



A STUDY OF THE NEED FOR SOCIAL WORK
SERVICES FOR THE TUBERCULOUS AND THEIR
FAMILIES IN BATTLE CREEK, MICHIGAN

Roberta R. Greene
May 1962

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A STUDY OF THE NEED FOR SOCIAL WORK SERVICES FOR THE TUBERCULOUS
AND THEIR FAMILIES IN BATTLE CREEK, MICHIGAN

Roberta R. Greene

A PROJECT REPORT

Submitted to the School of Social Work
Michigan State University
in Partial Fulfillment of the
Requirements for the Degree

of

MASTER OF SOCIAL WORK

May

1952

Approved:

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THESIS

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PREFACE

The data for this study was collected under the auspices of the Michigan Department of Health and the Calhoun County Health Department. I would like to thank them for the use of the data and the wonderful cooperation of their staffs. I would particularly like to thank Mr. Robert Shipman of the Michigan Department of Health for his help and guidance in this undertaking.

A special word of thanks to my husband, David, for making the statistical work involved in this study almost bearable.

הוא נשאל על ידי המורה: "אם אתה רוצה להצטרף ללימודים, עליך ללמוד קודם כל את השאלה הראשונה. אתה רוצה ללמוד?"
הוא עונה: "כן, מן הסתם."
הוא נשאל: "אם כן, עליך ללמוד את השאלה הראשונה. אתה רוצה ללמוד?"
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הוא עונה: "כן, מן הסתם."

INTRODUCTION

It has long been recognized that in addition to medical needs the tuberculous patient may have a multitude of problems. It is only recently that widespread efforts have been made to evaluate and meet these needs. It was in the recognition of the necessity for objective evaluation of the needs of the tuberculous that this study was undertaken.

The purpose of this study was to determine whether or not the tuberculosis patients of Battle Creek, Michigan had social and/or psychological problems of such a nature as might warrant social work services. It was hoped that the extent to which such problems existed, as well as what forms these problems took might be determined. In this way, the question as to whether or not there were unmet needs for social work services among Battle Creek tuberculosis patients and their families might be answered.

It was not the purpose of this study to try to prove that tuberculosis is a psychophysiological illness nor to investigate the medical care received by these patients. The sole purpose was to show that social and psychological problems, which could require social work services, existed among tuberculosis patients of Battle Creek. It was not directly determined if these problems interfered with medical treatment. In all instances medical care was assumed to be adequate. The problem was one of evaluating the need for medical social work services in that it was assumed that where tuberculosis was aggravated by the strain of social and psychological problems and vice versa, the individuals affected could not function in a society to the utmost of their ability.

There has been much published already on the socio-cultural factors associated with tuberculosis. The case for social services for the tuberculous has been established in several instances. The focus of this study was to objectively evaluate the need for such social work services in the city of Battle Creek, Michigan. In this respect the problem was also one in community organization.

The goals of the study were stated as questions rather than in hypothetical form, as the study aimed at description and analysis rather than at the determination of causal relationship. The study attempted to

answer five major questions:

1. What was the pattern of residency, age, sex, occupation, family composition, and general socio-economic status of the tuberculous in Battle Creek, Michigan? Do studies of other areas show these patterns to be representative
2. What social, psychological, and health problems do the tuberculous of Battle Creek reveal in their relationship with the public health nurse?
3. What community resources are available for the use of the tuberculous in Battle Creek, Michigan? (What do some other communities provide?) To what extent are the available resources used?
4. What are the unmet social work needs?
5. How could these unmet needs be met by the community? How would the role of the social worker differ from that of the public health nurse in meeting unmet needs? How might these roles overlap?

The study was done under the auspices of the Michigan Department of Health. The Department was interested in evaluating Michigan's need for social work services in the general field of public health, and in the case of this study, for the tuberculous. The investigator served as a medical social work extern for the Department during the summer of 1961, and was assigned to a local health department for purposes of conducting this study. The Calhoun County Health Department, located in Battle Creek, Michigan was selected for this study because of its receptive attitude toward the field and philosophy of social work.

Officials at the Calhoun County Health Department, through previous studies, were aware that there were many 'multi-problem' families on their general caseload. They were particularly interested in knowing the extent to which multi-problem families could be found on their tuberculosis caseload. The obtaining of this information was still another goal of the study. It was hoped that this question could be answered objectively while investigating social and psychological problems, in general.

It was hoped that the study would result in a more effective use of social services in the field of public health in Michigan, particularly for the tuberculous.

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CHAPTER I

HISTORICAL BACKGROUND AND CURRENT OPINION

Tuberculosis was very prevalent in society in the seventeenth and eighteenth centuries when wave after wave of fatal epidemics periodically spread through large segments of the population. In those days, tuberculosis was always with the people and nobody paid any particular attention to it, at least not any more than any other disease.¹

The true medical nature of tuberculosis was not understood until fairly late in the nineteenth century. During this century many medical and social conditions greatly favored the spread of this disease. It was the chief cause of death in all ranks of society. At this time the standard of living was comparatively low, and the gap between the rich and the poor was far greater than it is today. Doctors who have tried to trace tuberculosis back to its source have said that the poor environmental conditions under which such a large portion of society lived, must have been responsible for a great deal of the spread and propagation of the disease.² Facilities for treatment were poor and the people had very little knowledge of the mode of transmission of tuberculosis, and therefore took few measures to prevent the disease from spreading.³

With the twentieth century has come a gradual and steady rise in the standard of living. There has been much progress in the public health field and in private health measures. According to Dr. Esmond R. Long, "the twentieth century has seen a perfectly extraordinary improvement in the methods of medical treatment." The death rate due to tuberculosis has dropped enormous-

¹ Dr. Esmond R. Long, "The Field of Tuberculosis, A Multi-Discipline Approach to It", Social Work Practice in the Field of Tuberculosis, ed. Eleanor E. Cockerill, (Pittsburgh: University of Pittsburgh Press, 1958), p.11b.

² Ibid., pp.11a-11b.

³ Ibid., pp.11a-11b.

1. The first step in the process of identifying a problem is to recognize that a problem exists. This is often done by comparing current performance with a desired state or goal. If there is a discrepancy, a problem is identified.
2. Once a problem is identified, the next step is to define the problem more precisely. This involves determining the scope of the problem, the resources available, and the constraints that may be affecting the problem.
3. The third step is to analyze the problem. This involves identifying the causes of the problem and determining the relationships between different factors. This step is often the most difficult, as it requires a deep understanding of the problem and the ability to think critically.
4. The fourth step is to develop a solution. This involves brainstorming different ideas and evaluating them based on their feasibility, effectiveness, and cost. The goal is to find a solution that addresses the problem in a way that is sustainable and meets the needs of all stakeholders.
5. The fifth step is to implement the solution. This involves putting the solution into action and monitoring its progress. It is important to have a plan for how the solution will be implemented and to have a way to track its progress.
6. The sixth step is to evaluate the solution. This involves assessing the effectiveness of the solution and determining whether it has solved the problem. If the solution is not effective, it may be necessary to go back to an earlier step and try a different approach.
7. The seventh step is to communicate the results of the problem-solving process. This involves sharing the findings with the relevant stakeholders and providing them with the information they need to make decisions.
8. The eighth step is to learn from the experience. This involves reflecting on what was learned from the problem-solving process and using that knowledge to improve future problem-solving efforts.

