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**Social and emotional problems in the
rehabilitation of cancer patients: a study
of 13 patients age 30-39 with cancer of
the cervix.**

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Thesis

SOCIAL AND EMOTIONAL PROBLEMS IN THE
REHABILITATION OF CANCER PATIENTS.
A STUDY OF 13 PATIENTS AGE 30-39
WITH CANCER OF THE CERVIX

Submitted by

Savannah Althea Mitchell

(A.B., North Carolina College at Durham, 1954)

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

1956

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CHAPTER I
INTRODUCTION

This study, which is a part of a group study,^{1/} will endeavor to show the social and emotional problems of rehabilitation in 13 cases of cancer of the cervix and the medical social service given to these patients. These patients were part of a group of 54 patients treated at Peter Bent Brigham Hospital, Free Hospital for Women and Massachusetts General Hospital in a cancer research project undertaken under a special grant to the Harvard University Medical School. By rehabilitation is meant restoration of the disabled person to the highest level of functioning within his capacity; it does not always mean complete restoration to previous level of capacity. Rehabilitation begins when the patient begins to learn to live with his disability.

1/The three other parts of the study are also social work theses at Boston University. These all bear the same title as this study with subtitles as follows: Loretta Dixon, "A Study of 14 Patients Age 40-49 with Cancer of the Cervix"; Rita Kaplan, "A Study of 13 Patients Age 50-59 with Cancer of the Cervix"; Eileen McNulty, "A Study of 14 Patients Age 60-79 with Cancer of the Cervix."

Background.

Cancer of the cervix produces many physical, social and emotional problems. The disease is usually thought of as fatal and fear about this often prevents people from seeking medical care early. The chronicity of the disease evokes in patients emotional responses which require careful and sympathetic handling.

"To add to the insecurity created by this illness, about which so little is known, is the fact that more frequently than in any other disease the doctor hesitates to tell the patient his diagnosis. All this unfamiliarity with the disease and the secretiveness about the diagnosis may magnify the patient's fears."^{1/}

In addition to the patient's fears of painful and prolonged treatment the fears of the other members of the immediate family who will be directly affected must also be considered.

"Socially, family relationships often become impaired when cancer strikes one of its members. There may be the attempt to overprotect the patient or the tendency to separate him from former responsibilities. There may be other social problems in the patient's home and community which prevent him from seeking a diagnosis, and accepting or continuing with treatment. In turn, these problems can influence the patient's course of illness. In the relationship developed with the cancer patient, the medical social worker detects these various social factors and helps the patient to alleviate or adjust to them constructively."^{2/}

^{1/}Ruth D. Abrams and Jacob E. Pinesinger, "Guilt Reactions in Patients with Cancer," Cancer (May, 1953), 6:474-482.

^{2/}American Cancer Society, Inc., Cancer and the Social Worker, American Cancer Society, 521 West 57th Street, New York, 1955, p. 12.

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"The medical social worker, as one member of the medical team, makes his contribution to the welfare of the patient with long-term illness through direct contact with the patient and his family, through his role as a consultant within his own agency, and through his relationship to social agencies concerned with the welfare of the patient."^{1/}

Surgery has been the usual treatment for cancer of the cervix in its early stages. In the research upon which this thesis is based, an attempt was made to demonstrate the effectiveness of another type of treatment, radiation, for certain patients.

The medical research project, the objective of which was to demonstrate the most effective ~~based on the hypothesis that there might be a way of solving what is the best~~ treatment for cases with a diagnosis of cancer of the cervix, began in June, 1954, and some of the patients are still being followed at this time. However the four theses will include only fifty-four patients who became a part of the project between June 1, 1954, and April 30, 1955. A social worker was part of the team during that time and served as both case worker and research worker.

For the sake of continuity it was necessary for the four members of this group ~~theses~~ to work out the areas we wished to explore in the treatment of the fifty-four

^{1/}The National Foundation for Infantile Paralysis, The Place of the Medical Social Worker in the Home Care of the Long-Term Patient, Arden House, Harriman, New York, 1953, p. 17.

patients. As a result the following research questions were devised.

Research Questions.

In the course of this study the writer will attempt to find the answers to the following questions which were devised by the group.

1. What is the meaning of the illness to the patient and how does she deal with it emotionally?
2. What is the extent of the disability and the extent of return to previous level of activity?
3. What is the effect [extent] of the illness on the interpersonal relationships within the family?
4. What is the role of the social worker in the treatment of these cases?

Research Design.

Method of Data Collection.

1. Social Service records were used to study the role of the social worker, the worker-patient relationship, the meaning of the illness to the patient, the extent of disability, and the effect of the illness on the interpersonal relationships within the family.
2. Medical records were used to obtain a better understanding of the medical aspects of these patients with cancer of the cervix.
3. Case record data were supplemented by consultation

with the social workers who interviewed and worked with these fifty-four patients.

Sampling Selection. Every patient who came to clinics at the three hospitals within the specified time period and was diagnosed as having a lesion of the cervix was included in the project regardless of age, culture, or other characteristics. In addition, a few private patients with this diagnosis were included in the project. Patients who had been diagnosed previously as having cancer of the cervix were not included. Thus, the student theses are based on the fifty-four cases treated at Massachusetts General Hospital, Peter Bent Brigham Hospital and the Free Hospital for Women. (See discussion of Limitations below for four cases that were discarded.)

It was thought that fifty-four cases was too large a number for each student to work with effectively and that it would be better to divide the cases between the students. Some diseases affect certain age groups differently and therefore age was considered as a basis for this division. The patients varied in age from thirty to seventy-nine years and it was found that our sample fell into four age groups of approximately equal size. As a result the cases in our study were divided in the following manner:

Ages 30-39	13 patients
Ages 40-49	14 patients
Ages 50-59	13 patients
Ages 60-79	14 patients

Each student worked with all the cases in one of these groups. The writer worked with the thirteen cases in the age group thirty to thirty-nine.

Limitations.

The student theses deal with fifty-four cases seen from June 1, 1954 until April 30, 1955 and do not include the entire number of patients seen under the research project. The cases known to the research project but omitted from this study were: (1) patients under treatment at the Pondville Hospital; (2) cases entering the project after April, 1955; (3) two patients where records had been misplaced and were not available for this study; and (4) two patients whose diagnosis was uncertain.

The writer had no actual contacts with the patients and had to depend upon the case records of the two social workers. Principal reliance was placed on the workers' recordings supplemented, when desirable, by interviews with the workers. However, the element of time prevented full and extensive consultation with either of the social workers. In instances where some of the material had been summarized it was difficult to obtain some of the information needed for the study.

