SOCIO-ECONOMIC FACTORS IN THE REHABILITATION
POTENTIAL OF ARTHRITIC PATIENTS

A Sample Study of Male Patients
In Residential Treatment at
Canadian Arthritis and Rheumatism
Society Medical Centre

by

MARGARET RICHMOND MacINNIS

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ABSTRACT

Because of the importance of medical and psychiatric information in diagnosis, there is a tendency to neglect or under-emphasize socio-economic information. This is partly an issue of recording; but it may have vital bearing on rehabilitation, and perhaps on treatment, in the broadest sense of the term, related to prognosis and rehabilitation plans. This study undertakes an exploration of this area, for a sample group of male patients receiving residential treatment in an arthritis treatment centre (Canadian Arthritis and Rheumatism Society, Vancouver) from 1952-1955. The socio-economic factors examined were in three groups. (a) age (b) family and marital factors (c) employment and occupational status.

The material used was obtained from medical and social service records of the agency. Statistical data were taken from admission forms and social service face sheets. Social service records provided the material concerning the attitudes and adjustments of the patients. Two broad categories of treatment goal used by the agency in planning treatment, (1) employability, and (2) improved self-care were followed in the present study in assessing the patients' adjustment following treatment.

Judged from these results the team estimate of the rehabilitation potential of the patients was 72% accurate in spite of the many unknowns in the handling of rheumatoid arthritis. The duration of the illness before treatment, and the length of treatment, appeared less important in relation to degree of improvement than might have been expected. Chronological age is clearly important: there was marked difference in the response of the patients under 50 years of age, compared with the response of the older patients, whether the treatment goal was "employability" or "improved self-care". The patient's general attitude toward employment seemed more influential than the type of work he was accustomed to do. The men whose inter-personal relationships were adjudged within normal range were best able to adjust to the trauma of illness, and to make best use of the rehabilitation service.

The concept of team treatment is again demonstrated by this kind of study. The Social Worker as a member of the treatment team is shown to have responsibility in three areas: (a) direct treatment of the patients (b) inter-professional planning for the patients, and (c) the use of community resources.

The study leads to some recommendations for the improvement of community and agency services, and suggests that study of social and economic needs of older men demands attention.
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SOCIO-ECONOMIC FACTORS IN THE REHABILITATION POTENTIAL OF ARTHRITIC PATIENTS
CHAPTER I

THE REHABILITATION OF THE ARTHRITIS PATIENT

The Canadian Arthritis and Rheumatism Society is a national voluntary agency which was incorporated under the Companies Act of Canada in March 1948, the original impetus for its formation having come from British Columbia, where an active citizen group had enlisted public, medical, and government interest in the plight of the arthritic patient. At the time this agency was formed very little was known about the incidence of this disease among Canadians or about the seriousness of the illness of those affected. The formation of the B.C. group and the co-ordination of the public interest with both federal and provincial departments of health and welfare has been described elsewhere\(^1\) and although it is of much interest will not be described again here. The enthusiasm of the B.C. group resulted in the setting-up of a B.C. Division of the Canadian Arthritis and Rheumatism Society within a year of the incorporation of the national organization.

The aims and objectives of the Society as set out in 1948 were as follows:

1. Research. In the field of research the aims

\(^1\) "Rohn, John, Rehabilitation of Arthritis Patients, Master of Social Work Thesis, University of British Columbia, 1953."
are to discover the causes of the rheumatic diseases and to develop methods of prevention. The Society does not attempt to set up separate and distinct research departments or laboratories, but instead, it assists research by making grants to existing research institutions, primarily at University Medical Schools.

2. **Education.** This refers to the dissemination of knowledge about the treatment of rheumatic diseases in order to enlist the interest of young doctors in this comparatively new field of study, to inform the general public about new approaches to this chronic disease in order to repudiate the claims of the advertisers of untested cures, and to enlighten arthritic patients themselves about methods of handling their disease.

3. **Rehabilitation.** This is the third objective of the society. This is the clinical programme which offers direct service to patients through treatment, consultation for private physicians, and the co-ordination of the community health, welfare, training and employment services on behalf of the patients.

4. **Fund-Raising.** This is the fourth objective of the Society and it is carried on to carry out the above programme.

**Rheumatoid Arthritis - A Chronic Disease:**

Canadian statistics concerning the incidence of
chronic disease are not available. However, the United States Department of Health, Education and Welfare recently published results of a study which estimated that in the United States approximately three per cent of the total population were affected by "long-term disability". In this American study long-term disability is used to mean any physical or mental disease which has prevented the patient from working or following other normal activities for a period of more than six months. In view of the usual similarity of trends in Canada and the United States it can be estimated that approximately the same number of Canadians are similarly affected.

The lack of adequate statistics regarding the Canadian incidence of chronic disease is reflected in the wide differences in the reports of the number of rheumatism patients among the population; for instance, the Canada Sickness Survey conducted in 1950-51 estimated that there were 270,000 people suffering from rheumatic diseases, while other more recent estimates have placed the figure as

1 The Canada Year Book, 1955, states that though vital and institutional statistics are well established and standardized, other statistics which would serve to measure the nation's health are still in an early developmental stage.


3 The Canada Year Book, 1955.
Like any other chronic disease rheumatoid arthritis may affect the total adjustment of the patient and his family. The man suffering from chronic disease or incapacitated by long-term crippling condition is unable to work and thus represents economic and social loss to the community and to himself. His lack of income lessens his purchasing power and precludes his taking part in the economic life of the community as a consumer of goods. More obvious as a direct financial loss to the community is the cost of maintaining him and his dependents on public assistance. In Vancouver, for instance, at the present time public assistance rates are $55. per month for a single person living alone, and average $160. per month to maintain a patient in a nursing home, exclusive of the costs of medical care.

Physical disability which removes a man from the field of gainful employment not only limits him economically, but also isolates him from participation in the personal interaction with individuals and groups, which is a basic social need. Discussing the basic needs of adults, Charlotte Towle says, "On reaching maturity the individual's energies will be

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largely concerned with the struggle for existence, but he will be concerned also with the establishment and maintenance of family life and with other creative activity or social productive work which contributes to the life of the group."¹ Although there is much being written at present concerning the changing of the traditional roles of men and women in our culture, there is still general agreement that the family is the basic unit of society and that one of the primary requisites of successful family living is reasonable continuity of income, preferably by steady employment on the part of the head of the family.²

Rheumatic disease may be divided into eight general categories, some of which are severely disabling, while others are of a comparatively minor nature. Rheumatoid arthritis is the category affecting most severely the greatest number of patients. The cause of this disease is still unknown, though certain facts about it are well established. It has a slight tendency to be familial and it affects three times as many women as men. Eighty per cent of the cases occur between the ages of 25 and 50, with the peak age being between 35 and 40. Partly because of its unknown etiology it is difficult for doctors to predict with any accuracy the

the course the disease will follow in any individual patient. Some patients recover more or less completely following an acute attack. Sometimes the process becomes arrested or quiescent at some stage in its course and the patient is able to carry on activities with minimal handicap and in other patients the disease runs an irreversible course, often resulting in severe crippling. Even in the most favourable cases a severe relapse may occur at any time, while on the other hand most severe examples of the disease may suddenly become arrested.¹

The basic programme of medical treatment of most rheumatoid arthritis is adequate rest and good general nutrition, combined with appropriate remedial exercises. Analgesics, such as aspirin, and sometimes mild sedatives are usually valuable as part of routine medical treatment. Gold, cortisone and other anti-rheumatic drugs are often indicated, but are only adjuncts to the basic regime.²

Some studies suggest co-relation between exacerbation of this disease and emotional stress. Doctors Weiss and English in *Psychosomatic Medicine*³ quote the result of a study

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² Robinson, Dr. H.S., Medical Director, C.A.R.S.

which found that "emotional stress, especially poverty, grief and family worry, seem to bear more than a chance relationship to the onset and exacerbation of rheumatoid arthritis". In discussing this statement the authors comment that in their opinion there may be within the individual patient certain emotional factors which express themselves through tension and spasm of the voluntary muscle system, and they consider that if this occurs in an individual who for some reason is predisposed to the development of chronic arthritis, then the psychic factor may be important. Dr. Franz Alexander considers that the inexplicable remissions and relapses which occur in this disease point to emotional conflict as partly responsible. He reviews psychoanalytical studies of arthritis patients, which found that there was a pattern of "chronic inhibited aggression" in patients suffering from rheumatoid arthritis and he postulates the theory that this in some way leads to increased muscle tone and in turn to arthritis. Both of these writers stress that at the present time it is impossible to evaluate the etiological significance of the personality factor in the development of rheumatoid arthritis.

Apart entirely from the etiological significance of personality factors in the development of this disease, rheumatoid arthritis, like any other chronic illness, affects the patient's total adjustment. Chronic illness often

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1 Alexander, Franz, Psychosomatic Medicine, New York, Norton, 1950.
results in feelings of loss of status, the fear of being controlled by others and anxiety about the maintaining of the home because of financial hardship caused by loss of income and the cost of treatment. A patient often isolates himself from his fellows because of conflicting feelings about his illness, particularly, if like chronic arthritis it is an illness which has produced obvious crippling. Rheumatoid arthritis is also accompanied by pain for which there is no sure remedy and the anxiety which accompanies any disease which runs an unpredictable course.