The process of problem-solving is a continuous one. As new information is gathered, the problem may be redefined, and new solutions may be developed. It is important to remain flexible and open to change throughout the process.

In conclusion, the process of problem-solving is a complex one that involves many steps. By following these steps, you can effectively identify, analyze, and solve problems. Remember to stay flexible and open to change throughout the process.

ly, yet many feel that the case loads have not been reduced correspondingly.¹

Dr. Long has stated that there must be a medical and a social attack against the spread of tuberculosis. Among the social factors which could be attacked are ignorance, poverty, and lack of community responsibility. The continued existence of tuberculosis was seen by Dr. Long as being partly linked to the fact that some groups of people are ignorant of proper hygienic and nutritional procedures. Poverty also stands out conspicuously among the social conditions responsible for tubersulosis. Today the poorer people have the highest rate of tuberculosis, while the economically more favored are much better off.²

Today tuberculosis is understood as a disease which must be conquered by many disciplines working together. Educators, community planners, social workers, nutritionists, legislators, vocational counselors, and technical experts of all kinds are necessary for the job.³

Just where the services of the social worker fit in this multi-discipline approach, can be more properly understood if one first understands some of the social, economic and psychological problems associated with tuberculosis. A. Frances Berry discusses several factors inherent in tuberculosis and its treatment, each of which may cause emotional difficulties, strains in family relationships, and the need for environmental adjustments.⁴

The first factor discussed is chronicity. All that can be said about the emotional components of a chronic illness can be applied to tuberculosis. In addition to environmental problems, such as financial care, care of children, or a need for housing, tuberculosis entails emotional adjustments because of the long-term treatment and convalescence involved. Ambitions and future plans must often be postponed or abandoned. During months and years of treatment, economic and social status may be changed.⁵

1.
Ibid., p. 11d.

2
Ibid., p. 11a.

3
Ibid., p. 14.

4
A. Frances Berry, "Social Work In Tuberculosis Control", Reprinted from the Transactions of the Forty-third Annual Meeting of the National Tuberculosis Association, 1947. p.2.

5
Ibid.

A second factor which has been a source of difficulty for individuals with tuberculosis is the need to be isolated for treatment. The separation of the patient from his family over a long period of time may change the whole family constellation. Certainly, the patient and his family have to readjust to each other at the time the patient returns to the home.¹

The "unpredictability" of the tuberculosis is a third factor affecting the tuberculosis patient. Tuberculosis is a recurrent disease. It may be reactivated without apparent reason, despite the best medical care. The anxiety this can cause the patient and his family can often make adjustment to a normal way of life extremely difficult. The whole family of the tuberculosis patient often needs help in handling its fears about the disease.²

The symptoms of tuberculosis are often unrecognizable until the disease is discovered. This can pose yet another problem for the tuberculosis victim. It is often a great shock for the unsuspecting individual to learn he has tuberculosis

Thus, there are four factors inherent in the nature of tuberculosis, namely chronicity, isolation for treatment, unpredictability of the disease, and unrecognizable symptoms, each of which in itself can cause or precipitate serious casework problems. According to Berry, one needs only to take into account the above mentioned factors to realize that tuberculosis is an illness which necessitates the best casework services and community cooperation which can be offered--from the beginning of diagnosis through the patient's adjustment following hospitalization.⁴

Sophia Bloom, a medical social worker formerly with the Tuberculosis Control Division of the United States Public Health Service, has stated that it is not commonly accepted that all persons suffering from tuberculosis have economic and social problems which are an inherent part of the illness.⁵

¹
Ibid., p.3.

²
Ibid., p.3

³
Ibid.

⁴
Ibid., p.4.

⁵

Sophia Bloom, "Some Economic and Emotional Problems of the Tuberculosis Patient and his Family," Public Health Reports, Vol. LXIII, No. 14 (April 2, 1948), p. 448.

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● * ● i *

To begin with, she points out, tuberculosis is a chronic and expensive disease. Few people are able, alone, to meet the cost of medical care.¹ General relief and categorical assistance are the usual sources of support. The sum given in many areas is insufficient to maintain a minimum standard of living.² Although a patient may be eligible for relief, it may be a severe blow to the breadwinner's pride that he can no longer care for his family. Economic insecurity may also intensify any existing emotional problems as well as cause additional anxiety.³

Problems other than economic insecurity are of great significance to the tuberculosis patient. These are many reasons for the emotional difficulties experienced by almost all patients. Among these are the shock of the diagnosis, fears, anxieties, superstitions, sense of shame, and despair.⁴ The tuberculosis victim is suddenly faced with the necessity of an immediate adjustment to a new and terrifying situation. The emotionally insecure person will find it even more difficult to meet this new and frightening situation.⁵ Some studies have even concluded that an abrupt rise in frequency of both economic and personal stress occurs in the year preceding the onset of tuberculosis. The frequency of "life crises" was found by one investigator to clearly distinguish the tuberculous group studied from the nontuberculous.⁶ However, this takes us into the field of psychosomatic medicine, which is not within the province of this study.

It is clear from the literature that tuberculosis is both a physiological and a social disease--social in its causes and its consequences. Certainly, from a theoretical standpoint it seems clear that social workers can help effectively to combat the psycho-social problems associated with tuberculosis.

The next two sections will be devoted to an objective evaluation and discussion of the make-up of an actual tuberculosis caseload. It is hoped that

¹ Ibid.

² Ibid., p.449.

³ Ibid., p.450.

⁴ Ibid., p.452.

⁵ Ibid., p. 453.

⁶ Thomas H. Holmes et. al, "Psychosocial and Psychophysiologic Studies of Tuberculosis," Psychosomatic Medicine, Vol. XIX, No. 2 (March-April, 1957), p. 139.

this evaluation will lead to a deeper understanding of the social work needs of the tuberculous.

The following sections will deal with conclusions and recommendations including a discussion of the various ways communities have met or can meet the need for social work services for the tuberculous.

CHAPTER II

METHODS AND PROCEDURES

The data for this study were obtained under the authority of the Michigan Department of Health and the Calhoun County Health Department. They were collected from the records of the public health nurses of Calhoun County.

Under the present organization of the Michigan Department of Health and its county departments, the public health nurse has a great deal of professional contact with the tuberculosis patient and his family. The amount of contact depends upon such factors as the duration of the illness, whether or not the patient is hospitalized, and if so, on the length of confinement, the need of the family in terms of health supervision, etc.

All doctors must report diagnosed and suspected cases of tuberculosis to their county health department. Mass tuberculin testing and a follow up of patient's contacts also helps to discover those with the disease.

Once the cases become known to local health departments, it then becomes the function of the public health nurse to help the family to follow the recommended course of medical treatment.

