

## Casework Treatment

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The chronically ill homebound adult must deal with many losses. In my work with these individuals and their families I have seen certain themes emerge around issues such as object-loss and loss of identity, self-esteem, and physical capabilities. I will discuss these themes, using case material to illustrate them.

One must always begin "where the client is," and often the point at which the request for service is made is when the client has begun to experience loss. For many of our clients the process of becoming homebound may be thought of as taking place in four stages. The first is the actual hospitalization, or medical crisis, when the patient is surrounded by hospital personnel and immediate family. After this crisis passes, and a diagnosis is made, a period of treatment and restorative efforts follows. The patient has a schedule he must work within and he has hospital staff and family as a support system. The third stage begins with his release from the hospital. This is a time when friends and family visit and call often and promise to continue doing so. But just as the patient must adjust to his disability, friends and family must return to their daily routines and make adjustments to life without the patient as an active participant. In the fourth stage, visits become less frequent and the patient feels disappointment as he sees promises aren't kept. It becomes increasingly difficult for him to believe that the visitor will return or that elicited needs will be met. Therefore many of our clients are at first reluctant to respond to the variety of our programs with interest, fearing they will be open to further disappointments should we not follow through. We have to begin slowly, allowing the client to become gradually more trusting as he sees we are consistent in our interest in his situation.

Mr. R. made a request for service at a time when he was overwhelmed by the financial and emotional burden of caring for his wife, diagnosed as having amyotrophic lateral

sclerosis. He applied for Medicaid and was turned down because he did not have the necessary documents. Mr. R. felt he could not cope with the reapplication procedure. His anxiety was such that it was becoming increasingly difficult for him to function. He and his wife were enraged at family and friends, whom they felt let them down. When I introduced the Quality of Life program they felt there was little they could make use of. After a period of several months, involving frequent phone calls and visits, we placed a family aide\* and helped Mr. R. successfully reapply for Medicaid. It was only then that Mrs. R. was willing to risk expressing interest in working with our art therapist. By addressing ourselves to the immediate needs of the family, by being consistent in our interest and not turning away in the face of Mr. R.'s rage, we were able to convince Mr. and Mrs. R. that there were people they could trust.

As a result of working through the initial resistance, the R. family has become involved in other facets of our program. She looks forward to reading our newsletter and has contributed an article in response to a poem written by another client. We recently arranged ambulette service enabling Mrs. R. to share in the joys of her grandson's second birthday party and to see her daughter's home for the first time. At this point our working relationship is such that Mr. and Mrs. R. feel free to call upon us whenever they feel the need to.

Perhaps most devastating, and certainly most immediate, is the loss of one's identification as a "whole" person. We interact with others and use their perceptions of us as part of our definition of self. We look at our environment and use it to further define our roles. The physically healthy person, successful in roles as parent, spouse, and breadwinner, experiences a loss of self when these roles are taken from him as a result of physical disability. He tends to see himself only in terms of his disability and no longer thinks of himself as a functioning individual. His

\* Sometimes termed "homemaker."

environment is four walls, a wheelchair, or hospital bed. His activities, if he has any, are usually around his disability, such as physical therapy, or group meetings with others who have similar illnesses. The chronically ill adult needs to identify with the healthy part of himself, and he can do this only by being able to relate to the healthy part of another individual.

Mrs. K. is a 60-year-old woman with multiple sclerosis. She has been confined to her wheelchair for over 10 years. In my early contacts with her she spoke of her experiences as mother and wife and discussed at great length her pride in being self-supporting both prior to and during her early years of marriage. Always interested in music, she taught piano and played professionally. It became clear as Mrs. K. discussed these roles that she could no longer relate to them. It was as if she were talking about someone else. Mrs. K. identified herself only as a woman in a wheelchair, unable to fulfill her roles, as she perceived them, as wife, mother, and grandmother. We encouraged Mrs. K. to meet with our art therapist and as a result she became interested in working with oils. Her husband took a new interest in what his wife was doing and one Sunday he drove her to a park to sketch her next painting. She sat in her wheelchair while he helped her set up her easel next to another artist. During the course of the afternoon she borrowed an eraser from the artist and they briefly discussed their work. That was the turning point for Mrs. K. She no longer identified herself in terms of her disability, but as she was able to relate to another person—an artist. She was able to use this interaction to come to a new definition of self, and with this new self she found different ways to relate to her husband, son, and granddaughter. Just as she took pride in exhibiting her musical talents prior to her illness she is now proudly exhibiting her paintings at various shows in the community.

