

Table 4. The Amount of Weekly Income and the Number of People Supported

Case Code Number	Number of People Supported	Under $39	$40-59	$60-79	$80-99	$100- over	Unknown
1	2		x				
2	2		x				
3	3				x		
4	3	x					
5	2						x[a]
6	9		x				
7	2						x[b]
8	2					x	
9	3	x[c]					
10	4			x			
11	1	x[d]					
12	2						x
13	3	x					
14	2	x					

a. Patient gave up her job one month prior to coming to the clinic when her ill mother and brother moved into her home.
b. The income from the rooming house was estimated as varying from $35-96 a week.
c. Patient contributed her earnings to her sons' business.
d. Patient received tips.

7. Occupation

Occupation is defined here as work out of the home for wages and work done in the home in connection with a business. Eight of the patients were employed; one of these did housework in the rooming house she operated. Five patients were not employed, and there was no information on one patient. The types of jobs held by patients are shown in Table 5. Further discussion of the occupations is contained in Chapter V.

Table 5. Occupations of the Patients

Occupation	Number of Patients
Domestic	4
Nurses' helper	1
Waitress	1
Stapler	1
Spray painter	1
Not employed	5
Unknown	1
Total	14

8. Number of Living Children

Four patients had one child. Four patients had two children. Three patients had three children and one patient had eight children. Twelve patients had a total of twenty-nine children. In Table 6 is shown the distribution of children in the home according to ages. The remaining eleven children lived outside the home. Six of them were married. Discussion of the roles of the children in connection with the illness is contained in Chapter VI.

Table 6. Children in the Home According to Age

Case Code Number	Number of Children in the Home	Approximate Ages 1-9	10-19	20-over
1	1	x		
3	1	x		
4	2	x	x	
5	1		x	
6	7[a]			
9	2			xx
10	2	xx		
13	2		xx	

a. The patient's children ranged from 8 to 25 years.

9. Living Arrangements

In Table 7 the living arrangements of the patient group are found.

Table 7. Living Arrangements of the Patients

Living Arrangements	Number of Patients
With husband	5
With husband and children	3
With children	5
With friends	1
Total	14

The housing accommodations of the patients varied. The extremes were a patient who lived in a single house with no bath room facilities, and a patient who lived with her husband in an $85 a month apartment. Six patients lived in apartments and three lived in low-rent housing projects. One patient lived in a cottage and one in a seventeen room house which was a rooming house. One patient lived in a boarding home with two female friends.

10. Distance from the Hospital

The following categories were considered in determining the distance of residence from the hospital: Boston proper; Metropolitan Boston; outlying areas and out of state. Five of the patients lived in Boston proper. Six patients lived outside of the city but in Metropolitan Boston, and two lived in outlying areas. One patient came from out of state, Maine. Distance

was considered significant in view of the medical regime.

CHAPTER III

ILLNESS AND TREATMENT

In this chapter the history of the present illness, including treatment, hospitalization, and out-patient visits will be presented. This will be followed by data on the past medical history of these patients.

1. Stage

The stage of the disease was rated by the Harvard Medical School research project on the basis of histopathologic techniques. The stages were a medical indication of the extent of the cancer, with Stage I the least serious and Stage IV the most serious. Table 8 shows the distribution of the patients according to the stage of the disease.

Table 8. Medical Rating of Stage of Disease

Stage of Cancer	Number of Patients
I	5
IIa	3
IIb	3
III	2
IV	1
Total	14

2. Treatment

Two types of treatment were given: radiation, which was always radium therapy followed by a prescribed course of x-ray

therapy, and surgery. In some cases surgery was followed by a course of x-ray treatment. The patients fell into three treatment groups: 1) group which received radiation; 2) group which had surgery; 3) group which received a combination of these, (a) radiation followed by surgery, or (b) surgery followed by radiation. In Table 9 is shown the distribution of cases according to stage, and the type of treatment. The surgery performed was a hysterectomy, of which there were several types.

Table 9. Stage and Type of Treatment

Group	Case Code Number	Stage	Type of Treatment
1			
	4	IIb	radiation
	5	IIa	radiation
	9[a]	III	radiation
	13	IIb	radiation
2			
	6	I	surgery
	7	I	surgery
	8	I	surgery
	12	I	surgery
3			
a)			
	1	IIa	radiation; surgery
	2[a]	III	radiation; surgery; radiation
	3	IIb	radiation; surgery
	10	IIa	radiation; surgery
b)			
	11	I	surgery; radiation
	14[b]	IV	surgery; radiation

a. Patients are deceased.
b. Patient had a sigmoid colostomy for advanced cancer.

The type of treatment was determined by careful examination which indicated the probable response of the patient to treatment. Table 9 indicates that surgery was performed in ten cases;

however, in four cases other treatment was tried before surgery was elected. All Stage I cases had surgery and one, Case 11, had radiation treatment afterwards. The other stages followed no definite pattern but were treated according to the degree of their sensitivity to radiation.

3. Hospitalizations

Patients who were treated by surgery usually were hospitalized from two to three weeks, while those who had radium implantation remained in the hospital about one week. The number of hospitalizations is shown in Table 10.