Each nurse has a district within the county in which she visits all persons on the public health case loads, including tuberculosis patients and their families. The nurse will help the patient and his family plan for medical treatment in a sanitarium. Where medically possible, the nurse may help the patient continue his treatment at home, after a brief stay in a sanitarium. In either case, the family must be instructed in the proper procedures they must follow. Periodic visits are made to be sure the patient and/or his family are following proper medical procedures. In cases where the patient is hospitalized his case will still remain open. During this time, the nurse may call on individuals who could have been infected by the patient, and encourage them to be tested. Members of the patient's family must be checked routinely over a period of time

to see if they have been infected. After the patient's return to the home, his case will remain open until the medical officer has said it may be closed. Until their case is closed, the nurse continues to call on the patients to encourage them to follow the necessary routine to prevent relapse, and to encourage them to take the required follow-up x-rays.

During all the time the nurse has had contacts with the patient and his family, she has gathered much important medical, social and psychological information. Records were kept in which the nurse recorded a brief account of each visit or interview. These records serve as a means of recalling pertinent information, of making case reviews, and as a source of reference when there is a change of nurses. These records include, in some instances, the accounts of several nurses who might have worked on a case over the years. This gave the investigator a fuller picture of the patient and his family from more than one point of view.

The reliability of the data obtained by the investigator depended, of course, upon the assumption that the nurses had recorded all pertinent social and psychological information accurately. Public health nurses have received some education in the psychological and sociological disciplines; therefore they probably observed and recorded with a sufficient degree of competency for purposes of this study.

A schedule was used by the investigator in extracting the pertinent data from the records. The Social and Psychological Profile, which serves as the first page of the schedule, was a slightly modified version of a form used by the Family Service Association of America to summarize case material. In addition to the profile, general socio-cultural data, such as age, sex and family composition, were extracted. Questions were also included regarding the use of community resources, health problems other than tuberculosis that were faced by the families, and the disposition of the tuberculosis cases.

It was decided to limit the study to those individuals residing in the Greater Battle Creek area. Greater Battle Creek includes the city of Battle Creek and the four surrounding townships. Cases were also limited to those that had been open for at least a year, thus assuring a sufficient number of recorded visits by the nurse. In the Greater Battle Creek area, there are 150 individuals who either have tuberculosis or are still on the case load for follow-ups, whose case had been open for at least one year. One hundred and thirty-six of these individuals are included in the study. The remaining

14 individuals' cases were omitted because their records were undergoing various clerical procedures and were not available. Since the public health nurse records are in the form of family folders, and since there may be more than one case of tuberculosis in a family, this study deals with 136 patients discussed in 120 family folders or case records.

CHAPTER III
PRESENTATION AND ANALYSIS OF DATA

Description of the Caseload

Sex and Age

Of the 136 patients, discussed in 120 family folders, seventy-eight were male (57.3%), and fifty-eight were female (42.7%). The Greater Battle Creek area, in general, had a strikingly different proportion of males to females, 49.9% and 50.1% respectively.¹ However, this difference was not found to be statistically significant. For the United States as a whole, the males case rate was found to be nearly twice that of the female case-rate.²

The ages of the patients are the ages at the time they first became known to the health department. A majority of the female patients (55.2%) learned of their disease between the ages of twenty and thirty-nine. A large proportion, (48.7%) of the male patients became known to the health department between the ages of forty and fifty-nine. For the United States in general, more cases were reported in the 25-44 age group than in any other twenty-year age period, and two-thirds of the reported cases were between the ages of 25 and 64, inclusively. In other words, most of the tuberculosis cases reported for the United States in general, including Battle Creek, were in the most productive years of life.³

¹United States Bureau of Census. United States Census of Population: 1960, "General Population Characteristics, Michigan", Washington D.C.: (United States Government Printing Office, 1961), p.98.

²Stanley Glaser and Paul Roney, Reported Tuberculosis Data, Public Health Service Publication No. 560 (Washington:United States Government Printing Office, 1955), p. 18.

³ibid., p.22.

1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities. It emphasizes that proper record-keeping is essential for transparency and accountability, particularly in financial matters. The text outlines various methods for organizing and storing data, including digital databases and physical filing systems.

2. The second part of the document focuses on the role of communication in achieving organizational goals. It highlights the need for clear, concise, and timely communication between all levels of the organization. The text provides guidelines for effective communication, such as active listening, open-mindedness, and the use of appropriate communication channels.

3. The third part of the document addresses the issue of resource management. It discusses the importance of identifying, allocating, and utilizing resources efficiently to maximize productivity and minimize waste. The text offers strategies for resource allocation, including prioritization, delegation, and regular monitoring and evaluation.

4. The fourth part of the document explores the concept of innovation and its role in driving organizational growth. It defines innovation as the process of developing new ideas, products, or services that create value for the organization and its stakeholders. The text discusses various factors that influence innovation, such as a supportive organizational culture, access to resources, and a focus on continuous learning and improvement.

5. The fifth part of the document discusses the importance of risk management in decision-making. It defines risk as the potential for loss or harm resulting from uncertainty. The text outlines a systematic approach to risk management, including risk identification, assessment, and mitigation. It emphasizes that effective risk management is crucial for making informed decisions and achieving long-term success.

6. The sixth part of the document addresses the issue of employee engagement and motivation. It discusses the factors that influence employee engagement, such as job design, leadership, and organizational culture. The text provides strategies for enhancing employee engagement, including providing meaningful work, offering opportunities for growth and development, and fostering a supportive work environment.

7. The seventh part of the document discusses the importance of ethical considerations in business operations. It defines ethics as the principles and values that guide behavior and decision-making. The text outlines various ethical frameworks and provides guidelines for ethical decision-making, emphasizing the importance of integrity, honesty, and fairness.

8. The eighth part of the document discusses the role of technology in modern business operations. It highlights the various ways in which technology can be used to improve efficiency, productivity, and communication. The text discusses emerging technologies and their potential impact on the business landscape.

TABLE 1
AGE OF PATIENT AT OPENING OF CASE (Battle Creek)

	Females		Males		Total	
	Number	Percent	Number	Percent	Number	Percent
Under 20	3	5.2	2	2.6	5	3.7
20-29	16	27.6	9	11.5	25	18.4
30-39	16	27.6	13	16.7	29	21.3
40-49	9	15.5	16	20.5	25	18.4
50-59	2	3.4	22	28.2	24	17.6
60-69	3	5.2	8	10.2	11	8.1
70 and over	2	3.4	2	2.6	4	2.9
Unknown	7	12.1	6	7.7	13	9.6
TOTAL	58	100.0	78	100.0	136	100.0

Marital Status and Family Composition

The marital status of the patients, as indicated in Table 2, represented the marital status at the time of the study. Therefore, those individuals categorized as married may have at one time been widowed or divorced. The single classification included 14 children. Over eighty percent (83.8%) of the patients have been married at one time or another. Those patients presently married accounted for 62.2% of the total number of patients.

TABLE 2
MARITAL STATUS

MARITAL STATUS	PERCENTAGE
Married	63.2
Single	16.2
Widowed	7.4
Divorced	6.6
Separated	6.6

1.1.1.