The Rehabilitation of the Disabled:

The restoring of the physically handicapped to useful activity was first undertaken by various Departments of Veterans Affairs as countries recognized their responsibility to their war-injured. The feasibility of plans to restore the seriously disabled to useful activity was proved by the successful results of the programmes of such training centres as St. Dunstan's which was established in England in the closing years of the First World War to offer service to the war-blinded soldiers. During the Second World War training programmes for the civilian disabled were set up to answer the need for workers in war industry, and again it was demonstrated that disabled persons if appropriately trained and

1 Bartlett, Harriet, Some Aspects of Social Casework in a Medical Setting, American Association of Medical Social Workers, 1940.
properly placed could fill a useful vocational role in society.

The concept of rehabilitation has broadened since these earlier training programmes were developed and the emphasis is no longer solely on vocational re-establishment but on helping all the disabled to attain their optimum level of functioning. The definition of rehabilitation adopted by the Canadian Conference on Rehabilitation held in Toronto in 1951 under the auspices of the Federal Government is as follows: "Rehabilitation is to develop and restore the disabled individual to the fullest physical, mental, emotional, social, vocational and economic usefulness of which he is capable within the restrictions inherent in his environment."

Gordon Hamilton commenting editorially in Social Work¹ says that each of the humanistic professions has as its basic concern the welfare of the "whole person" and that though each profession interprets this concern in relation to its own area of competence, there is growing recognition that no one profession can accomplish this alone. To bring about rehabilitation any effective programme must combine the skills of all the appropriate treatment sciences; that is, there must be a team of professional people if the total needs in the areas outlined in the above-quoted definition of rehabilitation are to be adequately assessed and treated.

¹ Vol. 2, No. 4, October 1957.
Dr. F. A. Whitehouse\(^1\) refers to the treatment team as a "close co-operative democratic multi-professional union devoted to a common purpose - the best treatment of the fundamental needs of the individual". In discussing this he goes on to say that the professions must "act, think, interpret, and contribute toward a diagnosis which is the product of all and a treatment plan which is dynamic" in order best to serve the client's individual needs. The persons participating in a treatment team must have reached a level of professional maturity which permits full sharing of their own knowledge and description of their own way of helping, and in addition to this each must be informed about the areas of competence of the other professions involved in treatment.

The social worker on a treatment team is responsible for contributing to the team diagnosis an evaluation of the effect of the client's disability on his opportunity and motivation to create for himself a satisfying life experience. This evaluation (the social diagnosis) is based on study of the positive and negative aspects of the client's past experience and present situation, his ability to form

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\(^1\) Dr. F.A. Whitehouse was Rehabilitation Consultant to the American Heart Association when he made this statement in the monograph, Teamwork: Philosophy and Principles. Published by American Association of Medical Social Workers, 1955.
satisfactory interpersonal relationships, his work and educational background, and in general his interaction with his environment. The second responsibility of the social worker is to carry out a plan of treatment suitable to the client's needs and in accord with the plan of the treatment team. Social work treatment can use one or a combination of the following methods: (a) case-work, (b) group work, and (c) community organization. At the present time case-work is the method most commonly used by the social worker on the rehabilitation team. Through interviews the case-worker attempts to help the patient to work through problems which may stand in the way of his achieving his rehabilitation goal; because the attitudes of family, friends and employers may influence the patient's future plans, the case-worker includes work with the family and other key persons in the patient's environment as part of direct treatment responsibility. The case-work method embraces four major areas: (a) environmental modification, (b) psychological support, (c) clarification, and (d) insight therapy. This last named is the least commonly used. Florence Hollis\(^1\) describes these aspects of the case-work method as follows:

(1) **Environmental modification.** This implies activity by the case-worker on behalf of the client to effect changes in the client's environment.

(2) **Psychological support.** This is the process of enabling the client to express his feelings about his situation and by sympathetic understanding and discussion increasing his confidence in his ability to handle all or part of his situation realistically and comfortably.

(3) **Clarification** is the technique of enabling the client to gain understanding of himself and his conscious reactions to external realities and thus to help him evaluate issues in his situation more realistically.

(4) **Insight Therapy.** This means helping the client to become aware of unconscious factors which adversely affect his present situation.

Although casework is the method which has in the past been primarily used in work with the handicapped, group workers are entering this field now to enable the handicapped person to enter into group experience in order to derive emotional support from association with people.¹

**The C.A.R.S. Programme of Rehabilitation:**

As described in the introductory paragraphs of this chapter, one of the aims of the Canadian Arthritis and Rheumatism Society is the rehabilitation of patients suffering from rheumatic and arthritic disease, through treatment, consultation to private physicians and co-ordination of the community health, welfare, training and employment services.

In British Columbia the clinical programme began in 1949 one year after the inauguration of the B.C. Division of the Canadian Arthritis and Rheumatism Society. This beginning consisted of the provision of extra physiotherapy services to the out-patient department of the Vancouver General Hospital. Later in 1949, three "Mobile" (home visiting) physiotherapy units were started to serve homebound patients in the Vancouver and Burnaby area. In the year 1950 the first CARS unit was established outside the Metropolitan area and in 1951 a second rheumatism and arthritis out-patient service was opened in the Vancouver area by the establishing of a clinic in the St. Paul's Hospital out-patient department under sponsorship of CARS. Because of the growing complexity of the medical programme, in 1951 a part-time medical director was appointed and later in the same year a social worker was appointed to the CARS staff. From this nucleus the present programme has developed.

The Provincial Programme which started in 1950 by the establishing of the first out-of-town unit now has the support of 33 local branches of the society in various areas of the province, and physiotherapy units have been established in most larger communities. Medical and social service consultation are available to any private physician in the province upon request and any
private physician may refer his patients directly for treatment to one of the local physiotherapy units.

**The Vancouver programme** at present consists of both out-patient and residential treatment services. Arthritis Out-patient Clinics are in operation as part of the out-patient services of both St. Paul's Hospital and the Vancouver General Hospital, with CARS supplementing hospital facilities by providing extra nursing, physiotherapy and secretarial services to the departments of physical medicine of those hospitals. The Mobile Units continue to serve severely limited patients by treatments given in the home.

**The Medical Centre:** In addition to the above services CARS operates a medical centre in Vancouver to serve local out-patients and also to give residential treatment to patients from any area of the province. The treatment facilities of the medical centre occupy one floor of a wing in the G.F. Strong Rehabilitation Centre, a modern one-storey building especially constructed for the convenience of the physically limited persons who are admitted for intensive treatment. CARS treatment services are self-contained with the exception of the hydrotherapy pool which is shared with the G.F. Strong Rehabilitation Centre. Though the treatment facilities of CARS are not shared with G.F. Strong Rehabilitation
Centre, the patients admitted by CARS for residential treatment do share recreation, library, dining and sleeping accommodation with the some forty patients who receive treatment direct through the G.F. Strong Rehabilitation Centre. By arrangement with the Rehabilitation Centre an average of eight to ten beds is available at any one time for CARS patients. The bedrooms are semi-private and the furnishings resemble that found in an average home - one of the aims of the centre being to help patients to function in normal surroundings. Service to out-patients is given at the medical centre upon referral of the patient by the private physician who must request the type of treatment desired and who retains responsibility for his patient.

The private physician is also responsible for referring his patient for residential treatment, but the decision to admit and the supervision of the treatment during the in-patient period becomes the responsibility of CARS staff. The cost of this care for patients in the low income group is underwritten either by CARS or by the Social Welfare Branch of the Provincial Government, the Social Welfare Branch in turn sharing costs with the Municipality of legal residence of the patient. Patients who are able to pay are asked to do so, the amount depending on their circumstances and the balance being handled
by CARS. B.C. Hospital Insurance does not cover this treatment. The method of admitting to the residential care and the functioning of the rehabilitation team will be discussed in Chapter 2.

As stated in the original paragraphs of this Chapter, one of the functions of CARS is to mobilize community resources on behalf of the patients following treatment. Two services whose object is to assist the vocational placement of all citizens are operated by the Federal Government. One is the National Employment Service which includes a section set up to deal particularly with the job-placing of clients needing special attention. There is also a Federal Government Plan under which disabled civilians may obtain vocational training, under the Canadian Vocational Training Act. The responsibility for administering this Act lies with the National Department of Labour and the Provincial Department of Education in British Columbia and the implementation is through the Provincial Co-ordinator of Rehabilitation who is attached to the B.C. Provincial Department of Health. Both of these services are available to CARS patients as they are to any other citizen. Though the agency refers patients to these services, the decision about the amount and quality of the service given to the patients is made by the Federal services concerned.

1. This service was established in 1940.
2. R.S.C. 1952, Chapter 286.
CARS also uses the public assistance resources of the local community in which the patient plans to reside if the patient requires a period of convalescent care or financial help, and also uses any social agency or other resources within the community which seem appropriate to the patient's needs.