Table 10. The Number of Hospitalizations of the Patient Group

Case Code Number	Number of Hospitalizations	Case Code Number	Number of Hospitalizations
1	3	8	3
2	3	9	3
3	3	10	3
4	3	11	2
5	4	12	1
6	4	13	2
7	1	14	2

The average number of hospitalizations was 2.6. No consideration has been given to the length of hospitalizations because the medical records were kept differently in the three hospitals, and these data were difficult for this writer to obtain.

4. Out Patient Check-up and Treatment Visits

The patients who had out patient treatment usually received daily x-ray on an out-patient basis, which usually covered a

period from three to six weeks. All patients were expected to return for check up visits at regular intervals. The patterns of out patient visits in the six-month period varied. The writer found that different methods of recording were used for treatment visits and check up visits and these two types of visits will be discussed.

The patients can be separated into groups according to the pattern of the treatment and check up visits. In two cases treatment continued during the six months under study; five cases had one or two check up visits; and seven cases had three or more check up visits after treatment.

In the six-month period from August, 1954, through January, 1955, Case 2 received treatment consisting of radiation, surgery and radiation. Case 9, from December, 1954, through May, 1955, received treatment on both an in patient and out patient basis.

Case 1, from June, 1954, through December, had one check up visit in July after radiation treatment and was hospitalized for the remainder of the time. Case 4, from September, 1954, through February, 1955, received radiation treatment on an in patient and out patient basis. She had two check up visits, one in December and one in January. Case 6, from October, 1954, through March, 1955, had one check up visit in November after surgery and was hospitalized intermittently for the remainder of the time. Case 10, from January, 1955, through June, 1955, had one check up visit in June after both in patient and out patient treatment. Case 14, from March, 1955, through August, 1955, had two check

up visits, one in July and the other in August after treatment on both an in patient and out patient basis.

Case 3, from August, 1954, through January, 1955, was seen three times in December and four time in January for check up visits after in patient treatment. Case 5, from October, 1954, through March, 1955, was seen once each in January, February, and March for check up visits after in patient treatment. Case 7, from October, 1954, through March, 1955, had three check up visits after surgery, one each in November, December, and March. She failed to keep her January appointment. Case 8, from November, 1954, through April, 1955, had four check up visits after surgery. Three check up visits were in March and one was in April. Case 11, from January, 1955, through June, 1955, had two check up visits after surgery, both in March; then she had a course of radiation and four check up visits in June. Case 12 had three check up visits after surgery, one each in March, April, and June. Case 13, from March, 1955, through August, 1955, had four check up visits; three visits were in July and one visit in August. These visits were after both in patient and out patient treatment.

5. Previous or concurrent Illnesses

Five patients had either past or concurrent illnesses. Case 7 had had a hysterectomy 18 years prior to the present illness. Also, the medical record indicated she had cholecystitis and had been diagnosed as having diabetes two years ago and was treated

with insulin, which she had discontinued as her urine test was blue. Case 9 had had a rheumatic mitral stenosis heart condition for many years. The other three cases had minor conditions. Case 11 had had bronchitis for many years and 20 years ago had had a cholecystectomy. Case 8 had renal glycosuria and a history including pleurisy, bursitis, and hemorroids. Case 13 had had a goiter since adolescence.

Significantly, the group, except for the above cases, had experienced no illness problems prior to present illness. The other nine cases had no previous or concurrent illnesses recorded in their medical records.

CHAPTER IV

EMOTIONAL MEANING OF ILLNESS

In this chapter the emotional meaning of illness to the patients is discussed. This includes past stress situations, i.e., major illness and/or deaths of significant figures and the patients' reactions to these symptoms and delay in seeking medical care; knowledge of the illness, and the defense mechanisms used by the patients to cope with the present illness.

1. Major Illnesses and/or Deaths and the Patients' Reactions

Past experiences of the patient group with either illness, particularly cancer, or death of significant figures were considered important in evaluating the ability to handle the present illness. The patients' reactions to these events were considered important in understanding how they had coped with the events. This would possibly affect the patients' reactions to the present illness.

Twelve patients were known to have had experiences with death and/or major illness of a family member, and in six cases the experience was with cancer. Table 11 shows the patients' reactions to the major illness and/or death of significant figures. The information given by the patients who had experience with cancer was factual. It did not indicate the effect the experience may have had on them. This may indicate reluctance to discuss the subject of cancer.