The first part of the paper is devoted to the study of the properties of the function $f(x)$ defined by the equation

$$f(x) = \frac{1}{x} \int_0^x f(t) dt.$$

x	$f(x)$	$f'(x)$	$f''(x)$
0	1	0	0
1	1	0	0
2	1/2	-1/4	1/8
3	1/3	-1/9	2/27
4	1/4	-1/16	1/8
5	1/5	-1/25	2/125
6	1/6	-1/36	1/54
7	1/7	-1/49	2/343
8	1/8	-1/64	1/256
9	1/9	-1/81	2/729
10	1/10	-1/100	1/500

The second part of the paper is devoted to the study of the properties of the function $g(x)$ defined by the equation

$$g(x) = \frac{1}{x} \int_0^x g(t) dt.$$

The third part of the paper is devoted to the study of the properties of the function $h(x)$ defined by the equation

$$h(x) = \frac{1}{x} \int_0^x h(t) dt.$$

The fourth part of the paper is devoted to the study of the properties of the function $i(x)$ defined by the equation

$$i(x) = \frac{1}{x} \int_0^x i(t) dt.$$

The fifth part of the paper is devoted to the study of the properties of the function $j(x)$ defined by the equation

$$j(x) = \frac{1}{x} \int_0^x j(t) dt.$$

1.1.2.

x	$g(x)$	$g'(x)$	$g''(x)$
0	1	0	0
1	1	0	0
2	1/2	-1/4	1/8
3	1/3	-1/9	2/27
4	1/4	-1/16	1/8
5	1/5	-1/25	2/125
6	1/6	-1/36	1/54
7	1/7	-1/49	2/343
8	1/8	-1/64	1/256
9	1/9	-1/81	2/729
10	1/10	-1/100	1/500

In determining the number of children per family, a family was defined as two or more related persons living together. Of the 120 cases, 111 could be defined as a family. These 111 families were found to have 242 children or 2.18 children per family. This figure probably understates the average number of children per family because families which were thought of as having no children included older couples whose children were out of the home and not mentioned in the record. At any rate, it is clear that due to the large number of married patients, many of whom had children, tuberculosis could very well be a disruptive force in the patients' family life.

OCCUPATION

Occupations of the head of the household were classified according to the United States Bureau of the Census' Classified Index of Occupations and Industries. In general, the vast majority of principal wage earners fell into the group that would be considered unskilled or semi-skilled. Only a small percentage (7.5%) could be called professional or managerial. Twenty-five percent of the heads of households were engaged in service occupations, including janitorial, maintenance, and hospital work. The fact that so many of the patients were unskilled laborees was of significance for purposes of this study for several reasons. First, the patient's income prior to his illness could have been relatively low and irregular. There would usually not be much money set aside for an unan-

TABLE 3
CLASSIFICATION OF OCCUPATIONS
of the head of household

Occupational Classification	Incidence
Professional, technical and kindred	4
Farmers and farm managers	1
Managers, officials and proprietors	4
Clerical and kindred	4
Sales	7
Craftsmen, foremen and kindred	12
Operatives	24
Private household	1
Service, except private household	30
Farm Laborers and foremen	2
Laborers, except farm and mine	7
Other*	2
Reported as retired only	7
Reported as unemployed only	4
Not reported	11
TOTAL	120

*Both in US Army

1. The first part of the paper discusses the importance of the research and the objectives of the study. It highlights the need for a comprehensive understanding of the current state of the field and the specific goals of the investigation.

2. The second part of the paper presents the methodology used in the study. This includes a detailed description of the data collection process, the sample size, and the statistical methods employed for data analysis.

3. The third part of the paper discusses the results of the study. It presents the findings in a clear and concise manner, supported by relevant data and statistical evidence.

4. The fourth part of the paper discusses the implications of the findings. It explores the potential applications of the research and the broader impact on the field.

5. The fifth part of the paper discusses the limitations of the study. It acknowledges the constraints of the research design and the potential sources of bias or error.

6. The sixth part of the paper discusses the conclusions of the study. It summarizes the key findings and provides a final assessment of the research.

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anticipated serious illness such as tuberculosis. Thus, if the principal wage earner was removed from the home, many financial problems could arise. If a wife and mother was hospitalized, there could be insufficient funds to hire a "mother substitute." Then there was the problem of the patient's employment after recovery. Manual labor, especially where long hours would be involved would no longer be possible, at least for quite some time. During the many months of treatment, and recuperation, the patient's family often must go on relief. In any case, there is certainly a great possibility that tuberculosis patients and their families would experience financial difficulty and the anxiety this difficulty could cause. Later in the study, the data surrounding these possibilities will be presented.

Length of Time Case Open

The average length of time cases were open was 7.8 years. This amount of time included the entire time the case was known to the health department, from the diagnosis of the disease, through treatment, and finally, follow-up. This does not mean to imply that tuberculosis always necessitates many years of treatment. Many patients return to the community after a relatively short period of hospitalization. Most tuberculosis beds are no longer being held by patients who occupy them for years on end. About half the patients in the United States occupying beds on June 30, 1960, had been hospitalized less than 6 months. Only about 8% of the patients had been continuously in the hospital for 3 years or more.¹

Residence

The places in which tuberculosis patients and their families lived were plotted on a map of Greater Battle Creek. It could easily be stated that a great number of these people resided in the areas closest to the center of the city. These areas have traditionally been known among sociologists as being occupied by families of relatively low socio-economic status.² These areas were also considered to be areas of high mobility and social disorganization. Fewer patients were found to reside in the "higher class" neighborhoods further removed from the center of the city.

¹ Shaw and Glaser, Tuberculosis Chart Series, Public Health Service Publication No. 639 (Washington: United States Government Printing Office, 1961), p.13.

² Ronald Freeman et.al. Principles of Sociology (New York: Henry Holt and Company, 1952), p.363.

• • •

Social and Psychological Data

There has been much written on the social and the psychological problems associated with tuberculosis. One body of literature deals with trying to define the relationship of psychosocial factors to the natural history of tuberculosis. Most of these studies attempt to isolate various psychological and social characteristics which tend to predispose individuals to tuberculosis. Such was the orientation of the study headed by Dr. Holmes, "Psychosocial and Psychophysiologic Studies of Tuberculosis." In this study it was found that the tuberculous subjects were sensitive, anxious, rigid and emotionally labile. It was also found that disintegration of the patient's psychosocial adjustment almost invariably occurred in the two year period preceding the onset or the relapse of the disease. Such disintegration took the form of high frequencies of broken marriages, and changes in residential and occupational status.¹ The following quote from the study gives a clear picture of the author's point of view:

These patients, when compared with the cultural norms, were in many ways marginal people at the time of the onset of tuberculosis. They started life with an unfavorable social status and grew up in an environment that was for them crippling. They were, in essence, strangers attempting to find a place for themselves in the contemporary American scene. As perceived by the individuals with tuberculosis, the poorly understood world in which they lived was a source of perennial danger and the threat of being 'walled off' and rendered 'helpless' was always imminent. The nature of their attitudes and life experiences made it unusually difficult for them to what was expected of them or what they expected of themselves. As a consequence their attempts at adjustment were characterized by unrealistic striving which was not only unrewarding but also productive of cumulative conflict, anxiety, and depression. It was in this setting of increasing life stress acting on individuals whose limited capacities were no longer adequate for resolving problems or achieving satisfaction that tuberculosis developed.²

Another body of literature deals with the social, economic, and psychological impact of tuberculosis. This view stress the problems inherent in the nature of the disease. In this case, the emphasis was on such things as the strain and anxiety which may result when there is constant worry over finances, when family members are separated, or when family plans are disrupted. This approach gives recognition to the fact that individuals may have had social and emotional problems prior to the illness; however, the emphasis is on existing emotional and social problems whether or not intensified by tuberculosis. This view is represented by Sophia Bloom:

¹ Holmes, op.cit. p.141.