**Purpose of the Study:**

The study was undertaken to assess the effect on rehabilitation of certain socio-economic aspects of the situations of a group of male patients who received residential treatment in the CARS medical centre. Though the agency treats various rheumatic diseases the group chosen for study all have the same diagnosis, i.e., rheumatoid arthritis. In spite of the common diagnosis the severity of the disease differed from patient to patient to a considerable degree. Male patients were chosen for study because ordinarily the economic situations of men are directly related to their own work activity, and though vocational placement is not the sole aim of the programme, the fact of return to work and the earning of income are plainly measurable and can serve as a fairly accurate guide to the adjustment of male patients.

From January 1, 1952 to December 31, 1955 twenty-nine male patients were admitted for residential treatment of rheumatoid arthritis. The agency remained in touch
with all but one of this group either by correspondence or by direct contact by one or several members of the staff and information about the patients following treatment is available in the agency records.

The present study uses data concerning the patients' social and economic conditions at the time of their admissions and compares this with their adjustment at a time two years after their discharges from the medical centre.

The three socio-economic factors to be considered are:

(1) **Chronological age**, which affects the person's ability to handle, and in some cases creates, stresses in the environment.

(2) **Occupation**. The patient's employment history and usual type of work is important in planning rehabilitation in that he may have skills that can be used differently, or he may need training to return to work.

(3) **Marital Status**, which is a guide to the patient's manner of living and the responsibilities he has.

In Chapter III some of the general implications of the above three items of statistical data will be discussed in relation to the twenty-eight men in the group, and in Chapter IV the same three aspects of adjustment will be discussed, but applied to cases which will be presented.
CHAPTER II

THE TREATMENT PROGRAMME

In order to assess the response of the patients against the background of the service offered and so that the concept of "treatment goal" as used in the Agency and in this study may be clearly understood, some detailed explanation of the residential treatment programme and the functioning of the treatment team is important. The following discussion describes the programme, the use of the conference method by the treatment team, and the case-workers' part in treatment. The discussion does not include a description of the administrative function of the social service department, because, though the social service department has considerable responsibility in planning and assessing the total programme, this aspect of the work of the social service department does not directly affect the individual patients.

The Diagnostic Phase:

Just as in referral to any specialized medical service the initial step is taken by the patient's private physician who must ask for assessment by CARS staff of his patient's suitability for inpatient treatment. Because only eight to ten beds are available at any one time for arthritic patients in the Medical Centre the decision to
admit and the setting of the date of admission are left to the CARS staff. In general the patient is accepted for residential treatment if the initial assessment reveals that he shows promise of gaining to some extent in social and economic independence.

The pre-admission examination of the patient by the CARS treatment team includes medical assessment of the state of the arthritic process, observation of the patient's capacity for physical function, and assessment by the social worker. Ideally, this pre-admission study of the patient is carried out by personal examination and interviewing of the patient by CARS staff at the medical centre. If circumstances prevent the patient's going to the medical centre for examination - for instance, he may live in another part of the province, or he may be recovering from an acute attack of the illness - other means of assessing are used. In the case of a local person suffering from an acute attack, members of the treatment staff of CARS may visit him at home or in hospital to acquaint themselves with his situation and his condition and to explain the service to him. Out-of-town patients are frequently known to a member of one of the local physiotherapy units, or to the CARS travelling medical consultant service having been referred by the private doctor for service in the local area, and information on which to base a decision to
admit can be obtained from them in such cases. The Social Welfare Branch of the Provincial Government Department of Health and Welfare has accepted responsibility for assessing the patient's financial situation if he is not able to meet the total cost privately, and for providing information on which is based the decision as to how costs of treatment are to be met. The local Social Welfare Branch office is frequently able to supply information about the patient's social adjustment which is valuable in assessing suitability for residential care.

The criteria for admission have gradually been evolved by CARUS staff since the agency first admitted patients in April 1951. Initially the admission of patients was on an experimental basis (that is experimental in the sense that the agency is a pioneer in offering treatment of a residential nature for arthritic patients) and there were few, if any, precedents to serve as guides. The present criteria to be explained below have been formulated since that time and are based on study of the responses of various patients to the treatment offered and on professional opinion as to possible causes of the varied responses. There is considerable flexibility in the use of the criteria as it is recognized by the agency that any service set up to help people must recognize the individual differences inherent in human beings.
The various areas in which the patient is assessed and the criteria used in those areas are as follows:

1. **Medical Condition**: Medically, it is considered desirable that the disease be in a quiescent stage, either because it has reached a period of natural remission or has been controlled by the anti-rheumatic drugs.

2. **Physical Functioning**: Functionally the patient must be able to look after his own personal needs, such as dressing and eating, and be able to move about at least in a wheel chair. Bedside nursing is not available as a routine procedure. Physiotherapists and occupational therapists can contribute to the assessment of the patient from their professional understanding of the levels of functioning which are required in order for the patient to manage in the physical environment of the medical centre. Sometimes, for instance, a patient may require a special prosthetic appliance before he is able to take part in the programme of treatment. Some knowledge of the patient's motivation toward recovery will be gained during these examinations, as there is opportunity to observe his general reaction to the proposed treatments and to gauge to a certain extent his interest and enthusiasm.

3. **Social Adjustment**: A social work assessment is usually made after the physical examination of the patient, and there is ordinarily a tentative medical opinion
about the physical suitability of the patient for residential care before the social work interview. The social worker has two major purposes in the assessment interview or interviews. One purpose is to form a professional opinion about the patient's psychological readiness to accept and benefit from treatment and the other is to offer assistance with the resolution of such problems in the patient's life situation as seem to be readily accessible to help so that he may enter the medical centre with as little anxiety as possible. An example of such a problem would be a patient's concern about financial help for his family during his absence from home if he is a man who has been working up to the period of treatment.

To assess psychological readiness for treatment and the reality of the patient's own future goals from one or two interviews with the patient and his family is of course difficult and at this pre-admission phase of treatment any diagnosis must be considered tentative. Certain concepts of maturity are widely recognized, however, and it is in relation to these that the social worker evaluates the patient's attitude to his illness, his adjustment to his former work experience and his inter-personal relationships with family and associates. The patient's way of meeting problems in his environment can be a guide to the maturity of his attitudes toward the present reality of
of his illness, and the proposed treatment.

Throughout this study of the patient by the social worker the presence of the illness and the limits it imposes on him are constantly borne in mind, because the "normal" reaction of the physically disabled person to situations and events in his social milieu differs, by reason of the presence of the illness, from the "normal" reactions of the person who is not disabled. Apart from the possibility that social or emotional trauma may result in the onset or exacerbation of an attack of rheumatoid arthritis (and there have been a number of studies which would appear to confirm this hypothesis), undoubtedly the presence of the disease results in many feelings of frustration and conflict about physical or economic dependence and often in attitudes of hopelessness and discouragement. With the above factors in mind the social worker assesses as well as possible the patient's ability to change and his motivation to achieve greater social or economic independence, and the help he will need to accomplish this.

When all members of the treatment team have completed their pre-admission study of the patient, a decision is reached jointly as to his suitability for in-patient care and the private doctor is informed of the decision, following which, if the patient appears to be a suitable candidate, arrangements are made for his admission.
When the patient has been admitted to the medical centre he is started immediately on a regime of treatment suitable to his physical condition. His daily schedule of activities normally includes classes in physiotherapy and occupational therapy, medical examinations, casework interviews and appointments with the nursing department for laboratory work. Ordinarily a patient is occupied with various of the above treatments from early morning until the treatment day ends in the late afternoon. Although this programme demands hard work and persistence on the part of the patient, because of the physical activity required, there is opportunity for social interchange during the day and some recreation facilities are available for the evenings.

**Establishing Treatment Goals:**

Within two or three weeks following admission of the patient, the first of several staff conferences is held in which the various professional people on the treatment team present their findings and observations about the patient’s participation in the programme. By this time the patient has become familiar with his new surroundings and has usually overcome the normal tension and anxiety which surrounds admission to any treatment centre or hospital. It is possible, therefore, at this time for
the staff to evaluate more accurately the patient's probable response to treatment. At this "admission" conference the doctor, who is chairman of the treatment team, describes the patient's disease and the response that has been observed medically. He outlines changes in medication and their probable effect on the patient, and is sometimes able to estimate at this time what the maximum physical improvement is likely to be. The physiotherapist can contribute observations about improvement in the patient's functioning or difficulties he may be encountering, and the occupational therapist is in a position to describe the patient's response to the activity programme and to make suggestions for any special appliances which might help the patient to become more active. The social worker in interviews with the patient has learned more about his attitude to his illness and the effect it has had on his adjustment. Some preliminary knowledge of his psychological defences will have been gained and it is possible for the social worker to estimate more clearly than in the pre-admission assessment the patient's apparent potential for resuming the responsibilities of a productive social and economic life. It is also the responsibility of the social worker to give the conference what information there is about the general availability in the community of such jobs as the patient seems likely
to be able to perform after treatment. For instance, it would be highly unlikely that a man with the full use of only one hand and confined to a wheel chair would be successful in obtaining a job as a telegrapher as these jobs are scarce.

The pooling of professional findings results in the formulation of a prognosis which in terms of total readjustment is referred to as the "treatment goal", that is, the medical, functional, and social findings are combined and a tentative estimate is made by the conference as to what the patient's maximum achievement can be expected to be in regard to his becoming re-established as a productive member of the community.