Table 11. Reaction to Major Illness and/or Death of Significant Figures

Case Code Number	Major Illness and/or Death of Significant Figures	Patient Reaction
1	Husband died six months before patient came to the clinic	She felt badly because of shock of finding him dead at bottom of stairs
2	One sister died of cancer, and two sisters died of cancer of the cervix; mother was "cured", died of shock	Patient was upset by mother's death
3	Sister died of cancer of the stomach	
4	No information	
5	One month prior to referral, mother had a cerebral vascular accident	Brother and mother moved in with patient
6	Husband had a heart attack 15 weeks prior to patient's referral	
7	Youngest brother died from alcoholism and heart attack	She thinks of her brother that he died at 46, "just my age"
8	No information	
9	Husband died of cerebral hemorrhage 2 years prior to patient's referral	She was shocked by his death; was alone for some time before her sons returned
10	Mother died 10 months prior to the patient's referral	She was shocked by mother's death
11	Mother, a diabetic, died 24 years ago	
12	Mother had cancer of the rectum, is living and well; 3-4 years ago father died of heart attack; sister-in-law died of an enlarged heart about the same time; at time of referral, husband was in hospital for ulcers.	She has always cared for the sick, expected to, and was glad to do it

Table 11. (continued)

Case Code Number	Major Illness and/or Death of Significant Figures	Patient Reaction
13	Patient witnessed husband's death by a hit-run driver 4 years ago; father died of cancer of the throat 19 years ago	She was upset by his death
14	Mother-in-law died of cancer of the rectum 2 years ago	She was living with her at the time and caring for her

2. Symptoms and Delay in Seeking Medical Care

The patients indicated they had had symptoms for varying lengths of time. Statements of the patients indicated they sought medical attention when the symptoms continued for a period of time with no evidence of subsiding or disappearing. In Table 12 the duration of symptoms and the stage are shown.

Table 2 indicates that seven of the fourteen patients had symptoms between six months and a year before medical attention was sought. Their symptoms included irregular menses with and without pain; spotting of varying degrees; fatigue; loss of weight and constipation. Four patients had symptoms for less than six months. The symptoms included irregular menses, discharge and staining.

Table 12. Duration of Symptoms before Medical Care was Sought and Stage of Cancer

Case Code Number	Stage of Cancer	Duration of Time Patient had Symptoms			
		Under 6 Months	7 to 12 Months	Over 1 Year	Unknown
1	IIa		x		
2	III		x		
3	IIb		x		
4	IIb	x			
5	IIa		x		
6	I		x		
7	I		x		
8	I				x
9	III	x			
10	IIa	x			
11	I	x			
12	I				x
13	IIb			x	
14	IV		x		

Case 9 was suspected of having had symptoms longer and her symptoms were clotting and discharge. Case 13 had symptoms for slightly over one year and they were occasional inter-menstrual bleeding, staining and hot flashes. Case 8 learned of her illness when she had a physical examination at the Peter Bent Brigham. The record made no reference to symptoms she may have noticed. Case 12 was indefinite about the duration of her symptoms. The record gave no indications of the actual period of time she had her symptoms. She stated, "Can't remember time, six months, one year, two years."

Five patients thought their symptoms were connected with the menopause. Similarity of some of the symptoms to those ascribed to the menopause made this mistake possible.

In the foregoing, the writer has indicated the more prominent symptoms and not all the patients had all of them. As may be seen in Table 12, the duration of symptoms was no indication of the stage of cancer.

The delay in seeking medical care is defined as the time between the awareness of symptoms and the actual seeking of medical care for them. Table 12 indicates this delay before medical care was sought.

Nine patients gave reasons why they had not sought care earlier. Cases 1 and 10 gave change of life as the only reason they delayed. Cases 9, 11 and 14 said financial worries were the reason for their delay. The writer felt that two of these cases merit discussion. Case 11 stated that she could not afford medical care, although her brother was a medical doctor. She did not wish to bother him as he had just set up practice. Case 14 gave financial worries and concern about the high cost of hospitalization as her reasons for delay. She added she hoped everything would come out all right.

Case 13 had a fear of needles and referred to uncomfortable contacts with medical men as her reasons for delay. Case 5 gave as her reasons for delay not wanting to tell her mother about the symptoms and being afraid of what they might be. Case 12 never thought about herself. Case 4 said the doctor told her she had a cold.

The reasons for delay were subject to interpretation by the social worker and the reasons seemed both realistic and unrealistic.

Of the nine patients, two patients who gave reasons for delay indicate that although the symptoms are similar to those of menopause, they are not always the primary reason for delay.

3. Defense Mechanisms Used by the Patients

The writer felt the patient's knowledge of the illness could be related to the defense mechanisms used by the patient. In Table 13 the patient's knowledge of the illness and the defense mechanisms used are shown.

Table 13. The Knowledge of the Illness and the Defense Mechanisms used by the Patient

Case Code Number	Patient's Knowledge of the Illness	Defense Mechanisms
1	Knew she had a tumor; feared cancer.	Projection
2	Did not know she had cancer.	
3	Question of whether she knew she had cancer; suspected cancer.	Denial
4	Thought she had a tumor.	Denial
5	Knew she had a growth on the womb and was afraid of what it might be.	Denial
6	Knew she had cancer.	Projection
7	Knew she had cancer.	Projection
8	Knew she had cancer.	
9	Question of whether she knew.	Denial
10	Knew she had cancer.	
11	Knew she had a tumor.	Denial
12	Knew she had cancer	Projection, denial

Table 13. (Continued)

Case Code Number	Patient's Knowledge of the Illness	Defense Mechanisms
13	Knew she had something at the tip of her womb.	Denial
14	Knew she had a tumor and an obstruction in the womb.	