The total team work approach in treatment could not be evaluated as it was not known just how much the other disciplines contributed. Because these patients were not

all seen in one hospital but in three different hospitals
the difference in setting must be kept in mind although the
treatment goals were the same.

CHAPTER II

ANALYSIS OF PERSONAL AND SOCIAL CHARACTERISTICS

"The problem of cancer is one of vital concern to every living American. The disease is one which, paradoxically, is so intimate that it consists literally of the individual's own flesh and blood, while at the same time it is so alien and ruthless that if left unchecked it will kill him. Cancer concerns us all, not only because it represents such a biological enigma, but also because it is capable of affecting every one of us in one way or another. No age, race or stratum is spared the ravages of its onslaught, and it is assuming larger proportions every day as a public health problem."^{1/}

The writer of this thesis has no definite information from previous cancer studies to indicate particular problems, realistic or fantasied, encountered by cancer patients within a certain age range. However, as in most other diseases looked upon as impairing "normal" everyday living and possible death, I feel we may be safe in assuming that the young patients with the diagnosis of cancer may easily be threatened with the problem of a useless life.

This thesis is devoted to the group of patients ranging from age thirty to age thirty-nine. In this particular group there were thirteen white patients. All of the

^{1/}American Cancer Society, Inc., Cancer and the Social Worker, American Cancer Society, 521 West 57th Street, New York, 1955, p. 2.

patients were born in Boston, New England, or New York except one who was born in Canada. Table 1 shows the age distribution of the thirteen patients. None of the thirteen patients were under thirty-two years of age while five were thirty-nine. The mean age for the group is 36.3.

Table 1. Age of Patients

AGE	Number of Patients
30	0
31	0
32	3
33	1
34	0
35	1
36	0
37	1
38	2
39	5
Total	13

In planning long term treatment for patients which will involve single and multiple hospitalizations and regular Out-Patient Department visits, it is important to consider where they live in regard to the problem of transportation to and from the hospital.

Table 2 shows the residence of these patients. The largest number of the patients in this group were from the Metropolitan Boston area, only three were from out-lying towns in Massachusetts or out of the state. The nearness

of residence to the hospitals included in the project was not only an asset for medical care but offered good opportunities for long term casework contacts.

Table 2. Residence of Patients

Area	Number of Patients
Boston	1
Metropolitan Boston.	9
Massachusetts (outlying towns)	2
Out of state	1
Total	13

The educational level varied from eight years of formal school to additional training beyond high school. Two patients left school after the eighth grade, three after the second year of high school, two after the third year of high school and four were high school graduates. The educational status of two patients is unknown. Two of the patients sought additional training as practical nurses. One of these had finished two years of high school and the other three years.

Table 3 shows the religious faiths of the patients. Predominantly, the patients were of the Catholic faith. There were no Jewish women among the unselected group admitted to the cancer of the cervix project. It has been noted that the incidence of cancer of the cervix among

Jewish women is low.^{1/}

Table 3. Religious Faiths of Patients

Religion	Number of Patients
Catholic	9
Protestant	3
Albanian Orthodox.	1
Total	13

Table 4 shows the marital status of the patients. Ten of these patients were married and living with their husbands and children at the time of the diagnosis of cancer of the cervix. One unmarried patient, a thirty-two year old receptionist, lived with her widowed mother and felt that most of the financial responsibility was allotted to her. Two other patients, a widow and a divorcee, lived alone in single rooms. In the majority of the cases the social worker commented that the living conditions were either poor or fair. In most instances this comment seemed to be based on the fact that several persons were occupying an apartment or a house too small to accommodate them adequately.

^{1/}Stevenson, James A., M. D., and William J. Grace, M. D., "Life Stress and Cancer of the Cervix," Psychosomatic Medicine (July-August, 1954), 16:287-293.

Table 4. Marital Status of Patients

Marital Status	Number of Patients
Single	1
Married.	7
Divorced	1
Separated.	0
Remarried.	3
Widowed.	1
Total	13

Table 5 shows the occupations of these patients prior to their initial contact with the project. The level of activity outside of the home was considered strenuous for seven patients. The patient who was "not working" was supported by government pension and living alone.

Table 5. Occupations of Patients

Type of Work	Number of Patients
Waitress	2
Laundress.	1
Receptionist	1
Factory worker	1
Housewife.	7
Not working.	1
Total	13

From the information gathered from the social service records it is not possible to say how many of the patients discontinued working prior to the onset of their symptoms

or how many discontinued working after the onset of symptoms. However, at the time of their initial contact with the project none of the patients were working outside their homes. According to the social service records and the medical records only one patient returned to her job, as a waitress, shortly after hospitalization.

As was previously stated ten of these patients were housewives and mothers with the customary household duties to perform. With the exception of one patient who had an older daughter at home, all of these patients described their level of activity in the home as strenuous. In most cases this meant heavy housework including washing, ironing, and mopping and waxing the floors.

Table 6 shows the number of children born to each patient. It is to be expected that the patients in this age range would have more younger children living at home with them. Hospitalization caused these mothers much concern about the care of their children during their absence from the home.

Table 6. Number of Children Born to Patients

Number of Children	Number of Patients
0	2
1	2
2	3
3	4
4	0
5	1
6	1
Total.	13

Table 7 shows the weekly income of the families of these patients. The income of these families was based on the single income of the husbands as the patients were not working at the time. In only one family was there a combined income of the husband and a daughter who earned fifteen dollars a week working part time. Two patients were supported by a government pension, one a widow and one whose husband was unable to work. Only two patients received Disability Assistance. Neither of them had received any Public Assistance prior to their illness. The social worker who worked with these patients felt their income was inadequate to meet properly the needs of those dependent upon this income with the additional expense of medical care. In general this can be expected when members of families are eligible for clinic care.

Table 7. Weekly Income of Patients

Income	Number of Patients
\$30 - 39	2
40 - 49	1
50 - 59	4
60 - 69	4
70 - 79	1
Unknown	1
Total.	13

The average income for twelve patients and their families was approximately 54 dollars per week. The lowest income per week was 32 dollars, earned by the thirty-two year old single patient who worked as a receptionist. After the onset of cancer of the cervix this patient was no longer able to work and she was supported by her family. The highest income per week for this group of patients was 75 dollars. This sum was earned jointly by the husband and a daughter who worked part time earning 15 dollars per week. There were only two patients who were considered completely self-supporting and whose means of direct income was discontinued during their illness.

The low income level of these patients, in view of the extensive and expensive medical care needed, seems to be significant from the point of view of worry and anxiety about finances.