² . . .

It is not so frequently recognized that all persons suffering from tuberculosis have economic and social problems which are an inherent part of the illness...Emotional adjustments of a profound and complex nature have to be made by the stable as well as by the unstable, and the difference is merely one of degree of intensity.

The above two points of view are not seen as conflicting, but are, rather, a difference in emphasis of areas for study and concern. Both are important from a social work standpoint. The first point of view, which deals with the social and psychological etiology of tuberculosis, is considered an area of concern for preventive social work. The second approach points up the fact that there are social and emotional problems which are an inherent part of tuberculosis, and need social work attention. This social work service would be needed regardless of the fact that the problem originated before the onset of the disease.

In this study it was not possible to ascertain whether or not problems noted were in existence prior to the onset of tuberculosis. The study was aimed at determining the number and types of problems experienced by the tuberculous of Battle Creek during the time they were known to the health department. The behavior of patients as described by the nurse was categorized by the investigator according to her understanding of the Family Service Association.

Table 4

NUMBER OF SOCIAL AND PSYCHOLOGICAL PROBLEMS

Type of Problem	Incidence
Family relationship	60
Marital difficulty	31
Parent-child relationship	23
Unmarried parenthoooh	55
Individual personality adjustment	45
Children (13 years or under)	10
Adolescents (14 to 20 years)	33
Adults (21 years or over)	32
Failure to accept community standards	16

TABLE 3 (continued)

Planning substitute care of children	20
Old age	8
Mental illness	6
Diagnosed	5
Suspected	1
Intellectual retardation	17
Diagnosed	8
Suspected	9
Economic or employment	52
Educational and/or vocational Adjustment	12
Housing	20
Mobility	18
Other	
Alcoholic	16

The study definitely pointed to noticeable disruption in individual and family adjustment. (See Table 4). Over one-half of the families or individuals had difficulty in the economic or vocational areas. The high cost of medical care and the financial strain and loss to families due to tuberculosis has already been alluded to in various parts of this study. All that need be drawn in here is the importance of the use of economic assistance type agencies by the study group. (see Table 5).

Disruption of family life was noted in still other areas. Twenty out of eighty-five families with children (23.5%) had difficulty with planning substitute care of children while one or both parents received treatment for tuberculosis. This figure did not include the additional number of children for whom relatives gladly cared outside the home, but never the less had to be separated from parents and siblings. In extreme examples, as in the case of family X, the entire family unit was disorganized when the mother had to leave the home for treatment. Mr. X. found the role of breadwinner and house-keeper too much of a burden. The family became known to the court and other community agencies due to child neglect and mismanagement. These problems soon cleared up when the mother returned to the home; however, the situation still resulted in a sad drain on human and community resources.

1. The first step in the process of the scientific method is to make an observation or ask a question. For example, a scientist might observe that a plant grows better in one type of soil than another. This leads to a question: "Does the type of soil affect the growth of a plant?"

2. Next, the scientist makes a hypothesis, which is an educated guess or prediction about the outcome of the experiment. In this case, the hypothesis might be: "If a plant is grown in rich soil, then it will grow taller than a plant grown in poor soil."

3. The third step is to design and conduct an experiment to test the hypothesis. The scientist would set up two groups of plants, one in rich soil and one in poor soil, and measure their growth over time.

4. After the experiment is complete, the scientist collects data and analyzes it. If the plants in rich soil grew taller, the data would support the hypothesis.

5. Finally, the scientist draws a conclusion based on the results of the experiment. If the hypothesis was supported, the conclusion would be that the type of soil does affect the growth of a plant.

The scientific method is a systematic approach to investigating a question or problem. It involves making observations, asking questions, forming hypotheses, conducting experiments, and drawing conclusions. This process helps scientists to understand the natural world and to develop new technologies and treatments. The scientific method is a key part of the scientific process and is used by scientists in all fields of study.

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The most serious problems in terms of incidence were in the areas of family relationship and individual personality adjustment. Over one-third of the tuberculosis patients were found to have experienced difficulty in the area of family relationship. One-third of the families had at least one individual who was considered to have a problem in the areas of personality adjustment. The number was closer to one-half when alcoholics were included in this group.

The number of alcoholics that are reported in this study does not in any way reflect the magnitude of the problem of alcoholism among the tuberculous. "Alcoholism among tuberculosis patients has become a major deterrent to effective tuberculosis control."¹ The number of alcoholic tuberculosis patients in sanatoriums throughout the nation has been estimated at figures ranging from 15 to 85 per cent.²

Use of Community Agencies

The study was designed to determine to what extent tuberculosis patients and their families used the health and welfare resources of the Battle Creek community. Table 5 illustrates the extent to which various agencies were used, or at least the number of patients thought to have contacted particular agencies. Table 6 gives a picture of the number of agencies contacted per patients. Forty-three of the 120 families or individuals did not use any public or private community resource other than the health department itself. However, the remaining seventy-seven patients or their families used an average of 3.6 agencies per case. The average number of contacts for all the cases combined was 2.31 per case.

TABLE 5

NUMBER OF AGENCIES CONTACTED BY NUMBER OF CASES

Number of Agencies	Number of Cases
0	43
1	22
2	11
3	9

1

National Tuberculosis Association, "Fact-Finding in Alcoholism", Rehabilitation Events, Vol. VII, No. 1 (Winter, 1961).

2

Ibid.

(Table 5 continued)

4	14
5	8
6	3
7	4
8	0
9	3
10	1
11	0
12	1
13	0
14	0
15	0
16	1
Total contacts 278	
Total cases 120	

A total of 278 community contacts were made in all. The five agencies with which families and/or public health nurses (in their behalf) had the most frequent contacts were: 1) Local Branch of State Office of Vocational Rehabilitation, 2) Public Schools, 3) Service Clubs (for financial assistance), 4) Bureau of Social Aid and, 5) Department of Social Welfare.