Denial of reality is here defined as refusal to recognize the full reality of a deeply frustrating situation for the purpose of protection from the threat of this realization. In five, and possibly seven, cases the inability to communicate about the illness and not wishing to be told about the illness were taken as evidence of denial. Four patients, Cases 4, 5, 11, and 13, knew they had a tumor or a growth on the womb. They indicated either directly or indirectly that they did not want to know more. An example of direct expression was Case 13 in which the patient said she was more cheerful if she did not know. Case 14 was an example of indirect expression. She asked no questions and was unable to communicate her fears to the social worker. She did tell a friend that she could bear better what she did not know. She related this specifically to illness and stress situations. Case 3, the patient with a language difficulty, had no communication on the subject of her present illness. The question of whether she knew she had cancer was raised. In Case 12 the patient knew she had cancer; however, she did not worry about it nor could she remember when the symptoms started. The question

of denial was raised in Cases 5 and 9. In Case 5, the patient complied with the treatment procedures without questioning. The question of denial or lack of knowledge was raised. In Case 9, the patient was believed to know the diagnosis by the social worker.

Projection is here defined as the abandoning, to some degree, of the reality testing function by the ego by placing responsibility on some outside agent rather than on the self. Evidence of projection was found in Cases 1, 6, 7, and 12. In Case 1, the patient blamed a recent traumatic event for the illness, although the symptoms were present prior to the event. In Cases 6 and 7, the patients blamed hard work for their illnesses. In Case 12, the patient was concerned about other ill persons and the doctor who informed her of her illness.

Manifestations of anxiety were present in varying degrees in all fourteen cases. Indications included the patient's evaluation of self as having a tendency to worry, lack of composure, and verbal and non-verbal expression of concern about the symptoms or illness.

In Case 9, the patient expressed feelings of guilt about the length of time she delayed before seeking medical care. She cried when discussing the delay. The medical record indicated that the doctor felt she underplayed her symptoms.

Ten patients used observable defense mechanisms to handle the anxiety produced by the illness. The absence of observable

defense mechanisms in Cases 2, 8, 9, and 14 was the result of the writer's inability to discern them from the case recordings.

CHAPTER V

FAMILY RELATIONSHIPS AND PATIENTS' LEVEL OF ACTIVITY

In this chapter the family relationships and reactions to the patient's illness and the patient's level of activity prior to illness and at the sixth month check up are discussed.

1. Family Relationships and Reactions to the Illness

The family is used here in a broad sense to include the immediate members, i.e., husband and children, as well as blood relatives and relatives by marriage. The relationships between the family and the patient give indications of the positive and negative factors which operate in the life situation. These indications may give direction to the worker's handling of the patient's emotional and environmental needs.

The family reactions to the illness are related to the family relationships. The family's ability to offer emotional or environmental support may be based on their reaction to the patient's illness. Specifically, the family could assume temporary responsibility in the home and offer emotional support during the hospitalization and afterwards. In Table 14 the family reactions to the illness are described. Significant family relationships are later discussed in connection with this.

Table 14. Family Reactions to the Illness

Case Code Number	Family Reaction to the Illness
1	Daughter complained of stomach pains and was nervous.
2	Husband felt protective of the patient; he did not want her to return to work; he questioned whether illness was the result of not douching; did not want people to know of the illness.
3	Daughter had stomach pains; husband preoccupied with contagion; he also feared possibility of inheritance; he wondered if cancer came from prolonged anxiety about relatives abroad.
4	Sister who knew diagnosis able to talk with the social worker about it.
5	Daughter acted like a "little mother" when patient was hospitalized.
6	Not clear.
7	Patient did not discuss symptoms with husband because of his reluctance to discuss such matters; patient said he did not visit her or inquire about her; mother visited and talked with patient.
8	Patient discussed illness with husband freely.
9	Not clear.
10	Relatives in Connecticut were anxious about illness; husband was uncommunicative and uncomfortable in a hospital.
11	Not clear.
12	Patient talked to family members about illness.
13	Sister expressed anxiety about the illness; did not want the patient to recuperate in her home.
14	Not clear

Table 14 indicates there were varied family reactions to the illness. Four cases illustrate prevalent fears and concerns which the lay public has. The husband in Case 2 was concerned about people's comments if they learned his wife had cancer. Case 7 did not discuss the illness with her husband because of his attitude toward such matters. Case 13 was one in which the sister of the patient had many fears and concerns about cancer and was afraid to have the patient in her home. Case 3 was an example of the husband's fears of heredity and contagion as well as the question of the illness being the result of anxiety.

Two patients, Cases 8 and 12, indicated they could discuss the illness with family members. Three patients, Cases 1, 3, and 5, each had a young daughter who reacted to the illness. In Cases 1 and 3 the daughters incorporated the symptoms and in Case 5 the daughter became the "little mother."

The family relationships in five cases were significant. Case 1 stated she had scolded her daughter a great deal when sick. The daughter was one of the children who complained of stomach pains and was nervous. Case 4 stated her relationships with her sisters were good. A sister, who knew the diagnosis, was able to talk about it with the social worker. Case 5 stated her relationships with her ill mother and her children were good. Her sister-in-law knew the diagnosis; however, her reaction was not noted in the record. Case 6 had a history of family turmoil. Her husband drank and one son was a behavior problem. The same son was told the diagnosis by the doctor and told the patient.