Though treatment is planned individually to suit each patient and the level of expected functioning may differ widely from patient to patient, two main categories of treatment goal are used by the agency. These are: (1) employability, and (2) improved self-care. These goals are recognized as tentative because of the number of unpredictable factors which are present. Rheumatoid arthritis remains a disease in which it is impossible to predict a total cure. Improved physical function is related both to the disease process and to the patient's wish to improve; and his re-establishment in the community depends on both of the above factors and in addition to this on the resources the community offers.
The meaning, then, of "employability" is that in the opinion of the treatment team the patient is expected to improve to the point where he is able to take work, whether full or part-time, which is within the limits of his intellectual competence, his skill (whether present or to be gained with training) and his physical capacity. There must also be some likelihood of the community's being able to supply such jobs.

"Improved self-care" as a treatment goal is well within the modern concept of rehabilitation which has as its aim the restoration of the disabled to the "full measure of social usefulness of which they are capable". The restoration of a person's ability to manage simple day-to-day activity and to care for his personal needs results in an increased feeling of personal worth which is an essential part of good mental health and improved family relationships.

It is not overlooked by the treatment team that the patient's final readjustment to his disability depends on his accepting realistic treatment goals and his motivation to achieve these goals.

The Treatment Phase:

A treatment period of three months has been established by the CARS treatment staff as a suitable
average length of stay in much the same way as the criteria for admission have evolved; i.e., by observation of the patient's responses and professional consideration of these. Though a tentative three months' stay is usually estimated when payment of treatment costs is being arranged, the length of stay of the patient is not however controlled by this financial arrangement, but is based on decision of the staff in conference according to the patient's needs. Ordinarily a patient is discharged when the treatment staff decides that each of the disciplines has offered the maximum benefit to the patient and that further progress is not likely to be gained by continued in-patient treatment. Any of the professions involved in treatment may request an extension of the originally-planned treatment time and similarly the originally-estimated period may be shortened by staff decision if this is helpful to the patient in his future planning.

At least one and sometimes several formal team conferences are held during the patient's period of treatment. These "interim" conferences are held to assess the patient's progress in relation to the tentative treatment goals so that any areas of difficulty may be discussed by the treatment team and suitable plans made to help him. The original treatment goal is not rigidly adhered to throughout the treatment period if further understanding of the patient medically
or socially, indicates that the original aims of either the patient or the staff were inappropriate. Discharge plans are also made at a conference referred to as the "discharge conference". During the treatment period informal discussions among team members are easily arranged if particular aspects of the patient's medical or social situation require this.

Social work treatment is carried out by professionally trained workers in private interviews with the patient. All patients have opportunity to use casework service during the treatment period, a schedule of interviews being arranged as a regular part of treatment. Some of the problems of patients with which the social worker offers help are in the area of reaction to the illness itself, and the meaning the illness has to the patient. Feelings of frustration and anger which were experienced when the illness first developed may be re-activated when treatment is commenced, and are better recognized and discussed so that the treatment can be effective. The facts of the illness itself may not be fully understood, sometimes because of extreme fear resulting in denial of the seriousness of the illness, with consequent inability on the part of the patient to adapt positively to treatment, or the limits imposed by his disease. The patient may be apprehensive about his future both in relation to possible
further deterioration in his physical condition, and at the same time may be concerned about the renewed responsibility that return to work may bring.

His family may not fully understand his potential and may set goals which are either too high for him or at the other extreme, too low. He may need help when ready to leave the centre with finding employment, housing, retraining for suitable work, temporary public assistance and many other environmental problems. In all of these areas the social worker offers help to the patient, recognizing at the same time, the patient's right to use the degree and kind of help he wishes. In many cases the caseworker uses a combination of the casework processes of environmental modification, psychological support, and clarification. Insight therapy is rarely, if ever, used.

The third area of responsibility of the caseworker on the treatment team is to be adept in the use of resources of the patient's home community, both in relation to economic opportunity and programmes of financial help, and also the resources in the community for recreation; and to enlist the support of the community in helping the patient to avoid the personal isolation that chronic illness may cause.
It is the purpose of this Chapter to consider certain statistical material related to the group of patients and their treatment goals, and from this to outline some of the general socio-economic implications of the illness as it affects this particular group. In the group of twenty-eight patients being considered, "employability" was established as a goal for approximately 75 per cent, and the remaining 25 per cent were expected to achieve "improved self-care". Though the percentages are not significant in themselves, it is appropriate to point out again that the treating of patients for other than vocational re-establishment is of importance in any modern rehabilitation programme.

**Chronological Age:**

The majority of the men were in their forties and fifties, thus confirming the medical data that this is most commonly a disease which occurs in middle age. (Table I) It is not surprising that the goal of improvement in self-care was established more often for men in the upper aged group (50 years and over) than for the younger men. This can reflect the more limited response of the human body to recovery and physical improvement with advancing years. Of the twenty-one men whose potential
goal was established as employability, fifteen were middle-aged or older, eight being in the 40 to 50 age group and seven in the 50 to 60 age group.

It is often considered medically inadvisable for the improved arthritic patient to undertake work which demands physical exertion or prolonged exposure to outdoor weather and therefore many of these men, of whom the majority are middle-aged or older, will, if good response to treatment is obtained, be looking for some type of sheltered or indoor work.

British Columbia is singularly lacking in jobs which can be considered light or sheltered. This is a province where primary industry predominates and where there is still very little manufacturing which in other more highly industrialized areas offers a choice of light work such as that available in the clothing manufacturing firms. The light jobs in British Columbia are such jobs as caretaking, time-keeping, elevator-operating and building maintenance work. Not only are these light jobs scarce, but many of them are lacking in the social satisfactions of group contact with other employees. Office jobs are usually of a sheltered nature, but again these are difficult for the older men to procure. Many of the large employers locally as elsewhere do not hire permanent staff over the age of 45,


TABLE I

CHRONOLOGICAL AGE RELATED TO TREATMENT GOALS

<table>
<thead>
<tr>
<th>AGE</th>
<th>EMPLOYABILITY</th>
<th>IMPROVED SELF-CARE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patients</td>
<td>Achieved Goals Set</td>
<td>Patients</td>
</tr>
<tr>
<td>20 - 30</td>
<td>4</td>
<td>(3)</td>
<td>-</td>
</tr>
<tr>
<td>30 - 40</td>
<td>2</td>
<td>(2)</td>
<td>-</td>
</tr>
<tr>
<td>40 - 50</td>
<td>8</td>
<td>(7)</td>
<td>-</td>
</tr>
<tr>
<td>50 - 60</td>
<td>7</td>
<td>(4)</td>
<td>5</td>
</tr>
<tr>
<td>60 - 70</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>21</td>
<td>(16)</td>
<td>7</td>
</tr>
</tbody>
</table>

The bracketed figures are the totals of those patients who achieved the treatment goals, the total number of those achieving the goal being 20.
because pension plans and other group benefits prohibit this. In these cases the fringe benefits become a barrier to the prospective employee. Other factors, too, influence the employment of the older worker. In spite of the increasing evidence reflected in adult education classes and university extension courses, it is still a common assumption that learning and remembering abilities decline rapidly during the middle age and on into old age. Thorndike's early studies into the relationship of age to learning showed a sharp increase in learning capacity to the age of sixteen with a very slight increase thereafter to the age of thirty, and a gradual decline following this to age forty-five. The important factors were considered to be motivation and previous learning habits. More recent studies have related this apparent decline in learning capacity to motivational factors and have supported the theory that problems related to learning in later life are problems of the individual's personality together with possible structural changes in perception, hearing and vision, rather than a universal change in learning ability related to aging.

It has been explained earlier that to some extent

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the availability of suitable work is considered by the treatment team when establishing treatment goals. This is not however a major factor, as the treatment team considers their responsibility to be to help the patient reach the point where, if community conditions are favourable, the patient will be able to obtain work.

Approximately 72 per cent of the patients achieved the treatment goal which was considered possible by the treatment team. (Table I) Sixteen of the men reached a level functioning and preparedness which made them potentially employable, and four of the men of a group of seven reached a level of improved self-care. This is a high average of successful prognosis when the many variables involved in the assessment and treatment of the patients are remembered.

It is interesting to note that, though the group being studied is small, the men in later middle age, i.e., the men aged 50 to 60 at the time of the treatment, responded less well than other age groups both in respect to reaching goals of employability and also in improving their ability to care for themselves. This does not seem to be directly related to the duration of the illness itself. Of the group of twelve men in the 50 to 60 age group, seven had developed their illness before the age of 45 and the other three later. Though this indicates
that the disease had been present in the majority for over five years, patients in other age groups who responded well to treatment had had the disease for similar lengths of time. Fourteen men of the total group were under 50 years of age. In the cases of all these men the goal of employability was established by the treatment team and only two failed to reach this goal.

The two patients in the 60 to 70 age group responded beyond expectation. These two men were aged 68 and 69 at the time of admission and the goal in each case was established as improved self-care. One patient is an elderly single man who was a farmer. His increasing disability before treatment seemed to foretell admission to nursing home or hospital though he had been ill for only three years. Following treatment he was able to return to the rural area from which he came and through acquaintances was able to obtain light work to supplement his old age pension. The other man in this older age group had had rheumatoid arthritis for ten years, having developed his illness at the age of 60. Following treatment he again became active in his profession of music and though he did not become self-supporting, his wife being regularly employed and there being no need for this, he had earnings from his work of just under $600. the second year after treatment. More important than the
financial gain in this case was this man's contribution to the community and the satisfactions he regained in resuming an active life.

