THE EFFECTIVENESS OF CASE WORK TREATMENT IN A TEAM APPROACH

TO REHABILITATION OF RHEUMATOID ARTHRITIS PATIENTS
(RHEUMATIC DISEASES PROJECT, RHEUMATOID ARTHRITIS
SERIES, CANADIAN ARTHRITIS AND RHEUMATISM SOCIETY
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TABLE OF CONTENTS

Chapter 1. A Medical Experiment in the Treatment of Rheumatoid Arthritis

Rheumatoid Arthritis and the mystery of Cortisone. The Rheumatic Diseases Project sponsored by the Canadian Arthritis and Rheumatism Society of British Columbia, a medical experiment. "The patients selected for the Project," general description. Focus of present study.... 1

Chapter 2. The Team Approach to Rehabilitation

The team; The role of the social worker within the team and its limitations. Some theoretical assumptions of casework methods; direct and indirect treatment defined. Methods of evaluation of casework services; Method 1, Some casework criteria of treatability; Criteria indicating direct treatment; Criteria indicating environmental or indirect treatment. Method 2, The rating scale for measuring movement.......................... 13

Chapter 3. Treatability: Some Casework Criteria

Criteria indicating direct treatment, illustrated by the case of Mr. Z. Criteria indicating environmental or indirect treatment illustrated by the case of Mrs. X. Contra-indications for either direct or indirect treatment illustrated by the case of Miss A......................... 29

Chapter 4. An Approach to the Measurement of Movement

The rating scale as a yardstick of movement. Movement defined. Upward movement described in terms of Mr. Z. Downward movement illustrated by the case of Mr. R. No-movement illustrated by the case of Mr. L. The concepts of the rating scale. The patients ability to make constructive use of a casework relationship illustrated by Groups 1, 2 and 3. The effectiveness of direct treatment. The effectiveness of indirect treatment......................................................... 45

Chapter 5. Toward Maximum Helpfulness

The case of Mrs. O, a realistic approach to treatment. Limitations of the treatment role of the social worker. Vocational guidance and the social worker.
Team planning for maximum helpfulness needed. Some general conclusions and suggestions for planned treatment. The case of Mrs. D, a planned approach to treatment and illustrative of realistic social diagnostic evaluation. Planning the reality of the team approach, responsible leadership by the Doctor, sound social diagnostic evaluation, integration of the physiotherapist, conferences, consultative psychiatric services, need for interpretation, preparation of the patient for referrals and planned total treatment.

Appendices:

A. The rating scale for evaluating case work services.

B. Charts in the Text.

Chart 1. Age distribution, marital status and number of children of patients.

Chart 2. Comparative chart of movement, achievement of goals and criteria.

Chart 3. Illustration of movement score, Mr. Z.

Chart 4. Illustration of movement score, Mrs. B.

Chart 5. Illustration of movement score, Miss M.

C. Bibliography.
ABSTRACT

The Canadian Arthritis and Rheumatism Society, British Columbia Division has envisaged research as an important and integral part of its objectives and in February 1951 embarked upon an intensive study of the usefulness of cortisone in long-term medical treatment of the rheumatic diseases, including a series on Rheumatoid Arthritis. A comprehensive program of medical treatment has been put into effect, including the services of social workers. It is essentially a team approach to the aim of physical rehabilitation and a return to gainful employment.

The present study is directed to the evaluation of the case work treatment offered to those patients selected to participate in the Rheumatic Diseases Project, Rheumatoid Arthritis Series on Cortisone Therapy. Within a predominantly medical setting the function of the case worker has been considered from the viewpoint of what is expected of her by the medical profession and what might be expected from her as a professional social worker.

Two methods of assessment were employed both based on evaluation of each case according to selected case work criteria and the premise that effectiveness of treatment depends upon the appropriate use of skills in relation to the degree of treatability of the patient. The first approach made use of the available case records as far as possible. The second was the device of a Rating Scale devised for the purpose and completed by a group of social workers for each patient worked with.

The goals aimed at by the Medical Committee responsible for the project were stated as "physical rehabilitation and a return to gainful employment". Medically the cortisone therapy was successful in effecting enough physical improvement for a patient to become potentially employable. Socially results were discouraging because emotional difficulties and the non-availability of suitable positions prevented the actual return of many patients to gainful employment.