CHAPTER III

ILLNESS AND TREATMENT

"The organized fight against cancer is of comparatively recent origin. It was not until 1913 that the American Society for the Control of Cancer was incorporated and only since then has the full power of nationwide, concerted effort toward a better understanding of this disease been manifest and the complexities of waging a successful fight comprehended."^{1/}

"Treatment may be a minor procedure or it may entail the most dangerous and radical surgical procedures. Radium, X-ray, and surgery are the three methods recognized as effective in the treatment of cancer. Treatment by X-ray usually does not require hospitalization and is carried out by fractional methods over a period of days or weeks. If administered for the treatment of deep-seated cancer, it not infrequently causes some sickness and some reaction on the skin. Treatment by radium may be either from an apparatus suspended at a distance from the patient, similar to X-ray, or from an application directly to the body surfaces, or by implanting very small quantities of radium beneath the body surfaces either by incision or through the insertion of needles. The late reaction from radium is usually quite severe and must be understood as essential to effective treatment. Treatment by surgery runs the full gamut from the removal of a small growth under local anesthesia or its destruction by heat or electricity to the most formidable and mutilating operations."^{2/}

"The unselected number of patients with a possible or suspected diagnosis of Carcinoma of the

^{1/}Ellis Fischel, M. D., "What the Social Worker Can Do About Cancer," The Family (February 1937), 17:322-326.

^{2/}Ibid., p. 325.

Cervix became part of the cancer of the cervix project and were hospitalized within a few days following the finding of a suspicious lesion. There was no restriction of selection other than the elimination of known cases with the diagnosis who had previously been treated. The plan followed was to hospitalize within a few days all of these patients for a definite medical work-up in order to establish a positive diagnosis. During this period, after establishment of the diagnosis, the key to determining the type of definitive therapy was the interpretation of the vaginal smear to sensitivity for radiation therapy. The cases found to be insensitive to radiation were treated by surgery. Some cases were treated with endocrines in an effort to develop such a sensitivity to radium of the tumor cells."^{1/}

"Cancer of the more accessible internal organs--such as the uterus, the bladder, and the rectum--will manifest itself either by an unusual discharge or by bleeding. The unnatural appearance of blood from any of the normal openings of the body demands an explanation and the person who notices such bleeding must obtain a satisfactory explanation as to its cause."^{2/}

Eleven of the patients in this study gave histories of irregular bleeding between menstrual periods. In eight cases the irregular bleeding was accompanied by a profuse flow of foul smelling discharge often necessitating the use of pads. In five instances the bleeding was more profuse during and after sexual intercourse. One patient gave no history of irregular bleeding or discharge but complained of intermittent severe suprapubic pains before her menstrual period, pain and heat in the nipples of her

^{1/}Ruth D. Abrams, "The Rehabilitation of the Cancer Patient" (Manuscript).

^{2/}Ellis Fischel, M. D., op. cit., p. 325.

breast and in the whole breast. One patient suffered unusual backaches and headaches during her last pregnancy. A biopsy was performed after her post partum check-up and her local medical doctor suggested treatment at the Free Hospital for Women. Pain in the sides and left lower quadrant accompanied other symptoms in three cases. Only one patient complained of excessive fatigue.

Prior to admission to the hospital twelve of the patients were treated by local medical doctors. Treatment for one patient prior to hospitalization is unknown.

Table 8 shows the type of treatment administered after the patients became a part of the cancer of the cervix project.

Table 8. Type of Treatment

Type of Treatment	Number of Patients
Surgery	4
Surgery and X-ray	1
Surgery and Radium.	2
Radium and X-ray.	3
Radium, X-ray and Surgery	3
Total.	13

There were two types of treatment; first, radiation which was radium therapy followed by a prescribed course of x-ray therapy; and second, surgery which consisted of

some type of hysterectomy followed in many cases by x-ray treatment.

In preparation for radiation during hospitalization, the major medications prescribed were: testosterone, cortone, pyribenzamine, syntopherol and natopherol. Each patient's diet was carefully considered.

Table 9 shows the stages of cancer in these thirteen patients. The Harvard Medical School Project graded the stage of disease of the patient on the basis of histo-pathologic techniques. Stage I is the first stage of cancer of the cervix. Prognosis is considered good in Stage I provided treatment is begun immediately after establishing the diagnosis. The progressing severity of the disease is indicated by increase in the stage number. Stage IV is considered the most severe stage and prognosis is generally poor.

Table 9. Stages of Cancer

Stage	Number of Patients
I	8
II.	0
IIa	2
IIb	0
III	2
IV.	1
Total.	13

It is interesting to note that eight patients in this group were diagnosed as Stage I and all eight of these patients were treated by surgery. Four of these patients had, in addition to surgery, radiation therapy either before or following surgery.

Table 10 shows the number of hospitalizations per patient during this period herein studied. The number of hospitalizations varied from one to five for each patient.

Table 10. Number of Hospitalizations

Number	Number of Patients
1	2
2	5
3	4
4	0
5	2
Total	13

All thirteen of the patients had one or more hospitalizations during the period June 1, 1954, to April 30, 1955. Six patients were admitted more than twice with two of these having five admissions. Thus, treatment for most of these patients meant repeated absence from the home and considerable expense for hospitalization.

Table 11 shows the length of time that these patients were hospitalized. The length of time is given in weeks and includes in some cases more than one hospital admission.

Table 11. Length of Hospitalizations

Weeks	Number of Patients
3 - 8	6
9 - 14	3
15 - 19	2
Uncertain	2
Total.	13

In six cases the patients were hospitalized for a period of three to eight weeks. Two patients were hospitalized for a period of fifteen to nineteen weeks. In two cases it was not possible to compute the length of hospitalizations as their dates of admission and discharge were not clear in their medical records.

With the exception of two patients, the medical records revealed no other physical illnesses at the time of hospitalization. One of these patients, age thirty-nine, had multiple carious teeth, and the other, also age thirty-nine, had an arrested case of tuberculosis. A third patient, age thirty-nine, gave a history to the social worker of long term anemia but nothing to this effect was included in her medical record.

Each patient, after discharge from the hospital, was followed regularly in the Out-Patient Department. Vaginal smears were taken, x-rays were given, and when necessary recommendations for readmission to the hospital were made.

In general the physical progression or regression of each patient was to be kept under close observation through these regular clinic visits.

Table 12 shows visits to the Out-Patient Department after initial hospital admission for a period of six months.