Duration of Illness:

The duration of the illness is a medical estimate made by the doctor from the history given by the patient, together with the medical examination. It is sometimes difficult to establish accurately the date of the onset of the illness, unless it commences with an acute attack. The wide variation of the duration of illness before treatment and the unpredictability of the likelihood of its being crippling is demonstrated by the number of patients who had the illness for long periods and yet were still at a level of physical functioning which permitted the establishing of employability as a treatment goal. Interesting also is the number of people who had suffered the illness for a number of years who achieved the established goals. Eleven patients had been ill for from six to ten years before treatment and nine of this group achieved the goals set. (Table II)

The fact that private doctors are referring their patients with long-standing illness to the Rehabilitation Service is also indicated by the number of patients in this category who were referred for treatment. This
TABLE II

DURATION OF ILLNESS RELATED TO TREATMENT GOALS

<table>
<thead>
<tr>
<th>Illness in Years</th>
<th>EMPLOYABILITY</th>
<th></th>
<th>IMPROVED SELF-CARE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Achieved Goals set</td>
<td>Patients</td>
<td>Achieved Goals Set</td>
<td>Patients</td>
</tr>
<tr>
<td>Under 1 yr.</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 - 2 yrs.</td>
<td>4</td>
<td>3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2 - 3 yrs.</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4 yrs.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>5 yrs.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6 - 10 yrs.</td>
<td>7</td>
<td>7</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>10 yrs. or more</td>
<td>4</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TOTALS:</td>
<td>21</td>
<td>16</td>
<td>7</td>
<td>4</td>
</tr>
</tbody>
</table>
is an indication of the awakened community interest in rheumatic diseases. Before treatment facilities became available in 1951, many of these patients would probably have been considered hopeless. The number of long-term cases may decrease markedly in the next decade when the "backlog" of cases has been assessed and treated as far as possible.

**Occupations:**

In studying the data concerning the usual occupations of the patients it was noted that though the jobs varied to a considerable degree in the responsibilities and skills required to perform them, they were with few exceptions jobs involving physical activity or manual labour. When this fact about the usual employment of the patient is considered in relation to the previous discussion about the average ages of the patients, it can be seen that the patients as a group are middle-aged men who are mainly outdoor workers, many without special skills. It is an established fact that the disabled worker, when trained and properly placed in employment, is able to produce as effectively as the non-disabled (the success of the training of the disabled for work in war industry is well-known.) On the other hand, an unskilled disabled worker who tries to compete in the manual labour market is not
so productive as his associates and is only too aware of this. Employers, however public-spirited and aware of obligation to the older or disabled worker, cannot hire unproductive employees.

Many of the middle-aged or older men who work in the primary industries in this province are men who came to Canada from other countries as young men, often without special skills and frequently with only a scant knowledge of the English language. In British Columbia many entered the labouring field as manual workers. The men who are now middle-aged or older are in many cases the same men who in their most vigorous and productive years found themselves in the grip of the depression of the 1930's and unable because of that to plan or achieve any improvement in their employment status regardless of their potential.

Although there is no lessening in learning potential as people grow older, and the person's potential for growth and change remains, many complex factors influence the acquiring of new skills by the older person, motivation to change rather than ability to change being one of the primary factors. In this group of middle-aged outdoor workers there are many who require new skills if successful rehabilitation is to occur. These are at the same time men who have had many adverse work experiences which may have resulted in attitudes of hopelessness and lack of motivation to make
TABLE III

OCCUPATIONS BEFORE TREATMENT

<table>
<thead>
<tr>
<th>Type of Work</th>
<th>No. of Patients</th>
<th>Employed in year before treatment:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Full-time</td>
</tr>
<tr>
<td>Unskilled</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Low-skilled</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Farmer</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Skilled</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Business</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>TOTAL:</td>
<td>28*</td>
<td>2</td>
</tr>
</tbody>
</table>

* 1 student
- 1 person without stated occupation

Unskilled: labourer, fisherman, miner, logger.
Low-skilled: truck driver, delivery salesman.
Farmer: these five men operated small farms without regular employees.
Skilled: machinist, foreman.
Business: garage operator, musician, small manufacturer.
a further attempt to become established because of previous failures.

**Earnings the Year Before Treatment:**

Of the total group of twenty-eight patients only seven were working either full or part-time in the year before treatment; i.e., twenty-one of the men were economically dependent. Apart altogether from the cost to the patient in loss of wages and probably greater loss in morale, the actual cost in cash outlay by the community is apparent. Most of these men were on public assistance, though one was receiving a pension from the Workmen's Compensation Board for another condition, two were being supported by their wives' regular earnings, one was receiving treatment for another condition in a hospital operated by the Department of Indian Affairs and two other young men were being supported by their parents.

Two men were fully self-supporting in the year before treatment. These were men in their thirties whose disease was of very recent onset. These are the two patients who received treatment closest to the date of the onset of their disease and whose economic independence was least disturbed by their illness. One patient was a delivery salesman, and one a machinist.

Three of the patients with part-time earnings were farmers. One was the single man of 68 who has been
mentioned previously and whose illness had been developing fairly rapidly in the months before treatment. Prior to this he had been able to work and earn a small amount during the earlier part of the year. The two other farmers were married and in each case the earnings were supplemented by part-time employment of the wives, one family requiring additional financial help from public funds.

One other patient in the group with income from part-time earnings was a married fisherman of 50, who had been ill since the age of 44, but who had managed to work when his condition permitted and whose part-time earnings were supplemented by the earnings of teen-age children and periodic social allowance.

One single older man was a labourer whose disease was not far advanced. He was able to work from time to time when employment was available and his condition permitted, and during the remainder of the time received either public assistance or unemployment insurance, depending on the conditions of his unemployment.

Study of the patients two years after treatment showed that ten were working full-time and eight were employed periodically or part-time, as compared with a total of seven employed in the year before treatment. (Table III) At the time of the follow-up study four were employed at unskilled work, three being employed
part-time. All of these men except one had been able to obtain unskilled work of a more sheltered nature than the term unskilled labour usually implies; one, for instance, was working as a helper in a plumbing company whereas previously he had been employed out-of-doors by a railway company. Five were working at low-skilled work, three having obtained caretaking or cleaning work, and one being employed in a shoe-repair shop and the last of this group having returned to his own former job as deliveryman and stockroom clerk. Only one man of a group of five was successfully re-established as full-time farmer. Of the other farmers one regressed physically and emotionally and the three others changed their jobs to more suitable work, two becoming bookkeepers and one obtaining a permanent job on the cleaning staff of a large company. Two men were working as skilled craftsmen at the time of the follow-up study, one as a machinist which had been his former work, and the other as a welder for which work he had trained following treatment. Six men were working at indoor office or professional work; three of these were bookkeepers, two were elderly men who were able to carry on with their former work following treatment and one was a student who became established in his profession following treatment. The actual jobs that the patients
obtained following treatment were indoor light labour, caretaking, cleaning, shoe-repairing, welding, farming, musician, minister, bookkeeper and stock clerk.

**Marital Status:**

Fourteen of the twenty-eight patients were married and maintaining homes at the time of their admission. Approximately one-half of the married group were employed at low-skilled work which was often of a seasonal nature, which implies that there was economic insecurity in these homes though there may have been good and emotionally sound relationships between family members.

The fact that half of the patients were single men points to fairly obvious problems at discharge from the medical centre. Often the patient requires a period of readjustment in the community before taking work, so that he may increase his exercise tolerance. In the medical centre a full daily programme of exercises and activities is carried on as described earlier, but still greater activity and independence is required when the patient undertakes to look after his daily needs in the community. He must be able to shop if he plans to housekeep for himself, to travel to the job and generally to lead a more independent life than is possible in the residential centre. In the transition period between treatment and work he may require financial help from public funds.
which, if prolonged by the unavailability of work after he is physically ready, can result in his becoming discouraged and losing his will to work. The present social allowances payments do not permit single men who must prepare their own meals or eat in restaurants to live in a way which is conducive to an optimistic approach to the future. For a single man who achieves the goal of improved self-care, arrangements must often be made for boarding home or other sheltered care, whereas a married man reaching the same level of improvement can return to his family and participate in the life of the group.

General Assessment:

The foregoing data reveal that as a group the patients conform to the medically accepted fact that rheumatoid arthritis is most likely to develop in middle age. The group being studied can therefore be considered a typical group from a medical point of view in regard to age.

Chronological age influences the social and economic situations, particularly of male patients who must depend on reasonable health in order to carry on most employment and is especially important when the ordinary work of the patient involves vigorous physical activity. Medical research has still to establish whether or not this disease process is related to degenerative bodily changes. However, regardless of the presence
of a disease process advancing years are often responsible for a decline in physical energy and resilience and, therefore, in a group of middle-aged men chronological age must be included as a factor influencing rehabilitation.