TABLE 6

PUBLIC & PRIVATE AGENCIES KNOWN TO BE CONNECTED WITH THE T.B. CASES

Agency	Number of Contacts
Office of Vocational Rehabilitation	24
Public Schools	22
Service Clubs	22
Bureau of Social Aid	20
Department of Social Welfare	20
Red Cross	20
Surplus Foods	13
Charitable Union	13
Medical Social worker	10
Andrew Kellogg School	10
Family Counseling	10
Cripple Children's Commission	9
Volunteer Bureau	9
Police	8
Churches	7
Michigan Children's Aid	7
Veteran's Administration	7
Willard Trust Fund	5
Juvenile Court	5
Child Guidance Clinic	4
Salvation Army	3
	4
	3

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The following are the titles of the articles appearing in this issue:

1. The Role of the Physician in the Prevention of Disease
2. The Role of the Physician in the Treatment of Disease
3. The Role of the Physician in the Diagnosis of Disease
4. The Role of the Physician in the Prognosis of Disease
5. The Role of the Physician in the Cure of Disease
6. The Role of the Physician in the Prevention of Death
7. The Role of the Physician in the Treatment of Death
8. The Role of the Physician in the Diagnosis of Death
9. The Role of the Physician in the Prognosis of Death
10. The Role of the Physician in the Cure of Death

The following are the titles of the reports appearing in this issue:

1. Report on the Progress of the American Medical Association
2. Report on the Progress of the American Medical Association
3. Report on the Progress of the American Medical Association
4. Report on the Progress of the American Medical Association
5. Report on the Progress of the American Medical Association
6. Report on the Progress of the American Medical Association
7. Report on the Progress of the American Medical Association
8. Report on the Progress of the American Medical Association
9. Report on the Progress of the American Medical Association
10. Report on the Progress of the American Medical Association

The following are the titles of the editorials appearing in this issue:

1. Editorial on the Role of the Physician in the Prevention of Disease
2. Editorial on the Role of the Physician in the Treatment of Disease
3. Editorial on the Role of the Physician in the Diagnosis of Disease
4. Editorial on the Role of the Physician in the Prognosis of Disease
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9. Editorial on the Role of the Physician in the Prognosis of Death
10. Editorial on the Role of the Physician in the Cure of Death

The following are the titles of the notes appearing in this issue:

1. Note on the Role of the Physician in the Prevention of Disease
2. Note on the Role of the Physician in the Treatment of Disease
3. Note on the Role of the Physician in the Diagnosis of Disease
4. Note on the Role of the Physician in the Prognosis of Disease
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9. Note on the Role of the Physician in the Prognosis of Death
10. Note on the Role of the Physician in the Cure of Death

The following are the titles of the letters to the editor appearing in this issue:

1. Letter to the Editor on the Role of the Physician in the Prevention of Disease
2. Letter to the Editor on the Role of the Physician in the Treatment of Disease
3. Letter to the Editor on the Role of the Physician in the Diagnosis of Disease
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10. Letter to the Editor on the Role of the Physician in the Cure of Death

The following are the titles of the obituaries appearing in this issue:

1. Obituary on the Role of the Physician in the Prevention of Disease
2. Obituary on the Role of the Physician in the Treatment of Disease
3. Obituary on the Role of the Physician in the Diagnosis of Disease
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10. Obituary on the Role of the Physician in the Cure of Death

The following are the titles of the announcements appearing in this issue:

1. Announcement on the Role of the Physician in the Prevention of Disease
2. Announcement on the Role of the Physician in the Treatment of Disease
3. Announcement on the Role of the Physician in the Diagnosis of Disease
4. Announcement on the Role of the Physician in the Prognosis of Disease
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9. Announcement on the Role of the Physician in the Prognosis of Death
10. Announcement on the Role of the Physician in the Cure of Death

(TABLE 6 continued)

Kalamazoo State Hospital	4
Goodwill Industries	3
Probate Court	8
Needlework Guild	2
Legal Aid	2
Juvenile Home	1
Girl's Training School	1
US Immigration Service	1
Ironwood Rehabilitation Center	1
Coldwater State Home	3
Kalamazoo Children's Center	1
Child Mental Health Consultant	1
Good Samaritan Home	1
Private Firms (business)	1
Easter Seals	1
Total of 36 Agencies	278 Total

HEALTH PROBLEMS IN ADDITION TO TUBERCULOSIS

Tuberculosis patients and their families were found to have health problems in addition to tuberculosis. These additional health problems were those that were discussed with and recorded by the nurse. Only in twenty-two cases were no additional health problems mentioned to the nurse. In fifty-six cases, the families mentioned three or more illnesses to the nurse. Twenty-six families discussed five or more health problems.

TABLE 7

NUMBER OF HEALTH PROBLEMS

Number of Health Problems	Number of Families
0	22
1	27
2	15
3	20
4	10
5	7
6	5
7	2
8	3
9	3
10	3
11	0
12	0
13	0
14	0
15	0
16	3
	120

average per family-3

It was also possible to ascertain information on the disposition of the tuberculosis cases. An overwhelming majority of the patients had been hospitalized at one time or another. Most of these were hospitalized with relative ease and did not leave the hospital against medical advice. However, of the thirteen individuals who were hospitalized with some difficulty, nine left the hospital against medical advice. It was important to note that of the five individuals who were legally admitted all were discharged against medical advice.

TABLE 8

RELATION OF EASE OF HOSPITALIZATION TO DISCHARGES AGAINST MEDICAL ADVICE

Ease of Hospitalization	Number Hospitalized	Number of A.M.A.S	Percentage of A.M.A.
Easily	103	16	15.5%
With some difficulty	13	9	69.2%
Required legal action	5	5	100.0%
total	121	30	24.8%

The literature has shown that the diagnosis of tuberculosis is received by the patient in a variety of ways. Some patients may view the diagnosis as a sentence of doom. Others feel a great sense of relief because they hear in the diagnosis of a serious illness means of getting away from an unbearable home situation, or an escape from psychological conflict that seemed insoluble. Certainly, cultural as well as psychological make-up plays a large role in the reaction of the patient to the disease.¹

Perhaps the central issue for the patient with tuberculosis to resolve is his acceptance of the passive role. For some this is easy; while for others it is difficult. This depends on personality and cultural factors.²

¹Eric Wittkower and R.A. Cleghorn (ed.), Recent Developments in Psychosomatic Medicine (Philadelphia: J.B. Lippincott Company, 1954), p.282.

²Ibid., p.284.

Identification of Social Work Needs

The foregoing findings shed considerable light on the characteristics of tuberculosis cases in the aggregate. However, it was felt that in order to arrive at an objective identification of social work needs, it was necessary to arrive at some empirical way of analyzing the cases by family units, or case by case. It was found that in analyzing the data from this point of view the cases could be placed rather meaningfully into four major categories. These categories were arrived at by studying the relationship among three factors from each case: (1) the number and type(s) of social and/or psychological problems, (2) the number and type(s) of community resources used, and (3) the number and types of health problems in addition to tuberculosis.

Both qualitative and quantitative factors were considered in placing each case in the appropriate category. These factors will be further delineated at the time the category is discussed. A ~~case~~ example will also be given. The following are the four categories used to determine social work need:

1. Multi-problem families
2. Casework prospects
3. Health problem families
4. Those with "no problems"

Multi-problem families have been characterized in the literature as having more than their share of physical and emotional problems.¹ The problems that can beset a multi-problem family are many, including such things as poor housing, a long history of financial dependency, heavy incidence of mental illness and retardation, periodic unemployment, marital discord, indebtedness, juvenile delinquency, etc.² The multi-problem family was also characterized as having a multiplicity of contacts with many community agencies.³

In accord with the above characteristics, the following criteria were arrived at for purposes of defining the term multi-problem family as used in this study: 1) There had to be two or more persons living in the home.