Table 12. O.P.D. Visits After Initial Hospital Admission

Patients	Number of O.P.D. Visits					
	1st Month	2nd Month	3rd Month	4th Month	5th Month	6th Month
X6 . . .	3	Read-mitted	1	2	0	1
X7 . . .	Read-mitted	1	1	0	0	1
X16. . .	1	0	1	1	1	0
X21. . .	1	1	Read-mitted	2	3	Read-mitted
X31. . .	3	3	2	Read-mitted	0	Read-mitted
X51. . .	1	Read-mitted	0	1	1	0
X52. . .	5	4	Read-mitted	Hospi-talized	Hospi-talized	3
X64. . .	Read-mitted	2	2	Read-mitted	Hospi-talized	Died
X68. . .	Read-mitted	Hospi-talized	Hospi-talized	2		0
X75. . .	1	1	1	1	0	1
X76. . .	Read-mitted	3	4	3	Read-mitted	1
X93. . .	2	5	4	1	1	Read-mitted
X98. . .	3	2	0	1	1	0

CHAPTER IV

EMOTIONAL MEANING OF THE ILLNESS TO THE PATIENT

"Each diagnosis, whether it be of cancer or any other illness, may activate some preconceived ideas about the disease which are shared by many persons, and each individual patient, of course, reacts to the given diagnosis according to his own particular personality pattern. That cancer is a particularly dreaded disease, whose cause is unknown and whose ending frequently is fatal, is generally conceded. To add to the insecurity created by this illness is the fact that, more frequently than in any other disease, the physician hesitates to tell a patient the diagnosis. Secretiveness about the diagnosis undoubtedly magnifies the patient's fears and probably accounts for much of the restraint of professional groups and of the family in dealing with the patient himself. The need for skillful casework in this area cannot be stressed too much. Skill is also needed to determine what the illness means to the individual patient; an added complication results when one is not sure what the patient has been told.

"If we accept the hypothesis that 'the patient is usually concerned with, and often aware of the fact that he has cancer and is reacting to it--whether he says so or not,' we shall recognize the need for offering services to these patients which will afford them better treatment and greater freedom from suffering. And again, if we believe that in cancer, as in any other illness, the mental attitude of the patient is a tangible clue to the understanding of the patient and his family, we shall appreciate the need for further investigation and study into the attitudes or reactions of the patients to their diagnosis and treatment."^{1/}

^{1/}Ruth D. Abrams, "Social Casework with Cancer Patients," Social Casework (December 1951), 32:425-432.

"Each patient has his own ideas of what cancer means to him--not only do they involve phantasies of dying and death, but also thoughts of suffering, pain, gruesome wasting away, and helplessness."^{1/}

Table 13 shows the patients' actual knowledge about their diagnosis insofar as it was indicated in the research social worker's records.

Table 13. Patient's Knowledge of the Diagnosis

Awareness of Diagnosis	Number of Patients
Knew they had "cancer"	8
Knew they had a "tumor".	1
Were suspicious of "cancer".	2
Gave no indication of knowing they had Cancer	2
Total	13

In only two cases did the patients appear unaware of the diagnosis of cancer. However, it is possible that these patients may have been suspicious but blocked this suspicion by strong use of the defense mechanism of denial. It was firmly recommended by the doctors that one of the patients not be told her diagnosis. This thirty-two year old, single patient expressed much fear of anaesthesia and operations. She was so anxious about this that she continued to ask for reassurance that she would only have

^{1/}Ruth D. Abrams, and Jacob E. Finesinger, "Guilt Reactions in Patients with Cancer," Cancer, (May 1953), 6:474-482.

radium and no surgery. She felt that she had caused her illness and the onset of phlebitis by excessive physical activity. It was necessary that she have surgery. She did not adjust well to the hospitalization and the separation from home. Upon her return home she was no longer the jolly member of the family. She became dependent and depressed. She suffered cold sweats and insisted on not being left alone. This was her life pattern until her death on August 19, 1955, seven months after her initial contact with the project.

Even though the majority of the patients knew their diagnosis it was difficult for them to talk about it. When asked directly if they had discussed their condition with the doctor, most of them felt if there was anything of importance to discuss the doctor would tell them.

Four of these patients had been exposed to the symptoms and manifestations of cancer in members of their families. One patient spoke of two friends who had recently died of cancer. One of these patients, an extremely apprehensive person, wept constantly when she spoke of her mother who died of cancer of the throat, yet she refused to keep her clinic appointments and resumed former alcoholism to forget her troubles.

Five patients discussed their guilt feelings in such ways as: "I feel I should be working as it is not fair for

my husband to have to buy clothes for my son by a previous marriage," "I don't know why all of this has happened to me or what caused it," "I must have over-worked or lifted something too heavy and strained myself," and "I would like to move from my neighborhood as I know people are talking."

Ten patients were concerned about resuming sexual intercourse after hospitalization and during treatment. One patient related to the social worker the precautions she had taken in order that she would not become pregnant during this time. She did not know she had no need to worry about conception until the extent of her treatment was explained to her. Her comment in response to this explanation was that she had enough children any way. Another patient was so worried about having cancer of the cervix that she was emotionally unable to resume sexual intercourse after the doctors told her she was physically able to do so.

Table 14 shows the periods of delay after the onset of symptoms before the patients sought medical care prior to their initial contact with the project. In connection with another type of treatment, Allen defines delay as:

"....hesitation on the part of the patient to seek treatment after the onset of symptoms. Fear of diagnosis is usually the underlying factor."^{1/}

^{1/}Frederick Allen, "The Treatment of Maternal Attitudes in Problems of Guidance," American Journal of Orthopsychiatry (April, 1933), 3:113-127.

Table 14. Periods of Delay

Months	Number of Patients
1 month or less	6
2 to 4 months	3
4 to 6 months	1
Not clear	3
Total	13

For the purpose of this study any length of time up to one month between the onset of symptoms and first medical contact is not considered a period of delay. Six patients sought medical care within one month's time.

In three instances the length of delay is unknown. Four patients delayed getting medical care for periods of two to six months. One patient attributed the vaginal bleeding to a boil. One patient on her first contact with social service told the social worker she delayed because she did not have 3 dollars to pay a local medical doctor nor did she have any means of transportation to the doctor's office. Also, she had no one to leave her children with and hated to leave them alone. On another contact with social service the patient said, "It was all based on ignorance." She had not known what the signs were, therefore, she had not gone to seek medical care. In the social worker's opinion her delay was not due to lack of money or ignorance but rather on anxiety that her symptoms might be

of a serious derivation. Another patient who delayed first discussed her symptoms with a friend who explained them casually as "change of life." The patient said later she was afraid to find out what was causing the symptoms and felt she had waited too long to be helped. The fourth patient in this group said she was unaware of the symptoms. After diagnosis, this same patient expressed a fear of an actual change in her physical appearance and commented, "I'm allergic to mirrors and have been since my illness."