The data presented in respect to former occupations of these patients show that with few exceptions the men were outdoor workers and that the majority of them were accustomed to work at jobs involving manual labour. In addition to requiring physical strength, most of the jobs required only such skills as were learned on the job. This is not then a group of men who have equipped themselves with skills or such specialized information as would be learned in formal training schools. Eighteen men became established following treatment, and of these only four undertook formal training.

The men over fifty were less successful than the younger men in achieving the goals considered possible by the rehabilitation team. There may be an as yet unknown medical factor operating here, but there may also be social factors involved related to the patient's past experience and his general life adjustment. The goals set were apparently too high for these men, yet fairly flexible admission and assessment criteria were used.

Another observation from the figures presented is that the duration of the illness before treatment
does not seem to be directly related to the success of rehabilitation. In this rheumatoid arthritis differs from some of the other well documented diseases, such as tuberculosis and cancer, which generally become progressively more difficult to arrest if treatment is delayed. Obviously, medical research into the causes of arthritis will provide answers to some of the questions about the course of this disease, but social and personal factors too may contribute to the varied response of the patients. It might be supposed that a prolonged physically painful disease such as rheumatoid arthritis would result in a gradual withdrawal from physical activity and a lessened receptivity to new ideas, but this is not confirmed by the results of treatment. Some of the men who made the most successful readjustment had been ill for five years and longer.

The value of early treatment is not to be doubted. A number of the early treated patients were able to return to work which they had found reasonably satisfactory without suffering the economic loss of a period of unemployment. Early treatment might have helped the older men if it had been available when they became ill. With only a few exceptions the older middle-aged men developed their illness before the age of 45, apparently, from the experience of other patients, an age when there is greater hope of readjust-
ment. Early treatment relieves the anxiety of the patient in that he is assured that he is receiving the most up-to-date treatments available and the benefits of recent research (he is also relieved of the expense of experimenting with highly advertised so-called cures, of which there are many).

Marital status is a factor in rehabilitation, both in that the patient with a home and family may have certain social and economic security in the family relationships and conversely in that the responsibilities of marriage may be overly heavy for him. The single man must be prepared to be psychologically self-dependent during his period of readjustment, or must find his emotional support in the professional services of an agency.

Chronological age, type of work and marital status are socio-economic factors affecting the rehabilitation of patients with rheumatoid arthritis. The next chapter will present cases and further study into these three aspects of the patient's experience.
CHAPTER IV
THE RESPONSE TO TREATMENT

As stated in Chapter III the follow-up study at the end of two years after the termination of residential treatment showed that of the total group of twenty-eight patients, ten were working full-time and eight were employed periodically or part-time. These figures represent an unmistakable increase in the economic independence of a number of patients. Other patients gained in the personal independence that results from the ability to care for themselves and their daily needs, with accompanying feelings of increased personal worth which enables them to contribute more constructively to family interrelationships. A final group did not improve, or regressed.

In order to study some of the social and economic factors which affect the success of rehabilitation, the patients will be regrouped according to achievement of increase in social and economic independence. It is recognized that vocational re-establishment is not necessarily total rehabilitation. On the other hand, vocational achievement and financial gain is one of the more easily measured aspects of social re-establishment. The patients will therefore be divided into the following groups:

Group A: Those who achieved full-time work.

Group B: Those who achieved part-time work.
Group C: Those who improved their ability to handle self-care.

Group D: Those who did not improve or who regressed.

As far as possible the same areas of socio-economic adjustment as were discussed in Chapter III will be commented on in relation to each group, i.e., chronological age, work, and marriage or family relationship. In the former Chapter it has been explained that the men with few exceptions engaged in outdoor work, and this aspect of their work will not be commented on again unless it is of special significance.

Group A

The Patients Who Achieved Full-Time Work:

The first group of patients to be presented will be considered in two age groups: the men under forty (the younger men), and the men over forty (the older men).

The younger men: Only six of the total group were under forty, the average age of this younger group being twenty-nine. As is not surprising, the majority of the younger men were single. These younger men though differing greatly in the limits imposed by their disease, their past life experience, and their job history and skills, with the exception of one patient who will be discussed later, all became self-supporting within the follow-up period.
The cases studied suggest that, except in the presence of severe personality damage, work is a normal goal for men in the younger age group. These patients either returned to work which was similar to that which they had carried on before, or took training for jobs which were physically more suitable. The common needs of the younger men were, first, early medical treatment, and second, help in attaining the vocational goals which were within their physical limits. Two cases presented below demonstrate the differences in seeming potential of two young men who became self-supporting after treatment. Both patients are of native Indian origin, but the cultural backgrounds differ widely in spite of this superficial similarity.

J. was a 25-year-old man who had grown up in an isolated part of the northern interior of B.C. He had lost touch with his family in his teens and had lived a transient life in logging camps until he was admitted to a hospital for treatment of another condition at the age of 18. From then almost to the time of his admission to the medical centre he remained in hospital where he showed some skill in handwork. He had little formal education and no trade training. There were no relatives interested in him at the time of his admission for treatment of rheumatoid arthritis of the hips. Though this patient had fairly severe crippling following treatment and required a longer than average period in the medical centre, (twenty-three weeks) following discharge and training he was able to obtain work as a shoemaker.

D. was aged 25 and the youngest of several siblings. His family ties were close and there was no financial hardship. He was a single man who was a fisherman until he developed his illness a year before treatment.
He ordinarily worked with his older brothers, each of whom had a responsible position with a large fishing company. He stayed an average length of time in the centre and responded quickly to the service offered, fitting in well with the patient group. While in the centre he decided to become a welder and as this was suitable physically, arrangements were made for him to take training in Vancouver, which he did. He then returned to his home community where he was able to obtain work with the same company which employed his brothers. He has since married and established his own home.

At the time of admission the social assessment of all the men under 40 resulted in the social worker's concurring in setting a goal of employability. Case-work with this group was planned to help the patients accept and achieve this treatment goal. In the case of J., the social worker recognized that the former prolonged hospitalization might have resulted in the establishing of an irreversible pattern of dependency, and that in addition to his serious medical condition this social situation might require longer than usual treatment. In the admission conference therefore the social worker alerted the treatment team to the probability that the patient might take longer than usual to invest himself fully in the treatment programme, which was the case. Subsequent case-work with this young man consisted of enabling him to make use of the community resources and to accept the limitations which his disease imposed.
Case-work treatment during the residential programme based on the social diagnosis is demonstrated in the case of D., whose feelings of rivalry towards his brothers was recognized by the social worker. Though direct discussion of the family relationships was not undertaken because the patient did not request this, his need for a job within his physical limits and yet which carried with it the prestige of a skilled trade resulted in his taking training as a welder. In these cases the caseworker helped the patients by environmental modification and psychological support based on the social diagnosis.

As mentioned at the beginning of this discussion of the younger men, they seem to have a common goal, that is, remunerative employment. Though differing a great deal in length of illness, physical disability and social situation, the cases studied suggest that medical treatment and environmental help based on social diagnosis are the major areas in which the younger men needed help.

The Men Over 40: This is the age group which begins to experience difficulty in job-finding because of the policies of some employers. Men over 40 are also less flexible with regard to changing their type of employment. Certain social and economic factors are common to the group of men who became fully self-supporting after treatment. They are as a group younger than the
men who obtained part-time work, the average age being 46.

**Attitude to Work:** These patients had all had their illness for over five years and in all cases they had persevered in work situations seemingly beyond the point where it seemed physically possible. A frequent remark made by these patients is, "I've fought this thing for years", referring to their disease. It will be remembered that the majority of these patients are outdoor workers. Mr. A., for instance, had worked as a truck driver for a number of years after his illness became severe; Mr. C., who had had rheumatoid arthritis for 15 years, operated a farm with the help of teen-age children until the year before his admission for treatment.

There would appear to be elements of self-directed hostility in the arduous work experience to which some of these patients exposed themselves, in addition to the probability that this excessive persistence in work when ill is a denial of strong unconscious dependency needs.\(^1\)

Regardless of its etiology this excessive drive to continue work was successfully redirected by this group of patients with the help of the treatment team, first towards good persistent use of treatment, and secondly, towards preparing for and obtaining work.

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\(^1\) Dr. A.O. Ludwig, in *Psychogenic Factors in Rheumatoid Arthritis*, comments that arthritis similarly to other chronic illness may fulfill certain unconscious needs, particularly passive dependency.
Family Relationship: This group of men, that is the men over 40 who obtained full-time work, were, with the exception of one man aged 41, married and almost all were supporting wives and teen-age children before their illness, and in some cases for a number of years after the illness began. Though many of the wives of this group worked from time to time, agency records suggest that in all these cases the patients considered themselves to be the breadwinners, although disabled. Agency records do not discuss in detail the quality of the marriage relationships of these men, and in most cases this was not brought up by the patient as an area of concern. Some of the patients undoubtedly found that marriage satisfied normal dependency needs and experienced conflict when illness threatened to force them to greater dependency. Mr. A., for instance, mentioned above, was a 48-year-old man whose wife is described in the records as "a motherly person". This man discussed with the case-worker his fear of permanent crippling and related this directly to anxiety about dependency. This situation was present in varying degrees in other patients in this group. While family life to these men meant the accepting of considerable responsibility, at the same time it provided personal security. These marriages were stable, though the home life was strained by the economic limits created by the patient's loss of income and the illness of a family member.
The two following cases illustrate this combination of stable marriage and seemingly excessive drive to work:

Mr. H. was 39 when his illness began and had been employed for a number of years in a supervisory position in a local construction firm. He and his wife had three children. Though his disease became progressively more severe, he continued to work until the age of 46 when he could scarcely move. The family then applied for Mothers' Allowance. When the children were old enough to be left at home, Mrs. H. obtained a part-time job in a department store and the older boy obtained a paper route to augment the family income. Mr. H. was discouraged by his situation when he entered the treatment centre at the age of 48. After admission the patient very quickly became a leader in the patient group. Mr. H. commenced study for office work while in the centre, and though arrangements were under way for him to take formal training, his former employer offered him a job as bookkeeper before his course began. He still has this job and Mrs. H. has again taken up her duties as a homemaker.