Mrs. K., gratified by her successful endeavor in our art therapy program, is an eager participant in our various telephone groups and a contributor to our newsletter. No longer able to play the piano because of

her illness, she is now looking forward to meeting with our music therapist with the hope that she can find new ways to express her talent.

Chronic physical disability, so severe that it imprisons its victims at home, has a dramatic effect on one's personality. In my short-term counseling with these individuals I found that their present way of functioning differed little from their pre-morbid state. Those who were independent prior to their illness were able to structure their lives to retain this independence. Those who were dependent personalities often became more dependent, displacing this dependence onto their illness.

The quality of one's object relations shows little change, however these relationships become magnified. I saw this to be particularly true in marriage. Where small problems could be overlooked and forgotten as they became absorbed in the day's activities, now they become the focus of one's attention and the source of many hours of rumination as one partner sits home with nothing else to occupy his mind. He becomes too angry and resentful to relate to his partner's day, and often continues the battle of the morning when his partner returns home. Life together becomes one argument after another as the chronically ill adult projects his feelings of worthlessness onto his partner. Often the client cannot express his anger for fear of further alienating his spouse on whom he is dependent for financial and physical support. The healthy partner becomes less emotionally involved as the spouse withdraws further into his depression and communication breaks down completely.

Mr. G. requested counseling at a time when angry outbursts towards his wife were beginning to frighten him. In his late 50's, a victim of muscular dystrophy, Mr. G. was having a difficult time adjusting to life at home while his wife worked to support them. He found the only way to control his temper was to cut off communication from his wife completely, and she welcomed these silences in place of the constant bickering. While her husband became withdrawn and depressed,

Mrs. G. established a life of her own and proved herself successful as a business woman.

Both Mr. and Mrs. G. recognized their lack of communication and their need to change this situation. Their primary goal in short-term therapy was to be able to elicit each other's needs and listen to what the other was saying. A man easily frightened by anger, Mr. G. interpreted every disagreement as a rejection and felt shut out by his wife. By using interactions of the same nature with members of his telephone socialization group as a point of reference, I was able to help Mr. G. recognize this, and with his wife's support, work on modifying it. As a result he was able to listen to her when she pointed out that although he could not get up and walk out of the room when angry, he very effectively "left" her emotionally in the face of any conflict. Mr. G. was in touch with his over-reactions to minor problems and in our joint sessions Mrs. G. became sensitive to the dynamics behind her husband's escape into these ruminations.

Mr. G. is an active participant in many of our programs and with his wife's encouragement and interest he now shares many of these experiences with her at the end of the day.

In exploring the conflicts in this marriage I learned that they were the same conflicts present, to some extent, prior to Mr. G.'s illness. When Mr. and Mrs. G. had to restructure their lives to accommodate this illness, they were exacerbated.

For the marriage where communication and emotional investment have broken down prior to the onset of illness the task is often a more difficult one. Both partners have probably made use of their environment either to deny the deterioration of the relationship or to have begun, consciously or unconsciously, to move away from it. When one partner becomes chronically disabled he often has to come to terms with being physically dependent upon someone who may not be able to give him the emotional support he needs.

Mr. F. became known to our agency when his wife applied for help with their 13-year-old daughter. In my initial contact with Mr. F. it was clear that he needed counseling

for himself around his depression. A victim of multiple sclerosis, Mr. F. was in his late 40's and homebound for two years. Exploration of previous functioning prior to onset of illness showed Mr. F. to be a dependent man who externalized his need to function in roles as husband, father, and breadwinner. No longer getting support from colleagues and friends, he was forced to turn to his wife, who because of her own problems brought on by her husband's illness, was unable to address herself to his needs. Directly related to his depression, and not related to his physical condition, Mr. F.'s emotional and physical functioning decreased.