She thought possibly he was kidding. Her children were antagonistic towards their father for a while during her illness. Case 14 stated her relationship with her mother and daughter were good; however, her husband had been a drinker for many years.

The statements of the family relationships appeared superficial and, in relation to the stress of the illness, may have been lacking in depth and affect because of the patients' anxieties. Two patients, Cases 6 and 14, had alcoholic husbands, which put a stress on the relationship. Case 11 lived with friends, who showed concern by offering to forego the rent while the patient was hospitalized. Also, her brother, a doctor, provided transportation when he could. He brought her to his home on week-ends while she was staying at a convalescent home and receiving treatment at the hospital.

2. Role Changes

Role changes are here defined as variations in the activities or patterns of life of the patient or the family. In Table 15 the role changes during treatment are described.

Table 15 indicates that in eleven cases family members helped. In Cases 1, 4, 5, 10, and 13, the care of the children was assumed by family members. In Cases 5, 7, and 8 the husband assumed the care of the home and/or the children. In Case 9, the sons and their girl friends cared for the home. In Case 11, the patient's brother took her to his home on week-ends and when possible provided transportation for her. In Case 14, the patient

returned to her mother's home instead of to her own home. Her husband was an alcoholic. In Cases 2, 3, and 12, there was no information about changes which may have been made.

Table 15. Role Changes During Treatment

Case Code Number	Before	During
1	She worked and cared for her child.	Child cared for by step-daughter and later by a relative.
2	She worked and cared for home.	No information.
3	She cared for child and husband and worked	No information.
4	She cared for her children.	Sister cared for youngest child.
5	She cared for child and ill mother.	Sister-in-law and niece moved in and cared for child and ill mother.
6	She worked and cared for family.	Husband took over some family care.
7	She cared for husband and home.	Husband helped with heavy work.
8	She cared for husband and home.	Husband helped with housework.
9	She worked and cared for home.	Sons and girl friends took over care of home.
10	She cared for family.	Sister-in-law cared for children.
11	She worked and cared for herself.	She was in a convalescent home and her brother was helpful; took her to his home on week-ends.
12	No information.	No information.

Table 15. (Continued)

Case Code Number	Before	During
13	She cared for children.	Her sister cared for the children.
14	She worked and cared for home.	She went to mother's home.

3. Patients' Level of Activity

The level of activity is here defined as the patients' duties and tasks both in the home, i.e., house work, and outside the home, i.e., a job. The comments of the patients about their tasks contributed to the definition of the following categories: "heavy" house work, which includes washing floors, laundry, and the daily household tasks; "heavy" work, which includes standing, walking, and lifting jobs; "moderate" house work, which includes washing dishes, making beds, and dusting; "moderate" work, which includes jobs which require a limited amount of walking, lifting, or standing; "mild" housework, which includes dusting, with another person performing the other household tasks; "mild" work includes sitting jobs which required little physical exertion. In Table 16 are included the levels of activity before andup to six months after the patient came to the project.

Table 16. Level of Activity Before Illness and Six Months after Initial Contact

Case Code Number	Before Illness	Six Months after Initial Contact
1	Own housework and part-time light house-work.	Needs no extra help at home.
2	Own housework and general housework.	No information.
3	Own housework and full-time cleaning.	Doctor said she could take a part-time job.
4	Own housework.	Moderate housework.
5	Heavy housework.	Marked activity at home.
6	Heavy housework and nurses' helper (heavy).	Husband doing some of the housework.
7	Heavy housework.	Housework, except for lifting.
8	Heavy housework.	Moderate housework.
9	Heavy housework and sitting job.	Family assumed tasks.
10	Heavy housework.	At a convalescent home.
11	Waitress (heavy).	At a convalescent home.
12	No information.	
13	Heavy housework.	At sister's home.
14	Standing job.	At mother's home.

Table 16 indicates that four cases, 10, 11, 13, and 14, were not at home, which made it impossible to say the extent of their return to activity. Cases 10 and 11 were receiving treatment at the hospital; Cases 13 and 14 were coming for check ups. Case 1

indicated she did not need help in the home; however, there was no reference to the level of her activity in the social record. Case 3 did not return to her job, although the doctor said she could. The record did not indicate the level of her activity in the home. Cases 4 and 8 had resumed moderate activity in the home. Case 8 had done heavy house work before illness. Case 5, who had the care of her mother, was engaging in marked activity, and, as a medical recommendation, the doctor suggested that a housekeeper be obtained to give the patient time to relax. The patient did not accept this. Case 6 was readmitted to the hospital, and the record indicated that her husband was doing some of the housework. Case 7 was doing housework except for lifting, compared with her heavy housework before the illness. Case 9's family had assumed her tasks. Case 2 had done her own housework and general housework before the illness; however, there was no information about her later level of activity. Case 12 contained no information about level of activity before illness or six months after initial contact.

CHAPTER VI

CASEWORK AND ENVIRONMENTAL SERVICES

In this chapter the casework techniques and the casework services are discussed. The reality problems in the patient's life situation and the environmental services are also discussed.