Many of these patients had reality problems connected with treatment for their present symptoms which may have influenced their delay in seeking medical examinations.

Ten of these patients had children at home to be cared for. If the doctors said these symptoms were serious, this might mean hospitalization and hospitalization means separation from home and family. In the cases where the patient lived alone it meant separation from the familiar surroundings of her room and her friends.

Cost of treatment and hospitalization is certainly a reality problem. Of the thirteen patients only four had Blue Cross or Blue Shield to help with expenses.

Included with all these other factors which may have fostered delay are the common fears of hospitalization, expensive treatment, fear of mutilation by surgery, and fear of cancer.

In eight cases the social worker observed denial used as a mechanism of defense. The writer would not say that the defense mechanism of denial is the one used predominantly or most effectively by all patients with cancer of the cervix. However, in this group of patients, denial was the major defense mechanism used. Not only did the patient deny in regard to herself but in some instances in regard to other members of her family who had had cancer at one time.

With the use of case material the writer will attempt to show how denial was handled by one patient.

Case X75

Jane Doe, a thirty-five year old, married Protestant woman of Russian descent with six children, was referred to social service for help towards optimum rehabilitation.

Patient gave a history of about six months of post-coital staining, bleeding from the vagina characterized by gushes of blood on sudden standing or on exertion, and a foul smelling discharge which was most bothersome after bleeding. Her local medical doctor diagnosed this as "a small ulceration of the cervix" and she was told if it "worsened" to go to the hospital. Patient said she had always been level headed and never worried about anything for any length of time. She certainly was not worried much about this. She admitted she was a little frightened pre-operatively, as anyone would be. However, she was unable to discuss her feelings about her illness and the social worker felt the patient was handling her worry and anxiety by complete denial.

In discussing her family history the patient said her mother had suffered bleeding of the uterus, about twenty-five years ago, which necessitated an operation. Her father died of cirrhosis of the liver on November 16, 1953. The death of her father was the only

incident about which she was able to give an exact date. When questioned about this the patient said she was sure her father had died of cirrhosis of the liver.

Because the social worker worked with patients seen at all the hospitals she had access to the social service records in these hospitals. She found out that the patient's father had been known to social service at another of these hospitals. The following is an excerpt from his record.

9/14/53--"Mr. T was referred to social service for help with planning, in view of his diagnosis--inoperable cancer of the stomach with poor prognosis. The social worker worked with both Jane Doe and her mother around accepting and knowing the fact that Mr. T had a malignancy which was incurable. Jane Doe seemed anxious as to what her father would feel, should he learn the diagnosis. The social worker did not stress this, said it was not necessary for them to speak about it verbally, and put it into words, as people often know themselves."

The social worker for this project found this an interesting testimony that Jane Doe did not acknowledge that her father died of inoperable cancer of the stomach, and that she herself denied a malignancy of her own, just as her father appears to have done. This appeared to the social worker to be a very definite indication of denial and the need for doing so. She did not feel this patient should be told the truth about her condition unless it was necessary for optimum rehabilitation.

The feeling of rejection is experienced by many persons who have cancer. These patients feel they have been afflicted with an unclean and sinful disease. They feel they have suddenly become different from other people and, therefore, will not be completely accepted, by their family and friends. Patients who feel rejected because of cancer are usually sensitive to the remarks and actions of persons who are concerned with their care. Adjustment to

treatment for such patients is complicated by feelings of rejection.

In Case X76, with the use of case material the writer shall attempt to show how the onset and diagnosis of cancer of the cervix strengthened the patient's feelings of rejection.

Case X76

Mary Smith, a thirty-nine year old, widowed, Catholic woman with one daughter who was twenty-one and married, was referred to social service for help towards optimum rehabilitation. Patient finished three years of high school and two years of nurses' training.

Patient gave a history of an increasing foul smelling discharge for about six months. For the past year her menstrual periods had been irregular and there had been a decrease in the amount of blood. She had had hot flashes and had been excessively nervous.

Patient's mother died of "lung trouble" when patient was two years old. Then she lived with her grandmother who died four years ago of a broken hip. Three years ago her father died of a bleeding ulcer of the stomach. Her daughter was hospitalized for lung surgery.

Patient was married at age eighteen and her husband died two years ago of pectoris angina. At the time of hospitalization patient was living alone in one room and was supported by a government pension. At the time of hospitalization patient had an arrested case of tuberculosis. She was released from the sanatorium in June after a twenty-six months period of treatment. She resented having had tuberculosis. It made her feel very set apart from others. She had no friends. She was made to feel "like a leper."

She was very frightened about the diagnosis of cancer of the cervix and thought it would conflict with her lungs and cause a breakdown as she lost her appetite.

Patient was very lonely, frightened, dependent, and felt deprived of those she loved. She felt having cancer would set her apart from others even more as she now had two dreaded diseases, tuberculosis and cancer.

Perhaps if some of the people who have been cured of cancer or have been able to make favorable adjustments to life again could or would share their experiences with others and if the stigma of having cancer could be removed, some of the emotional problems which prevent patients from seeking early treatment could be removed.

CHAPTER V

FAMILY RELATIONSHIPS, FAMILY REACTIONS TO DIAGNOSIS, AND PATIENT'S ACTIVITY

"The hereditary factor in cancer is one that is very greatly feared by the unintelligent. Cancer as such is not considered to be inherited. Neither is cancer contagious.... Neither can cancer be transmitted through toilet articles or utensils used in cooking or eating. There is no need to fear the presence of a cancer patient in a family or home because of danger to those not afflicted."^{1/}

The writer of this thesis chooses to discuss the family relationships of each of these patients and the impact of her illness upon the family separately and will attempt to group and compare them at the end of the chapter.

The code number will be used to identify the patients.

X6

Family relationships before and at the onset of illness were considered relatively good. The patient and husband were of mixed religion, Catholic and Protestant. The patient felt her husband was very demanding sexually and admitted difficulty with the husband in many areas. During her illness the husband had helped her around the house more than he ever had. Patient had much concern about being disabled as she felt she should contribute to the income of the family. She expressed fears of losing her husband because of sexual reasons.

^{1/}Ellis Fischel, M. D., "What the Social Worker Can Do About Cancer," The Family (February 1937), 17:322-326.

During her hospitalization the children and her husband took over the running of the house and got along all right. After hospitalization she returned home to her previous role with much less marked activity.