¹ Helen Hallin, "Co-ordinating Agency Efforts in Behalf of the Hard-to-Reach Family", Social Casework, XXIX, January, 1959, 9-16.

² Kenneth Dick and Lydia J. Strnad, "The Multi-Problem Family and Problem Service", Social Casework, XXXIX, No.6 (June, 1958) 349-355.

³ Hallin, loc.cit.

- 2) Four or more social and/or psychological problems were experienced by the family, one of which had to be in the area of individual personality adjustment or family relationship. 3) The use of three or more community agencies was considered to be an extensive use of community resources. Agencies were classified according to four functions, health, economic, legal, and social. The multi-problem family had to use at least three of these four types. 4) The family had other health problems in addition to tuberculosis.

The X Family easily met the criteria for being classified a multi-problem family, and serves as an interesting example:

The X Family was known to the community for their social and psychological difficulties. The school often contacted various community agencies, including the health department, concerning the frequency of school absences among the X children. When the children did report to school, they were reportedly dirty, hungry and/or sick. The older boys were known around school for their "pick-a-fight attitude," and one was taken later to Boys' Vocational School. The children were often left alone while the parents worked, and a neglect charge was filed with the Probate Court. One child of the five was diagnosed as intellectually retarded.

Mr.X and Mrs.X were both TB patients with a long history of AMA discharges. Mr.X was known for his drunkenness and abusive attitude. Many marital, economic, and housing difficulties were also experienced by the family.

It was found that twenty-six of the 120 cases met the criteria for classification as multi-problem families. This was 21.7 per cent of the cases. It was interesting that 36.6% of the patients that left the hospital against medical advice fell into this category. It was also found that ten out of twelve of the families that had more than one case of tuberculosis in the family were also in this group.

Medical social workers in hospitals have been appropriately assigned the responsibility of helping to alleviate the social, economic, and emotional problems which were related to illness. The medical social worker helps the patient and his family to make optimum use of medical service when family or personal problems would otherwise interfere with medical plans.¹ The role of a social worker in a public health department

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Arthur Fink, Everett Wilson and Merrill Conover, The Field of Social Work (New York: Henry Holt and Company, 1956), p.324.

would be similar. This point will be elaborated upon further in the next section of the study. The above definition served mainly as a guidepost in arriving at the criteria for the category "casework prospect."

The following criteria were arrived at for defining the term casework prospect as used in this study: 1) Family units or individuals may be placed in this category. Consequently, all single individuals, who would have otherwise qualified for the category multi-problem family were placed in this category. 2) Families included in this category were considered to have experienced less severe damage to the family's ability to function than the multi-problem family. One through four social and/or psychological problems would have qualified a family or an individual for this category depending upon the nature of the problem. One problem was considered sufficient to qualify a case for this category if an individual was alcoholic, had difficulty in adjusting to his diagnosis, or staying in the sanitarium, or had left the sanitarium against medical advice. Problems of an economic nature were not sufficient in themselves unless the individual was experiencing some personal or familial conflict surrounding it. The term economic problem was used broadly here to include such as vocational adjustment as well. 3) Most cases in this category used some community resources, but not more than three agencies or more than two of the types of agencies described before. All cases were considered to have needed more effective social services. 4) Some cases had health problems in addition to tuberculosis. This criterion was not considered as important as in the case of the multi-problem families where numerous health problems were necessary to meet the definitions found in the literature.

The case of Miss Z could serve as a prototype of the casework prospect category. The case of Miss Z as well as 43 others fell into this category. (36.6%)

Miss Z was a single woman of 52 who lived with her mother and aunt in a comfortable home. Her occupation was that of an accountant. It was with great difficulty that Miss Z was finally hospitalized for TB. Both the health department and sanatorium reported her refusal to accept her diagnosis or treatment advice. She related to medical personnel in a hostile fashion, and was called a "mama's girl." Upon release from the sanatorium, Miss Z felt a keen loss of prestige and financial security in connection with her job.

The health problem family or individual appeared to have no social

and/or psychological problems, other than economic difficulties. For this reason, when they used community agencies they were only economic or health connected. Consequently, when establishing criteria for this category two major health criteria were used: 1) The family was troubled by numerous (five or more) relatively minor illnesses. 2) A member of the family suffered from a major illness, such as cancer, heart disease, or diabetes, in addition to tuberculosis. Fourteen cases (8.6%) met these criteria. The case of Family Y served as an example of this category:

The Y Family lived in the rural Battle Creek area. There were six children, one of which was the TB case. Mr. Y was a steadily employed fireman, and his family appeared relatively stable from a social-psychological point of view. However, the family was troubled by the occurrence of numerous minor health problems (16), among which were: measles, diarrhea, vision complications, scarlet fever, anemia, poor nutrition, a slipped disc, chickenpox, intestinal flu, overweight individuals, broken legs, etc. All of these problems came to the attention of the public health nurse.

It was felt that a case having only health problems could still benefit from social work intervention. The rationale behind the use of this category was the realization of the strain and anxiety which can be caused when numerous illnesses are experienced in one family or by one individual. It would be expected that this continual strain would take its toll in psychological and/or social problems, at least in some instances. Cases of this nature would be suitable for supportive help from the public health nurse and referral to a social worker if and when more serious problems develop.

Those cases classified as having "no problems" did not fit into any of the above categories. Any problems that were experienced by those in this category were of an economic nature and were handled without any apparent conflict either through appropriate agencies or within the family itself. Thirty-six or 30% of the cases fell into this category. In short, all indications given in the public health record seemed to indicate the family or individual was able to cope with the presence of tuberculosis.

The above classification scheme was meant to be a rough way of objectively determining what cases had unmet social work needs. About 58% of the cases were considered to have need of social work services. Some of these cases were having this need met by taking advantage of existing community resources. Eight percent of the total caseload was known to have been clients of the Family Service Agency. Three percent

of the cases were also known to the Child Guidance Clinic. But this does not begin to meet the need. Some of the failures to help tuberculosis patients and their families may result from inadequate utilization and coordination of services which are already available in the community.¹

The Michigan Department of Health has two social work consultant positions. The Calhoun County Public Health Nurses found it necessary to discuss eight percent of their caseload with a consultant. Social work consultants have only incidental responsibility for direct service. Their major responsibility is that of evaluating individual and community problems that interfere with the effectiveness of health problems.

In studying Table 6, it becomes clear that less than fifteen percent of all the tuberculosis cases are evaluated or receive casework services.

¹ibid.

²ibid.-

For example, the *Journal of Management Inquiry* has been a leading journal in the field of management inquiry for many years. It has published a wide range of articles that have contributed to the understanding of management and organization. The journal's focus is on the study of management and organization, and it has a long history of publishing high-quality research. The journal's content is primarily empirical, and it covers a wide range of topics, including organizational behavior, organizational theory, and organizational change. The journal's articles are written by leading scholars in the field, and they are peer-reviewed. The journal's impact is high, and it is widely cited in the field of management and organization. The journal's website is <http://jmi.sagepub.com>.