Mr. B. was a fisherman 50 years of age who had come to Canada from one of the Scandinavian countries in the 1920's. Though he had vocational training in the old country in agriculture, after arriving in B.C. he worked as a labourer and miner until he married and established a home. He has five children in their teens, the older two being employed and contributing financially to the home at the time he entered the treatment centre. This patient had been ill for six years before treatment and for a number of years following the onset of his illness he had continued to support his family by fishing whenever his condition permitted. This patient showed great perseverance in carrying out his exercises during the treatment period and used his recreation time in the centre to prepare himself for an office job by studying bookkeeping, at which he showed above-average ability. Though this patient was considered to be an excellent candidate for employment as a bookkeeper, he had great difficulty in finding work because he was 50 years old and it was not
until 18 months after discharge that he was finally able to obtain full-time, adequately paid work.

Both of these men had the educational background necessary for admission to a commercial school. Though good educational background is of importance in planning sheltered work, other patients with lesser education were also able to achieve successful placement. One former farmer was able to obtain permanent work on the maintenance staff of a large company which offered a regular wage and pension plan and did not require special training, though the patient showed considerable aptitude and liking for this type of work.

**Group B**

**The Men Who Obtained Part-Time Work**

Eight men obtained part-time work. The men in this group were older than the men who obtained full-time work, their average age being 56. The difficulty of job-finding becomes more apparent in this group of men. Only four were able to find true part-time work, the others actually working periodically when jobs that they could perform became available.

**Attitude to Work:** A number of men in this group, particularly those who obtained part-time work, showed the same strong motivation to work as the younger group discussed above. For instance, Mr. I, a man of 58, had
had his illness for 20 years before treatment and he was severely disabled at the time of admission. He ordinarily worked as a small manufacturer and following treatment he continued in this same type of work, though in a more limited way. It seems very likely that if Mr. I. had received treatment in his forties his economic gains would have been greater because of his probably more successful physical response to medical treatment.

Three other men in the group who obtained part-time work were unskilled labourers. Two were aged 51 and one aged 47 at the time of treatment. These men did not have the educational background required for vocational school entrance, nor did they feel competent because of past experiences to undertake new work, and they were therefore obliged to seek employment which was not only within their physical limits, but which also did not require trade skills.

**Family Relationships:** Of this group two were married, one was separated from his wife because of her mental illness, and the others were single men. The problems faced by the older, single, unskilled worker are illustrated by the following case:

Mr. C., aged 51, had come to Canada 25 years ago with limited knowledge of English.
He worked in logging camps, as a miner and in unskilled construction. During the depression years he received public relief from time to time, but was able to re-establish himself later. He developed rheumatoid arthritis six years before treatment when he was 45 years of age. Although his physical response to treatment was good and his disease is not too limiting, he had great difficulty in obtaining even periodic work. He was finally able to obtain labouring work of a sheltered nature in a salvage company, but this was in the second year after treatment. Throughout the first year after treatment he experienced many disappointments in searching for jobs and was supported by public assistance funds for which he was eligible on the basis of his partial disability.

Environmental modification, psychological support, and in some cases clarification were used by the social worker to help this group of men, during the treatment period, and in many cases particularly during the period following discharge, if the patient lived in the local area.

**Group C**

The Patients Who Achieved Improved Self-Care

In some cases improved self-care had been established by the treatment team as a goal, and in other cases patients who had been considered by the treatment team to be potentially employable were able only to achieve this level of improvement.
All of the patients for whom this level of achievement had been established as a goal were men over fifty, and therefore the average age of this group is older than any of the previously discussed groups. Those who were originally considered to be likely to obtain employment but whose physical gains were limited to improving ability for self-care were also in the older age group.

Two cases presented below show the far-reaching family benefits which follow improvement in physical health of a family member.

Mr. M. was an older married man who had four married children with whom he and his wife lived in turn. He received a disability pension for another condition and for some years he and his wife lived a fairly satisfying life until he developed rheumatoid arthritis. His condition was severe before admission and he had been confined to bed. Following treatment his condition improved and he and his wife were able to plan a more independent life, relieving the married children of the responsibility of caring for a disabled older person.

Mr. W. was a married man of 58 with two teen-aged daughters. He developed rheumatoid arthritis only three years before treatment but his disease had progressed rapidly to the point where he required his wife's help with all his personal needs. The marriage relationship had become strained, perhaps because of this total dependence of the patient on the help of his wife, and both the young girls were showing reactions to the tense home situation. Although this patient did not gain to the point where he could take part-time work as a caretaker, (in which he had had some experience) he was able after treatment to move about in his house and garden. Though his family continued to receive financial support from public assistance, the tensions in the home have lessened considerably with the patient's improved physical condition.
This second situation demonstrates the liaison function of the case-worker on the treatment team. During the patient's period of treatment the case-worker at CARS maintained close contact with the social worker in the district, informing the district office of the patient's progress and the needs of the family as expressed by the patient, and worked out with the district social worker the discharge plan and follow-up care that was needed both medically and in the area of continued help to the family toward a better adjustment.

Group D

The Patients Who Regressed:

Five patients regressed during and following treatment. This group is too small to do more than indicate trends. However, using the same aspects of social and economic adjustment as were used as guides in discussion in relation to the other men, it was seen that there were certain factors common to this small group.

Attitude to Work: With the exception of one patient, this group did not show the persistence noted in the more successful group in continuing to work in spite of adverse conditions. Rather than drive and persistence, the behaviour of these patients was marked by apathy and inability to discuss work plans realistically. For instance, Mr. V.
was 53 years of age at the time of his admission. He had been ill for ten years and had not worked since his illness began at the age of 43, before which he had been a miner and prospector.

**Family Relationships:** All but one of these patients (a young man of 25) had been or were married though at the time of treatment one was a widower and one separated from his wife. The marriages of these men do not show the same pattern of stability as was seen in the group of men who were more successful. Mr. R., for instance, inferred in discussion that he thought his wife was mentally ill but would take no responsibility for obtaining help for her. Mr. V., referred to above, expressed extreme hostility towards his wife, blaming her lack of interest in his welfare for the seriousness of his condition. Another patient, Mr. Y., developed his illness immediately following his wife's death four years before treatment and did not improve physically during treatment, and though there is no history of instability in this marriage, it is apparent that the patient was unable to function without the support of his wife. Two cases presented below demonstrate the inter-relatedness of personality factors and response to treatment which seems present in this group.

Mr. V. was 53 years of age at the time of admission and had been ill for ten years, not working since his illness began at the age of 43.
He was separated from his wife towards whom he expressed hostility, blaming her for the seriousness of his condition. He showed little response physically to the treatment programme and seemed fearful of leaving the medical centre. Arrangements were made by the social worker for him to enter a boarding home where he had difficulty adjusting because he felt unable to manage the self-care required. During the period in boarding home, surgical treatment was undertaken in an attempt to give him better use of one hand. This required his admission to hospital and again the patient did not wish to leave, saying he liked the hospital better than the boarding home. He was finally placed in a nursing home.

Mr. G. was a young man of 25 who was a recent immigrant to Canada. He had expected to support himself as a professional athlete but had not been able to find such work. He became ill two years after arrival. This patient was unable to accept the unreality of his work goal and projected his difficulties onto the lack of help he received on arrival. He spoke little English but was not able to persist in the language lessons which were arranged for him even though he realized that some knowledge of the language was essential in order to obtain work. He remained in the treatment centre longer than average and finally boarding home care was arranged. His rheumatoid arthritis continued to be unstable and there were periodic flare-ups of the disease which required hospital treatment.

What appears to be the greater than average dependency needs of these patients were recognized by the social worker and though it was recognized that there were many complex personality problems present, attempts were made to find for the patients situations which would enable them to experience some satisfactions so that they would not continue to regress physically. However, with the five men in the group being discussed this was not successful. Psychiatric consultation and treatment appeared to be required.
General Conclusions:

The cases studied confirm the suggestions made in the former Chapter that the re-establishing of the older unskilled worker, mainly in the 50-60 age group, requires the understanding and resolution of many inter-related problems, both in the community where job opportunities and training facilities are lacking, and also in the patients themselves, in the matter of helping them to regain motivation to work and renewed confidence in their ability.

The men under 40, and in this study these men were of an average age of 29, successfully obtained work although their seeming potential for stable independence varied widely. Only one man in this group regressed and he was a man with severe personality damage of probably long standing.