Both the husband and the children knew the diagnosis and seemed to be capable of handling the situation during the patient's hospitalization and upon her return home.

X7

This patient had a good marital relationship. During childhood she had not been close to her mother who worked all day but had a good relationship with her siblings and aunts. During her illness the husband became "housewife" and cared for the children. The couple were very concerned about the unpaid bills that piled up. Patient was mostly worried about being separated from the children. Prior to her illness she had done all of her housework. After admission her role as mother and housewife was limited.

The husband was very understanding of the diagnosis and agreed not to resume sexual intercourse until his wife was willing.

X16

According to the husband family relationships were good when the step-daughter was out of the home and at the time he talked with the social worker he had asked her to move. The social worker commented he seemed specific, realistic, and pleasant. Patient stated her childhood was unhappy. Her father was strict and as a result she married the first man who asked her. This was her second marriage. This patient had a "nervous breakdown" but felt it was natural for eighteen year old Italian girls. It became necessary for the couple to borrow from the patient's mother.

Her son became more of a behavior problem during her illness. During her hospitalization she felt she should have been at home. Upon her return home she became abusive to her family and was frightened by

this. It was arranged through the project for the son to go to nursery school.

Patient's husband said he understood both the diagnosis and prognosis.

X21

Family relationships appeared good. Patient's family and in-laws showed a great deal of interest. Patient's home was broken up during her illness and her husband and children moved in with her sister. It became necessary for her to apply for Disability Assistance. The husband became a heavy drinker. The patient was more accepting of the need to be separated from her family at the time of her second admission. Her previous role changed completely as she was forced to let her daughter take over the responsibilities of the house.

One sister felt guilty that she had not encouraged patient to seek medical care earlier. When told the diagnosis the husband began to drink more heavily than before. The daughter "who was really the head of the house" and patient's other sisters accepted the diagnosis, talked with the social worker, and tried hard to carry through all plans.

X31

Family relationships were poor. The husband admitted to many fights with his wife. He told the social worker he had promised to "turn over a new leaf" as it was necessary for him to be concerned. He promised to be gentle and make up for any differences in the past. Patient worried about being separated from her children. The husband stayed off from work for a while to care for the children. The younger children were placed with the patient's sister. The girls, twelve and eight, did not attend school while patient was hospitalized.

Patient's sister and husband felt cancer was a fatal disease. They were very anxious that the diagnosis be kept from the patient. The husband appeared much more anxious than he would admit and he constantly asked just what the diagnosis and prognosis would be. The children accepted their mother's

illness and did not become anxious. The husband had asked that the patient not be told the diagnosis. However, in his anxiety he told her himself and became very indignant when he was told it was the doctor's duty to tell and explain the diagnosis to the patient.

X51

Family relationships were good. Patient was very devoted to her children, possibly she was overly dependent upon them. She felt her separation from home was greatly felt. Her young daughter moved in to live with patient's sister. The children were protected from the facts of their mother's illness and the patient thought her husband would be upset and frightened by the diagnosis.

X52

This patient lived alone and had no family life. However, her landlord and landlady were interested in helping her to recover. They cared for her upon her return home from the hospital.

X64

This was the only single patient included among the thirteen patients. She lived with her mother and described her family relationship as a good one and she was considered dependent upon her mother. As she was no longer able to work her brother took over the financial responsibility of the patient and her mother. She did not adjust well to the hospital and became increasingly more dependent upon her mother and other members of the family.

Patient's family were quite concerned about her condition. One sister came in for social service interviews, said she knew patient had a bleeding polyp that was malignant. She never seemed satisfied with the explanations she received from the doctors.

X68

There was very little information on this patient's family relationships and the impact of her

illness upon it. The social worker stated there appeared to be no familial problems or any problems in personal relationships.

X75

According to the patient her family relationships were very good and were in her childhood also. Four of her children went to live with her sister and two with her mother. Her husband was left to live alone. She was not too upset about being separated from her home for she knew her children were being cared for adequately.

Social service had no contact with the patient's family and therefore had no information as to how they reacted to the diagnosis.

X76

This patient lived alone but described her childhood as unhappy and inferred that the last years of her marriage before her husband died had not been particularly happy years. At the time of discharge patient went to live in a nursing home for a while as there was no one to care for her.

When the daughter and son-in-law were told the diagnosis, they did not appear anxious or upset but were described as being "modest" and attentive.

X93

Patient felt her family relationships were good but she was greatly concerned about the financial strain they were under. Patient's mother and mother-in-law took her children to live with them. She was happy about the living arrangements made for the children but found it very difficult being away from home. Upon her return home a younger sister and her mother took over the care of the patient and helped with the care of the house.

Patient's parents were fearful of the diagnosis and protective of the patient. Her husband was hospitalized, during the patient's hospitalization, for bleeding ulcers and three fourths of his stomach

was removed. Her family did not tell her about this while she was in the hospital as her father thought it best that she not know.

X98

There was no history of family relationships or reaction of family to the diagnosis recorded for this patient.

In seven instances the family relationships were considered good. Two patients lived alone with no close family ties. In one case there was no recording of family relationships. In three instances there was some degree of tension in the home and the quality of relationship needed improvement.

In instances where there were children in the home too young to care for themselves with the help of their fathers it was necessary that some of these homes be broken up during the mother's hospitalization.

During the patient's hospitalization the husband's responsibilities were increased, particularly in cases where the children remained at home. His function was no longer the "breadwinner" of the family but a combination of "breadwinner" and father and mother to the children in the absence of their mother.

One patient's husband admitted to previous fights with his wife and discussed with the social worker his plans to "turn over a new leaf" and establish a better marital relationship.

Relatives and in-laws were concerned about the patient's condition and tried to lessen her anxieties about the home situation by either taking the children to live with them or by moving into the patient's home for an indefinite period of time.

The diagnosis was given to all the husbands and other members of the family who were concerned about the patients upon their request and sometimes without their request when the doctors thought it necessary. In only one case did the husband resort to drinking and in only one other instance did the husband repeat the diagnosis to the patient before she had been told by the doctor.

Table 15 shows the family relationships of these patients at the onset of illness.

Table 15. Family Relationships

Type of Relationship	Number of Patients
Relatively good	7
Tension in the home	3
No close family ties	2
Unknown	1
Total.	13

After hospitalization ten patients returned to their previous living arrangements with a decrease in their level of activity. It was necessary that some other

member of the family or an outsider take over the responsibilities of the home. Gradually the level of activity increased from mild to moderate but in no instance had any patient returned to full time strenuous activity at the time of this study. One patient, a thirty-nine year old divorced Catholic woman, who was completely self-supporting did return to work as a part time waitress after a period of time. Three patients entered nursing homes after hospitalization. One of these patients, mother of three children, died in a nursing home.