1. Casework Techniques

Four casework techniques, environmental modification, psychological support, clarification, and insight are defined by Florence Hollis.[1] Environmental modification is defined by her as ". . . steps taken by the caseworker to change the environment in the client's favor by the worker's direct action."[2] Psychological support is defined by her as[2]

> . . . encouraging the client to talk freely and express his feelings about his situation; expressing sympathetic understanding of the client's feelings and acceptance of his behavior; indication of the case worker's interest in the client, his desire to help. . . . All these are designed to relieve anxiety and feelings of guilt, and to promote the client's confidence in his ability to handle his situation adequately.[3]

Clarification is defined by her as ". . . understanding by the client of himself, his environment, and/or people with whom he is associated. It is directed toward increasing the ego's

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[1] Florence Hollis, "The Techniques of Casework", Journal of Social Casework (June, 1949), 30:235-244.

[2] Ibid, P. 236

[3] Ibid, P. 237

ability to see external realities more clearly. . . ."[4] Insight is defined by her as:

> . . . carrying understanding to a deeper level than that described in clarification. Sometimes conflicting feelings and strong emotions lead the individual to distort reality so seriously or react to it so inappropriately that understanding is impossible without the deeper perception we are referring to as insight . . . the worker must help the client to an awareness of his strong projection of his inner needs and his subjective responses upon the outer world, his magnification of careless slights into evidences of hatred or complete loss of love, his misunderstanding of chance remarks as severe criticisms, his reaction of anxiety and hostility without sufficient rational provocation.[5]

Psychological support was used in all 14 cases. Environmental modification was used in seven cases. Clarification was used in six cases. It was significant that the technique of insight was not used. The level and intensity of insight development was not suitable for the problems of the patients and/or their families.

In Table 17 the casework techniques and the person(s) with whom the casework techniques were used are shown.

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[4] Florence Hollis, op. cit., p. 239

[5] Ibid, p. 241

Table 17. The Casework Techniques Used with the Patient and Family Members

Case Code Number	Techniques	With Whom Used
1	Psychological support	Patient
	Environmental modification	Patient
2	Psychological support	Patient
	Clarification	Patient and husband
3	Psychological support	Patient
	Clarification	Husband
	Environmental modification	Patient and husband
4	Psychological support	Patient and sister
5	Psychological support	Patient
	Clarification	Patient
	Environmental modification	Patient
6	Pyschological support	Patient and husband
	Environmental modification	Patient and family
7	Psychological support	Patient
8	Psychological support	Patient
	Clarification	Patient
9	Psychological support	Patient
	Environmental modification	Patient
10	Psychological support	Patient
	Environmental modification	Patient
	Clarification	Patient's brother and sister
11	Psychological support	Patient
	Environmental modification	Patient
12	Psychological support	Patient
13	Psychological support	Patient and sister
	Clarification	Sister
14	Psychological support	Patient

Psychological support was used in Case 9 and she gained relief from talking about her symptoms, but did not express her fears. The social worker felt this patient would make a good adjustment to the present situation. In Case 6, both psychological support and environmental modification were used with the patient and the family. The social worker was able to bring about improvements in the home situation with these two techniques. Modification in the husband's behavior and some stablization of the family occurred. Some of the environmental modifications were achieved with the cooperation of other agencies interested in the family. Together, the following were accomplished: nursing services and clothing for the patient from the Visiting Nurses Association; medical supplies from the hospital; Christmas presents for the children from the Fragment Society; financial assistance from Public Welfare and from Cancer Funds at Thanksgiving and Christmas. The Housing Authority was contacted by the social worker in regard to a project apartment for the family. Psychological support was given to the patient and the husband continually. The husband became active in caring for the family and resented the housekeeper who had been sent to assist. He reduced his drinking for longer periods of time. The social worker discussed the problem son with the patient and her husband. She arranged an interview with him; however, he did not come.

Clarification was used to provide a better understanding of the illness and was given to the patient as well as to family members when there was need. An example of the use of this

technique was found in Case 10 when the patient's family was anxious. The social worker suggested to the patient that they call the doctor for the medical information. The patient preferred that the social worker talk with them, and she did. As the family was out of state, the contact was on the phone; however, the social worker was able to relieve some of the anxiety through detailed explanation and to comment on how difficult it is to tell the prognosis at this time.

Case 14 is an example of psychological support being a motivating factor in enabling the patient to change the environmental situation. The patient indicated in her interviews that her husband drank and was unstable. She had a good relationship with him as long as the family was with either his mother or her mother, but for two years they had been on their own. The patient said her mother was her mainstay. After treatment in the hospital the patient moved to her mother's home to convalesce. Later in the year, a note in the record indicated that she had separated from her husband. The patient's need to have a dependent relationship with her mother was apparent. The atmosphere of the hospital and the relationship with the caseworker helped to meet this need and when she was discharged she sought it again by returning to her mother's home.

The other cases indicated that when there was no specific need, the social worker's continued interest was still valuable. In Case 12, the role of the social worker was not understood and this patient did not continue to see the social worker. The

patient's doctor was an understanding person and she indicated she felt she could talk any problems over with him.