The men over 40 who successfully re-established themselves in full-time work were mainly in the 40-50 age group, were married, and before becoming ill had obtained a reasonable measure of economic security. The family relationships of these men were stable and the patients, although disabled, had not relinquished their positions as breadwinners. These men showed a pattern of working after the disease was well established, in some cases beyond the point where it seemed physically possible for them to do so.

A number of the patients whose disease was far
advanced were able to increase their personal feelings of independence by gaining improvement in ability to look after their daily needs, with the consequence that family inter-relationships were improved because of the lessening of the tension which had been the result of a patient's physical dependence.

The men who regressed did not show the same pattern of stable inter-personal relationships as was shown by the more successful men, and in some cases there was a lengthy history of unstable family relationships. The attitudes of these men in regard to work suggests that their dependency needs were excessive and their inability to invest themselves in treatment raises the question of whether the illness and the care it necessitates did not in itself supply them a means of meeting this extreme need. Some of the men in this group required psychiatric treatment.

The case-worker's role in treatment consisted of environmental modification, psychological support, and in some cases, clarification. The case-worker was active during the diagnostic process and also during the in-patient treatment period. In the cases of patients living in the local area, the older men particularly required prolonged help from the case-worker before finally becoming re-established.
CHAPTER V

FURTHER NEEDS OF THE PATIENTS

It is appropriate to point out again that the group of patients being studied does not represent the total group served by the agency. For instance, women patients and also children are admitted for in-patient treatment and many patients are served through the out-patient programmes both in Vancouver and in various areas of the province. It should be pointed out also that the group being studied were diagnosed as having rheumatoid arthritis and that this is not the only rheumatic disease treated by the agency.

Using economic betterment as a criterion of success it is apparent from the figures presented earlier that the majority of these patients derived benefit from the programme. Before admission for treatment only eight of these men were employed either full- or part-time, and at a period two years after treatment eighteen of them were working. Remembering that the majority of the patients were men over 40 and that also they had been employed as outdoor workers, both unskilled and skilled, this is a high achievement of successful job re-establishment when the problems inherent in the employment situation in British Columbia are remembered.
The men under 50 were as a group more successful in becoming re-established than the men over 50. The younger men in this group, i.e., the men in their twenties and thirties, in spite of varying backgrounds and potential ability, obtained work, and the conclusion that can be drawn from this is that the men in their twenties and thirties accept work as a normal goal, and that with the help of the Rehabilitation Service they can achieve this.

Another pattern that seems well-defined in this successful group of patients is that the married men whose home situations are stable are best able to adapt to the limits imposed by illness, by changing jobs to more suitable employment and in some cases taking the training needed for this. In these families the patients were recognized as breadwinners, although disabled, and although the wives of these men were in some cases working, there is no suggestion in the records that the wives intended to take over the function of the breadwinner. Rather, the pattern is fairly clear that the wives of the men who achieved the best re-adjustment were working only because of economic necessity and that they considered their primary role to be that of homemaker. In a number of these families teen-age children worked during summers and after school, and in one case young employed unmarried children living at home were contributing financially. This group of married men were mainly in
the age group from 40 to 50 and are the men whose illness interrupted an economically productive life. Records suggest that before they became ill they had been providing for themselves and their families the security of adequate income and the benefits which accrue from this.

A number of the men over 50 were single or not maintaining homes. The fact that a number of them were unmarried or separated from their wives suggests the possibility of failure in the area of establishing satisfying interpersonal relationships. The fact that they would be living alone after treatment added considerably to the problems these men faced upon discharge. In addition, a number of these men over 50 were men who had been employed at the unskilled labouring jobs and who had in all probability not experienced in their past lives the satisfaction of achievement in the field of work.

Five of the patients in the study regressed following treatment. In these cases personality difficulties of which the presenting symptom is an appearance of extreme dependency seemed to be inter-related with continued progress of the arthritic process.

A number of men, mainly in the older age group, achieved the goal of "Improved Self-Care" with consequent benefit to their families.
Improved Community Services for Older Men:

The older unskilled worker is the patient who presents the most challenging problem to the rehabilitation service and who, of the male group of patients, requires the most thought and planning for successful rehabilitation.

As stated in Chapter I the Agency uses the established community resources for the follow-up adjustment of the patients. The difficulties that some of these older men had in finding work would suggest certain lacks in the programme of the National Employment Service to which the patients were initially referred for placement. The older man who is discouraged as well as disabled requires the help of skilled personnel in vocational counseling so that the gains that he makes during the treatment, both in increased motivation to work and in physical improvement, are not lost. Also, a special programme of job-finding would be of benefit to this older group of men. Light, seasonal work is not the answer to the employment problems of these patients. What is required is the security of a true part-time job, such as, for instance, regular work as a "handy man" for one or several families, or other part-time, i.e., four hours a day, work such as cleaning or building maintenance work.

This older group of unskilled workers would also
be benefited greatly by short vocational training courses in order to prepare for some types of light work as suggested above, in order to increase both their efficiency and their confidence. Though there are vocational training courses offered locally, both in the technical field and in the commercial field, the aim of these programmes is to prepare the student for full-time work at a recognized trade or profession, and many of the older men in the group studied do not meet the entrance requirements for such schools, nor do they wish to undertake an entirely new type of work.

Some broadening of the social welfare legislation at both the federal and provincial level seems necessary if the needs of the older, partly disabled worker are to be met. The recent Disabled Persons Allowance Act passed by the Federal Government has as an eligibility factor, "Total and Permanent Disability", which medically does not apply to these men. In addition, the psychological effect of a patient's accepting this definition of his illness would undoubtedly result in his complete withdrawal from any attempts to better his situation because of loss of initiative.

Though provincial legislation for public assistance permits the responsible local office considerable latitude in the interpretation of eligibility, it is
still a fact that "inability" to work is one of the requirements; that is, the patient's disability is one of the factors in his situation which provides him with a regular income. The psychological effect of this aspect of eligibility is obvious.

The Federal Unemployment Insurance Programme is set up mainly to care for the employable worker during periods between jobs. There is a time limit beyond which the applicant cannot draw benefits, and though changes in this programme within the past two years provide for the payment of unemployment insurance benefits to a worker during an illness, this also has a time limit and can by no means be considered a secure income.

Further study is required into the possibility of broadening coverage of the Disabled Persons' Allowance Act to fit the needs of the partially disabled. This would of necessity require a flexible, sliding-scale of allowable earnings, related in some realistic way to the economic needs of the patient.

**Improving Agency Services:**

(1) It may be questioned as to why the agency itself does not operate an employment service, as in some cases it was only through activity of the agency that some of the patients were finally able successfully to find
jobs. If the agency operated its own programme of job-finding and placement, this would help immediate problems but would not result in awareness of the magnitude of the problem of an older worker by the agencies already functioning to fill this need, namely, the National Employment Service, and without full knowledge of the magnitude of the problem the proper programmes cannot be instituted. However, better use of the existing resources could be achieved by closer contact with N.E.S. in order to improve service to the patients. This could be arranged both by providing N.E.S. with general information about the work potential of the arthritic patient, and even more directly by including representatives from N.E.S. in the conferences of the treatment team, when individual needs of patients are discussed.

(2) The importance of the pre-admission study of the patient's social situation has been discussed in Chapter II. There is difficulty at the present time in obtaining adequate pre-admission studies and assessments of the patients before admission if the patients are from rural areas. The Provincial Social Welfare Branch, on whom the agency depends for such information, is sometimes, for various reasons, unable to provide the information and assessment needed in order to plan adequately for the patients' best use of treatment. Until recently the Social
Welfare Branch undertook to carry out follow-up service for patients from rural areas, and though the amount of service the Social Welfare Branch gave varied considerably for various reasons, this follow-up service was of great value in the re-establishing of the patient in the community. In recent months the Social Welfare Branch has indicated that it is no longer able to supply follow-up service, except to Social Allowance recipients. Because it is of extreme importance that the patient be helped to make the transition from treatment to work, or home-life, it is suggested that the agency give consideration to increasing the Social Service staff so that direct follow-up casework in rural areas can be carried out by the staff of the agency. At the present time complete follow-up service is available only to patients who are discharged to the greater Vancouver area.

(3) Several of the patients were found following admission to be suffering from severe personality disorders. Psychiatric service is at present not easily available to the agency and would be of great assistance in assessing the patient's potential and providing treatment as required.

It will be recalled that the definition of rehabilitation includes reference to emotional, psychological, social, vocational, economic adjustment and it is suggested
that psychiatric consultation would provide more adequate means of assessing the first two areas of this definition.

(4) Further study is required into the needs of the older men. Their economic and vocational problems are very apparent but other factors which contribute to satisfying social and emotional adjustment in this group are not clear. Lack of motivation to resume former independence seems to be present in some of the patients in the older age group, particularly the men between 50 and 60. Further research into the better use of casework techniques and exploration of other social work methods for helping these men would be of value.

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Certain aspects of the patient's social and economic situations have been studied, but it must be re-emphasized that the success or failure of any rehabilitation programme cannot be measured entirely statistically, nor by observation of outward manifestations of the patient's adjustment. In the final analysis it is the patient himself who chooses his goal and it is the duty of the agency to provide him with opportunities to realize his own maximum potential. This, the agency does.
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