CHAPTER VI

CASEWORK SERVICES

"Many professional persons in the medical setting individualize the patient, but the medical social worker uses an approach and method which are distinct from that of the physician, nurse, and others. The social worker seeks first to understand the patient as a person and the implications which this particular experience of illness has for him. Where is he in the experience of being ill? What specific problems does it present to him? Starting always at the point where the patient is--emotionally and intellectually--she endeavors to aid him to understand the situation which he faces and do something constructive about it. If there are possible alternatives, she helps him to make a decision. If there is only one possible outcome, she endeavors to assist him to accept and face this, so far as he is able. Always she tries to help him to move as much as possible through his own initiative and in the manner which will seem to be best for him, both as an individual and in terms of his social relationships. Seen in the perspective of the total personality, this means the objective of growth. Seen in the smaller segments of experience which actually represent social casework from day to day in a medical setting, it more often means some rather simple type of movement in relation to a difficult step in medical care or in adjustment to illness. We should realize that the humbler objective is not only appropriate but essentially the same as the larger one, that is, that a constructive type of movement in relation to a specific problem contributes toward growth of personality."^{1/}

"Since the process of seeking and receiving medical care in a clinic or hospital presents real difficulties for many people--difficulties which differ according to the person, the set up, and the personnel of the institution--there seems to be a contribution

^{1/}Harriet M. Bartlett, Some Aspects of Social Casework in a Medical Setting, George Banta Publishing Company, Chicago, Illinois, (1940), pp. 19-20.

which social casework has to offer to this situation which has a peculiar value because it is offered within the walls of the medical institution itself and as a natural part of its care of the patient."¹/

The social worker with this cancer of the cervix project was not over loaded with an excessive case load; therefore, she had sufficient time for a more comprehensive approach to the social and emotional problems of the patients. The scope of social service planned in this study provided opportunity for observation and practice within the Out-Patient Department, the hospital and within the home setting. Because of the growing conviction that cancer patients present problems characteristic for this disease and the need for relating this conviction to an evaluation of the patient's adjustment to this disease, it was possible to make the social work practice in this project research oriented.

Within a day following the initial hospital admission the social worker made contact with each patient and in most cases with members of the family. In this first contact the social worker's function as a member of the treatment team was interpreted to the patient. Psychosocial and economic data were gathered. At this time a beginning plan for ancillary aid and casework services was initiated. The objective was always focused upon optimum rehabilitation.

1/Ibid., p. 21.

The cancer patient brings a variety of problems to the clinic. Chief among these, of course, is his need for skilled medical treatment. He may also have other less defined, but equally significant, personal needs which are closely related to his disease and are important factors in its effective treatment.

Cancer is, perhaps, the most threatening to personal security of all the diseases which attack mankind. Not only is the abrupt and painful termination of life a possibility, but the radical procedures involved in adequate treatment often mean permanent disfigurement and disability for the patient. Thus the cancer patient is frequently faced by the necessity for making many personal adjustments. Sometimes these can be made by the patient without the assistance of another individual. More frequently, however, he is fearful and uncertain and in need of the service which a thoughtful, understanding trained social worker can give him. The type of service she renders depends upon the particular needs of the individual patient and includes a wide variety of activities ranging from simple errands to the highly specialized task of helping him to meet some of the emotional difficulties which may arise."^{1/}

The social worker in her relationship with these patients utilized the techniques of environmental modification, psychological support, and clarification in her effort to help the patients and their families make the best possible adjustment to the diagnosis of cancer of the cervix, medical treatment and separation from the home situation. The technique of insight therapy was not used in the work with these patients.

The following definitions of these casework techniques are taken from Hollis:^{2/}

^{1/}Ibid., p. 175.

^{2/}Florence Hollis, "The Techniques of Casework," Journal of Social Casework (June, 1949), 30:235-244.

Environmental modification involves "...steps taken by the case worker to change the environment in the client's favor by the worker's direct action."

Psychological support is "...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 caseworker'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."

Clarification is "...understanding by the client of himself, his environment, and/or people with whom he is associated. It is directed toward increasing the ego's ability to see external realities more clearly...."

Insight is "...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 projections 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."

The medical social worker was considered an essential member of the team for this project as the patients not only needed medical care but they needed help in making an adjustment to their illness. Each of the fifty-four patients included in this study was seen routinely by the social worker. Twelve of the patients, in the age group thirty years to thirty-nine years, accepted and used the services of the social worker. Only in one case, the thirty-two year old single patient, did the social worker comment that the patient resented her services. This was also the one case in which the doctor continuously stressed that the patient should not be told her diagnosis. Despite these facts the social worker was able to talk with this patient regarding the seriousness of her illness. The patient was concerned mostly with returning to work and the social worker was able to help her to see how unrealistic the idea was at that time. The social worker played an important role with this patient's family in arranging for the patient to remain with the family and return to the hospital for treatment rather than to be sent to another hospital as an in-patient. The worker made extra efforts to be available to the family as they had many questions

about the illness which she was able to clarify to some degree.

It would be expected that the social worker would have the responsibility of helping these patients to make arrangements for placement of their children during hospitalization. However, this was not true in any of the thirteen cases. Each of the patients who had younger children made these arrangements independently or with the help of their husbands or family. During hospitalization the social worker kept in contact with the children of these patients and was able to report their welfare to their mothers, especially in instances when the mother expressed much anxiety about her children being with someone else.

In only one case was the service of child placing rendered to a patient after hospitalization. Arrangements were made for the young son of a thirty-six year old patient to attend nursery school at the expense of the project. The mother considered the son a behavior problem before her admission to the hospital but saw him as more of a problem of care for her after hospitalization. She became abusive to the child, her husband and her mother. After a few interviews the worker decided it would be better to enroll the son in a nursery school than to send the mother to a nursing home. This patient continued to

be concerned about her abusive attitude to other members of the family. She was able to discuss this freely with the social worker who after a short time was able to get the patient to accept an appointment for psychiatric clinic.

In the case of the husband of one of the patients who had firmly insisted that no one tell his wife the diagnosis of cancer of the cervix and who later told her himself, the social worker had a tremendous job to relieve him of his guilt feelings. The social worker helped to relieve him of his guilt by making him feel comfortable and free to discuss with her why he had told his wife. She did not condemn him or point out the many reasons why he should not have told her but expressed her understanding of his need to do this as it was a burden for him to keep such a diagnosis to himself. It may not have worked out so well in another case but in this particular instance the patient helped to relieve her husband's guilt by saying to him and other members of the team that she felt better satisfied after knowing her true diagnosis rather than having to wonder and be suspicious about it. Without the services of the social worker this husband's guilt feelings about his actions might have caused much conflict in his relationship with the hospital and with his wife during the remainder of her hospitalization and upon her return home.