2. Environmental Needs

Environmental needs are here defined as the problems which existed in the patient's life situation and were related to the illness. Included are: care of children or relatives, financial troubles, transportation and convalescent care for the patient. In Table 18 the environmental needs in the patient's life situation are shown.

Table 18. Environmental Needs in the Patient's Life Situation

Case Code Number	Care of Children or Relatives	Transportation	Finance	Convalescent Care
1	x			x
2		x		
3	x	x	x	
4	x	x		
5	x			
6	x	x	x	
7				
8				
9		x		
10	x	x		x
11		x	x	x
12				
13	x	x		x
14			x	
Totals	7	8	4	4

Table 18 indicates seven of the patients had either children and/or other family members for whom care was needed. Eight patients had transportation problems related to reaching the hospital for continued treatment. Four patients had problems

about convalescent care, and four patients had problems about finances.

The seven cases in which care of children and/or other family members was a problem obtained help from outside sources and did not ask the social worker to make plans. The problems of transportation and convalescent care were worked out with the social worker. Four cases required convalescent care; Cases 1 and 13 were from Boston proper; Case 10 was from out of state, and Case 11 was from an outlying area.

The financial worries of the patient in Case 4 were caused by her husband's lay-off. The financial worries of the patient in Case 6 were based on her being the main wage earner for the family of nine. Case 11 was self supporting. She worried and cried about finances, yet opposed Public Assistance. Case 14 had an unstable husband and was concerned about meeting the hospital expense.

The writer believed cost, a reality factor, varied in degree from patient to patient. Case 1, who received Aid to Dependent Children, was assured of her medical expenses being met, at least partially. Cases 11 and 14 discussed their concern about the cost of medical care. The other patients did not verbalize their concern about cost. In view of the economic status, occupation, and life situation, the writer speculated that it was a concern. The speculation is based on the high cost of medical care and the treatment regimes of the patients.

The actual arrangements of financial matters were handled by the admitting office and the social worker intervened when there was a misunderstanding. Case 14 was an example: she had difficulties with the admitting office about readmission when she owed on a previous hospitalization, and the social worker intervened.

3. Environmental Services

Environmental services are here defined as the services which were provided by the social worker to enable the patient to continue treatment. This includes convalescent home care, housekeeping services, transportation, and financial assistance. The social worker received help from community agencies to provide environmental services. In Table 19, a description of the environmental services is given.

Table 19 indicates the environmental services which were provided. The Frank Wood Home provided free convalescent care except in Case 1, where the Aid to Dependent Children Program assumed the cost. The Red Cross provided transportation for Cases 4 and 9; however, taxi service was also provided. The Cancer Funds paid for taxi services in the above cases as well as in Cases 2, 3, 6, 10 and 11. Financial supplementation, on a temporary basis, was provided by the Cancer Funds which were at the disposal of the project. An example is Case 1, in which extra money for food was needed for the patient's daughter who was with a relative, and the Cancer Funds provided it. Cancer Funds also gave financial supplementation for food in Case 3

when the patient's husband was laid off and received Unemployment Benefits from Social Security. In all, nine patients used environmental services provided by the social worker.

Table 19. Description of Environmental Services

Case Code Number	Environmental Services	Comments
1	Financial supplementation; convalescent care	Cancer Funds used Frank Wood Home.
2	Transportation	Patient's daughter frequently provided it.
3	Transportation; financial supplementation	Cancer funds used
4	Transportation	Red Cross; Cancer Funds paid for taxi
5	No services provided	
6	Transportation; financial help; nursing and housekeeping services; medical supplies	Cancer Fund; Public Welfare; Visiting Nurse
7	No services provided	
8	No services provided	
9	Transportation	Red Cross; Cancer Funds paid for taxi
10	Convalescent care; transportation	Frank Wood Home
11	Convalescent care; transportation	Frank Wood Home; Cancer Funds paid for taxi
12	No services provided	
13	Convalescent care	Frank Wood Home; St. Luke's Home
14	No services provided	

CHAPTER VII

CONCLUSIONS AND DISCUSSION

In this chapter the conclusions and discussion of the findings are given.

1. Conclusions

The study of these fourteen cases indicates that the illness has a different meaning for each patient. Four patients delayed seeking medical care for under six months; seven patients delayed seeking medical care from seven to twelve months; one patient delayed over one year, and one patient learned of her illness when she had a physical check up. The delay in seeking medical care was not known in one case. The patients who delayed gave change of life, financial worries, fear of symptoms, or fear of doctors as reasons for the delay.

The illness presented environmental problems in eleven cases. The problems were: care of children or relatives, finances, transportation for the patient, or convalescent care for the patient.

All fourteen cases had anxiety over the illness. Defense mechanisms of ten patients were discernable. They used denial and projection to handle their anxiety. In thirteen cases, the patients had had experiences with major illness and/or death of a significant figure. Of these thirteen cases, five cases had had experiences with other members of the family who had had cancer. These patients did not discuss their feelings about the

effect of their experiences with cancer.