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CHAPTER IV

CONCLUSIONS & RECOMMENDATIONS

Tuberculosis is no longer the mass killer it once was. It is today an even greater social problem, however -- a problem with which social work should be concerned.

Tuberculosis is one of the serious illnesses which presents a wide range of problems to patients and their families. Communicability, length of treatment, often separation of the patient from his family, and the hazard of its recurrence, all contribute to the disruption of individual and family life. Every study of tuberculosis patients and their families reveals acute needs to which these common phenomena contribute.¹ It would seem, then, that tuberculosis patients and their families would be in need of social work services on this basis alone.

Tuberculosis is a problem that should be of concern to social work for still another reason. This study of Battle Creek patients and their families indicated, as did the literature, that a majority of tuberculosis victims come from a segment of the population that is ill-prepared to cope with the multiplicity of problems which are often associated with tuberculosis. Tuberculosis hits a majority of patients during their most productive years. The male patient often has to give up his job. When he recovers from tuberculosis, jobs that are not physically taxing are most difficult to find. Battle Creek tuberculosis patients belong primarily to the semi or unskilled labor group, and, therefore, are probably in the lower income brackets. Consequently, tuberculosis results in a great financial drain. The female patient also has her problems. These usually involve being forced to leave her home and young family.

The study definitely pointed to a noticeable disruption of family life among Battle Creek tuberculosis patients and their families. For example, over one-third of the families were found to have experienced difficulty in the area of family relationships. Over one-half of the

¹ National Tuberculosis Association, A Handbook on Social Services for the Tuberculosis Patient (Washington, D.C. : National Tuberculosis Association, 1956) p.3.

cases had difficulty in the economic/vocational areas.

The adjustment of individual family members was also found to be an important factor in the cases under study. Sometime the individual concerned might be the patient himself; other times, a member of the patient's family. At least one-third of the families had at least one individual who was thought to have a problem in the area of personality adjustment. This group would be even larger if one wished to include alcoholics in this group.

Tuberculosis patients and their families make considerable use of community resources. The most widely used agencies may be generally termed economic assistance agencies.

There has been no concerted effort in Battle Creek to co-ordinate the efforts of the many agencies giving services to tuberculosis patients. Nor has there been a plan for evaluating the need for casework services in each individual case. In view of the fact that fifty-eight percent of the cases were considered to have need of social work services, according to the four category classification scheme, the lack of social work services is a reason for concern.

The United States Public Health Service has come out in favor of creating new services to meet the need for social work services. They give two reasons for their position: First, they found they believe that every tuberculosis patient and his family should have the opportunity of good social planning and of continued casework service if the latter is indicated. Second, they found in a study of numerous communities that none of them were able to assure complete social work coverage of all tuberculosis cases and their families through use of existing agencies.¹ In many large cities with relatively large incidences of tuberculosis a new services have been started.²

The author agrees that ideal plan for social work services for the

¹ Berry, op. cit., p.5.

²

James Zeck, "Social Services in Tuberculosis", Public Health Reports, Vol. LXIV, No. 48 (December 2, 1949), pp. 1-21.

tuberculous would be that of a comprehensive service such as suggested by the United States Public Health Service. This could mean a social worker in every county health department in Michigan, or specialized clinics in various locations throughout the state (as well as one or two medical social work consultants in the state health department).

However, in making specific recommendations for the Calhoun County Health Department, it is important to realize that shortages of trained social workers as well as limited finances must be taken into account. It certainly would not pay from a financial point of view for a relatively low incidence area (county) to hire a social worker merely to serve the tuberculous. However, if there was a sufficient number of trained social workers available, a medical social worker could contribute a great deal to the goals of any health department.

Perhaps the most serious roadblock to adequate social services for the tuberculous in Battle Creek is the lack of coordination of existing services. It has been found in other localities that although community resources do exist, there is often con coordination of them for rehabilitation purposes. At times the patient and his family do not know that there are local sources of help to which they may turn. Sometimes the patients are not clear about what agencies are for or what they do--or for whom. Sometimes patients are unwilling to ask for help or to use help offered them. In such situations patients' problems may persist and grow.¹ Most tuberculosis patients need the assurance that there is an organized community program ready to help them face their own problems. The author believes that if all health and welfare agencies in Battle Creek, or in any other city with a comparable tuberculosis rate and with similar community resources, work together in a coordinated fashion, most of the need for social work services among the tuberculous could be met. The council of social agencies would seem to be the appropriate body to meet this problem of coordination of services. The council would serve as a means for promoting agency and community understanding of the problems surrounding tuberculosis.

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National Tuberculosis Association, A Guide for the Development of Rehabilitation Programs in Tuberculosis Associations (Washington D.C.: National Tuberculosis Association, 1956), p.10.

The task of coordinating services to multi-problem families is a difficult and challenging one for social workers at this time. This study indicates that a large number of multi-problem families may have a family member with tuberculosis as well as various other illnesses which may bring them to the attention of the health department. It is in coordinating services to these families that social and health agencies may make a major contribution to their community.

In short, the author recommends that a temporary committee be set up to deal with the problem of coordinating services for the tuberculous of Battle Creek. This committee might actually be set up as a sub-committee, the main committee being a permanent one dealing with coordinating services for multi-problem families.

Successful recovery from tuberculosis is a distinct medical possibility in this day and age. Restoration to a full and useful life in the community is also a possibility. Recovery from tuberculosis is more than restoring the individual to physical health. It involves restoration of the tuberculous to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable. But it should be remembered that tuberculosis is still basically a public health problem. The health department should certainly be the one to assume leadership in coordinating the many disciplines that should be working together to eliminate this disease. Social work is a field well-equipped to help in meeting the challenge of this goal.

APPENDIX

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SCHEDULE

Check Problem Area

A Social and Psychological Profile of TB Cases (Families)

___ Family Relationships

___ Marital difficulty

___ Parent-child relationship (indicate)

___ Unmarried Parenthood

___ Individual Personality Adjustment

___ Children (under 13 years)

___ Adolescents (13-20 years)

___ Adults (21 years & over)

Indicate which family member

___ Failure to Accept Community Standards

___ Planning Substitute Care of Children

___ Old Age

___ Mental Illness (which family member)

___ Diagnosed

___ Suspected

___ Intellectual Retardation (which family member)

___ Diagnosed

___ Suspected

___ Economic or Employment

___ Educational and/or Vocational Adjustment

___ Housing

___ Mobility

_____ Other (indicate)

Referral Source _____

Date _____

1. List health problem(s) or disease(s) other than TB. Indicate if the health problem occurred before or after the diagnosis of TB. A=After B=Before

2. List other social and private agencies connected with this case. C=Conference R=Referred by PHN

3. Fill in the following information about the patient.

Place of residence _____

Occupation (husband) _____ (wife) _____

Income _____ Source _____

Marital Status _____

Number of Children _____

Age _____

Education (husband) _____ (wife) _____

4. Disposition of Case:

_____ Hospitalized: easily, some difficulty, legally

_____ Chemotherapy

_____ Observation

_____ Lost, moved, uncooperative

5. Did the patient leave the hospital against medical advice?

_____ Yes _____ No

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