Psychological support was given to each of the thirteen patients and to the families of these patients.

Only one or two families were the exception to this as the worker was not able to contact them. In some instances the psychological support was only that the social worker made the patient realize she was available to assist with any problem, whereas in many cases it consisted of intensive casework and the actual administering of practical service.

Clarification was given to each of the thirteen patients and to the families of these patients with the exception of the one or two families the worker was not able to contact. In some instances the clarification was in terms of treatment but for the patients who knew their diagnosis it was in terms of the diagnosis and their adjustment to it.

It would be expected that these patients would have much anxiety about expenses and would try to enlist the services of the social worker in helping them to make arrangements with the hospital to pay their bills. However, it is interesting to note that most of these patients did mention their concerns about hospital bills but did not attempt to use the services of the social worker in this area.

Table 16 shows the use of environmental modification.

Table 16. Environmental Services

Type of Service	Number of Patients
Transportation by taxi	7
Transportation by Red Cross	3
Recommendation for nursing home care	3
Recommendation for Visiting Nurses' Association.	2
Recommendation for Disability Assistance	2
Recommendation for housekeeping services	2
Recommendation for nursery school placement.	1

Seven of the patients received transportation to and from the hospital by taxi. In three instances the total cost of taxi transportation was paid jointly by the cancer project and the patient. In two instances the total cost was paid jointly by the cancer project and Disability Assistance. The cancer project financed the round trip from New Hampshire, by car, for the daughter and son-in-law to visit one patient as she was some distance from home and felt neglected and dejected as a result of diagnosis of cancer of the cervix in addition to an arrested case of tuberculosis.

Nursing Home Care was completely financed by the cancer project for one patient and one half of the total bill was assumed by the project for another patient.

The expense of housekeeping services was met entirely for two patients by the project.

The sum of four dollars per week was paid by the

cancer project for the young son of one patient to attend nursery school.

Apart from the many services mentioned the medical social worker devoted much of her time helping the patients adjust to the hospital setting and their separation from their homes and families. In regards to discharge she helped both the patients and their families to plan realistically and adjust to the change in role and level of activity for the patient for an indefinite period of time. Along with the doctors, the medical social worker encouraged and stressed the importance of regular clinic visits after discharge from the hospital for optimum rehabilitation.

CHAPTER VII
SUMMARY AND CONCLUSIONS

This study of thirteen patients, age thirty to thirty-nine, as part of the total group of fifty-four patients used for this group thesis was made in order to investigate the social and emotional problems of rehabilitation of these patients with cancer of the cervix. The following phases of the social and emotional problems of rehabilitation were explored: the meaning of the illness to the patient and how she dealt with it; the extent of the disability and the extent of return to previous level of activity; the extent of the illness on the interpersonal relationships within the family; and the role of the social worker in the treatment of these cases.

In the group studied there were seven married patients, three who were married for the second time, one widow, one divorcee, and one single patient. Of this group nine of the patients were Catholic, three were Protestant, and one was Albanian Orthodox. There were no Jewish women among this group. The largest number of the patients were born in the state of Massachusetts, two were born out of state and one in another country. Most of the patients at the

time of diagnosis and treatment had residence in Metropolitan Boston. The average weekly income for these families was approximately fifty-four dollars. This seems to be a low income level considering that the number of children in these families ranged from up to six.

Of the thirteen patients studied eight were diagnosed as having cancer of the cervix stage I and all eight of these patients received surgery as the major part of their treatment. Two patients were diagnosed as stage IIa, two stage III, and one stage IV. The types of treatment administered were surgery, surgery and x-ray, surgery and radium, radium and x-ray, and radium, x-ray and surgery. Each of the patients was hospitalized for a period of time during treatment. The number of hospitalizations varied from one to five, whereas the length of hospitalizations varied from three to nineteen weeks. Only two medical records mentioned other illnesses present at the time of hospitalization. Regular clinic visits were scheduled for each patient after discharge from the hospital. Two of the thirteen patients died, one six months after her initial contact with the project and one eight months after her initial contact.

Eight patients knew their diagnosis of cancer of the cervix. Two were suspicious of having cancer of the cervix, one knew she had a tumor. In only two instances

were the patients unaware of the diagnosis. Despite the fact that most of the patients knew their diagnosis they were not able to discuss it easily with either the doctors or the social worker.

Four patients delayed seeking medical care after the onset of symptoms for periods of two to six months. The period of delay was unknown for two patients. The reasons given for delay varied from lack of finances and "no one to care for the children" to actual ignorance of the symptoms.

All of the patients expressed anxiety about their condition and many showed evidences of guilt about the diagnosis. The major defense mechanism used was denial.

In seven instances the family relationships were considered good. Two patients lived alone with no close family ties. In three instances there was some degree of tension in the home and the quality of relationship needed improvement. For one patient there was no recording of family relationships.

With the exception of those whom the social worker could not contact, the diagnosis was given to husbands, children, and immediate relatives of these patients in order to prepare them to receive the patient back into the home with limited or no activity for a period of time or to help them accept the idea of nursing home placement. Only one patient had returned to her job outside the home within

six months after her initial contact with the project.

The doctors recognized the emotional problems which develop around the diagnosis of cancer of the cervix and in order that medical care could be purposeful and optimum rehabilitation could be obtained every patient included in the project was referred to the medical social worker. The medical social worker gave help to these patients through such services as; transportation, nursing home care, recommendations for Visiting Nurses and Disability Assistance, housekeeping services, nursery school placements, psychological support and clarification in regard to both treatment and diagnosis. One of the social worker's major contributions was helping the patient to adjust to the hospital setting and to begin to learn to live a comparatively comfortable life.

The medical social worker seeks first to understand the patient in relation to the impact of her illness. She always tries to help her to move as much as possible through her own initiative and at her own pace.

The medical social worker is the one person within the setting of the hospital who has been specifically trained and equipped with the techniques to adequately help the patient make a favorable adjustment to the new and frightening situation. The social information she gathers from the patient and the patient's family can be most

helpful to the other members of the team, particularly the doctor in his plans for treatment.

The medical social worker's understanding of human behavior and her knowledge of the meaning of illness to the patient and the patient's family makes her an important member of the medical team.

Accepted 5-21-56
Katherine Spencer

APPENDIX

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:

SCHEDULE

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

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