My short-term treatment goals with Mr. F. were to work with him towards not personalizing his wife's inability to respond to his needs, but rather to understand them as part of a problem of her own on which she was working with her therapist. Mr. F. had to learn to look to himself for gratification when he accomplished a task. After a period of several months Mr. F. was able to take pride in his physical and emotional accomplishments and relate in a less defensive way towards his wife. Although Mr. and Mrs. F. are a long way from what one would call "good communication," they have begun to share some feelings regarding common concerns around their daughter and their marriage. Before Mr. and Mrs. F. could begin to relate as a couple, Mr. F. had to become emotionally more self sufficient than he was prior to the onset of his illness.

In addition to using our counseling services Mr. F. frequently contributes poetry to our newsletter, works with our art therapist, and is a member of our art history telephone group.

The cases I have outlined above are not really very different from the ambulatory individuals we see in our offices every day. It is common practice for individuals to come to our offices with problems related to identity, self-esteem, and object relations. What about the people who cannot come to our offices because these problems are further exacerbated by chronic, physical disability? The Quality of Life program has reached out to this population at home and given them tools with which to function more effectively in their own environment.

## Issues in Public Funding of Jewish Communal Services\*

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*Our Jewish agencies and the whole voluntary sector are at a turning point in deciding whether to seek large amounts of increasingly available public funding. If they do receive such funds they can serve more people and become larger and more powerful. If they do not, they would do less, be smaller, and operate within more traditionally prescribed limits as to program and clientele. It is apparent that many agencies believing that "more is better," have opted for the former and will continue to do so.*

### Straws in the Wind

The new "Program for the Future" of the United Way of America projects that by 1985 its affiliates could be raising 3 billion dollars per year in the United States, which would be applied to total member agency budgets of 12 billion dollars; currently the local United Way organizations provide 1 billion dollars against total member agency budgets of 3 billion dollars. Notwithstanding the great growth projected in fund-raising, United Way expects that the gap between the amount of funds that can be raised by its local affiliates on the one hand, and the needs of their agencies on the other hand will increase to 9 billion dollars. It is anticipated that the gap will in part be filled by increasing governmental support of voluntary agencies.

Presently there are discussions in some communities, including Cleveland, about the reorganization of public service delivery systems. The discussion is also going on at the Department of Health, Education and Welfare. The main question is whether the proposed reorganization would provide more effective and efficient public services and hence better use of available resources. Central to our local discussions is a new way of contracting for purchase of service from voluntary agencies by the public agencies. The objective is for the public agencies to provide all or most of the services, or give leadership, do the coordinating, and "leverage" the

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public dollars used to purchase service in such a way that the voluntary agency utilizes the public dollar for sound public purposes. The private or sectarian purposes for which these agencies were established may not be considered at all unless they coincide with public goals. The rhetoric of such proposals tips its hat to pluralism and to the mission of the private agencies. However, the rigid formulae that often emerge call for a system in which the entry point for all clients will be the public agency. In the words of the preliminary report of the Cuyahoga County (Cleveland) proposal, the "challenge is whether voluntary agencies will accept the growing leadership role of public agencies (when it comes to the use of public funds)."<sup>1</sup>

The report of the Commission on Private Philanthropy and Public Needs<sup>2</sup> (the Filer Commission) indicates that in 1974, 23.2 billion dollars of government funds were received by private non-profit organizations (excluding religious organizations), while only 13.6 billion dollars were received from private philanthropy. A recent study<sup>3</sup> by the Council

<sup>1</sup> A Report to the Board of County Commissioners of Cuyahoga County; by the Ad Hoc Committee on Public Social Services. "Toward an Improved System of Social Services in Cuyahoga County." April 1, 1977.

<sup>2</sup> Report of the Commission on Private Philanthropy and Public Needs, *Giving in America*. 1975.

<sup>3</sup> Alvin Chenkin, background paper for the Sidney Hollander Colloquium, "Government Support to Jewish Sponsored Agencies in Six Major Fields of Service, 1962-1973," Council of Jewish Federations and Welfare Funds, April, 1976.