The medical treatment for the fourteen cases involved hospitalization and/or daily trips to the hospital. Four patients were not in their home setting and their return to previous levels of activity was not known. Two of these four were in the homes of relatives and the other two were in convalescent homes while receiving treatment at the hospital. Five patients resumed house work; however, it was to a lesser extent than prior to illness. Notably, no patient had resumed work outside the home. One patient had been told by the doctor she could take a part-time job but she did not take one. In two cases other family members were doing household tasks and no information was available in three cases.

The illness affected eleven patients' interpersonal relationships within the family. The family members assumed household tasks, care of the children, relatives of the patient. Role changes were observed in six cases.

The reactions of one or more of the family members to the illness was indicated in ten cases. In three cases, the female children had emotional and/or physical reactions to the illness. In five cases, family members were anxious or fearful about the illness. In three cases the patient was able to discuss the illness with family members.

The social worker played a major part in the treatment of the fourteen cases by providing psychological support. In seven cases, environmental modification, i.e., transportation, conva-

lescent care, or supplementation of income for special needs was provided. In six cases, clarification to either the patient or member(s) of the family was given. The families of the patients were also given psychological support and understanding when the need was indicated. The anxiety caused by the illness, the treatment regime, and the check up care were reasons why the social worker needed to establish a relationship with the patient in the initial stages and to stand by for later developments.

2. Discussion

The reluctance of the patients to discuss the illness or experiences they had had with other members of the family who had had cancer suggested the fear which is associated with cancer. A study of this one aspect of the illness might bring out ways which patients can discuss the fears and concerns without weakening their defenses.

The symptoms exhibited by some of the female children would be worth investigating in terms of understanding their interpretation of the illness. This would be focussed on the thoughts and feelings of the children in relation to the illness.

An understanding of the patient and doctor relationship might make more selective the cases followed by the social worker and allow more time with the individual patient. Significantly, one patient indicated no need for a social worker because of the understanding nature of the doctor who tended her.

Further research would include the actual cost of care and

how the patient met it. The meaning of cost to the patient and the family may have bearing on other phases of the illness.

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APPENDIX

SCHEDULE

I Identifying Social Data:

1. Case number:_____ 2. City, town:_____ 3. Address:_____

4. Distance from hospital in miles:_____

5. Date of birth:_____ 6. Place of birth:_____ 7. Race:_____

8. Religion:_____

9. Marital Status:_____ 10. Date of marriage:_____
(specify changes)_____

11. Children:____ 12. Date of birth:_____ 13. Sex:_____

14. Whereabouts of Children:_____

15. Members in household:_____ 16. Housing:_____

17. Number of rooms and number of persons:_____

18. Comments of patient or social workers:_____

19. Occupation of patient:_____ 20. Education of Patient:_____

21. Occupation of husband or other wage earners:_____

22. Estimated income:_____ 23. Other means of support:_____
(specify)_____

24. Number in family dependent on income:_____

II Medical Data:

1. Onset of symptoms and how discovered:_____

2. Date and description:_____

3. Date of first medical contact:_____ 4. With whom:_____

5. Date of first contact with the project:_____

6. Stage:_____

7. Type of treatment (specify):_____
   a. Radiotherapy:_____
   b. Medication for radiotherapy:_____
   c. Surgical:_____

8. Dates of hospitalization:

   a. Admission:_____ b. Discharge:_____

9. Date of OPD visits:_____

10. Type of treatment:_____

11. Other diseases present: _____

III Emotional Meaning of the Illness:

1. Past major illnesses and the dates:_____

   A. How handled (describe): _____

2. Major illness in the family or other significant figures: _____

   A. Relationship and date:_____

   B. Describe patient's reaction to this:_____

3. Attitudes and feelings about present illness:

   A. Understanding and reaction to initial symptoms and final diagnosis:

B. Feelings about seeking medical attention (including fears, hostility toward medical personnel, and so forth):_____

C. Patient's reasons for delay:_____

D. Describe fully defenses used:

1) manifestations of anxiety:

2) evidence of guilt:

3) evidence of denial:

4) evidence of projection:

4. Attitudes and feelings about treatment:

A. Patient's understanding about medical recommendations:_____

B. Describe patient's feelings about treatment procedure:

1) fears:

2) acceptance:

3)

4)

C. Description of reality factors involved in patient's planning for treatment:

1) cost

2) transportation

3)

4)

IV Impact of Illness on Family Relationships:

1. Description of family relationships before and at the onset of illness:

2. Description of family's reaction to diagnosis(fears, acceptance, guilt, anticipated deprivation, and so forth--specify who):

3. Description of reality problems posed to family by patient's absence and/or illness:

4. Description of patient's feelings about separation from home; effect of her disability upon previous role in the family:

5. Description of changes in family roles during and after illness:

V. Level of Activity (task effect)

A. Prior to symptoms

1. Work activities in the home:

2. Work activities outside the home:

B. At three-month check-up

Medical status:
(describe)

Nursing care required:
(describe)

C. At six-month check-up

Medical status:
(describe)

Nursing care required:
(describe)

VI. Case Work Services (include service to both patients and family)

A. Environmental modification (indicate fully when financial aid given:)

1. Transportation:

2. Provision of Nursing Services:

3. Housekeeping Services:

4. Other use of Community Resources:

B. Psychological support

C. Clarification

D. Insight development