The Long-standing personality problems, characterizing this group of patients, precluded the use of intensive case work techniques in roughly 75% of the cases. The evidence is that face-to-face interviewing involving the skilled use of relationship is not appropriate and that supportive techniques designed to prevent further deterioration, alone are relevant for the majority.

Sound social diagnostic evaluations with the use of appropriate treatment methods are essential. It is suggested
the reality of the team approach should be made available, and that more use should be made of social work skills in the selective screening of applicants for rehabilitation, and that the contributions of social work in the total team plan merits deeper exploration.
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CHAPTER I

A Medical Experiment in the Treatment of Rheumatoid Arthritis:
Rheumatoid Arthritis and the mystery of Cortisone.

The word "rheumatism" refers to the pains and aches of the muscles and joints that result from a good many causes, including a large and miscellaneous group of diseases and disorders of the supporting tissues of the body. Specifically, it accounts for several kinds of arthritis, rheumatoid, osteoarthritis, arthritis due to injury and infections, gout, rheumatic fever, and rheumatic diseases of the tissues other than the joints. Two types of arthritis, rheumatoid and osteoarthritis (a joint disease due to the wear and tear of old age) account for about seventy per cent of all cases of rheumatic disease.⁴

From an economic aspect, rheumatoid arthritis is the most serious of the arthritides in that this disease is most prevalent in the younger age groups when productivity and life expectancy are at the highest level. There are indeed grave social implications in terms of economic and human wastage in the fact that eighty per cent of all patients are between the ages of twenty-five to fifty years, with the peak at thirty-five to forty years. It should indeed be a matter of concern to the community at large that three times as many

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¹ Primer on the Rheumatic Diseases, prepared by a Committee of the American Rheumatism Association, 1950.
patients come from families with incomes under $1,000, as among families with incomes of $3,000 or more. It is a disease which continues for months or many years and, unless early medical treatment is instituted, crippling and deformity result, with the patient becoming bedridden or confined to a chair.

No single factor has been found which can adequately account for the production of rheumatoid arthritis. Many theories of causation have been proposed but none has withstood critical evaluation. There is, however, fairly general agreement among authorities on the disease as to certain predisposing or precipitating factors. Among these may be mentioned physical and emotional shock the latter probably more frequent and exposure to dampness, rain or cold. Weiss has commented that "there is good reason to believe that a significant relationship exists between life stress and the disease of arthritis with environmental stress, especially poverty, grief and family worry being more than a chance factor in the onset and exacerbations of rheumatoid arthritis". Constitutional or hereditary influences, while not well understood, seem to have a bearing in the genesis of rheumatoid arthritis as well as unfavorable social factors such as

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2 Primer on the Rheumatic Diseases, prepared by a Committee of the American Rheumatism Association, 1950.

3, 4 Weiss, Edward and English, O.S., Psychosomatic Medicine, Saunders, 1943.
poverty, overcrowding in the home and poor housing conditions.

Because there is a convergence of many influences in the genesis of the disease, there is no "specific" which can be alone relied upon, whether it be vaccine, diet, drug or physiotherapeutic agent, to effect a cure. Successful treatment can be carried out only through the co-operative effort of patient, physician, nurse, social worker and physiotherapist. The outcome is determined, however, to a great extent by the adequacy of treatment during the early stages of the disease. It depends on the doctor's knowledge and whether doctor and patient will submit to the requirements of logical therapy, or whether they will angle constantly for some quick "sure-cure". The rigorous discipline imposed by rheumatoid arthritis must be accepted, and the patient must have the desire and the will to get well. He must guard against tension lest he wear himself out, and much depends upon his ability to accept help in the complexities of his emotional life.

It has been estimated that one in twenty persons are affected by arthritic diseases and that there is hardly any therapeutic process that has not been utilized in their treatment. The discovery in the United States, by P.S. Hench and his co-workers in 1949, that cortisone, a steroid hormone secreted by the adrenal cortex, profoundly affected the course

5 Public Affairs Pamphlet #166, Arthritis and the Miracle Drugs, Dominion Government.

6 Hench, P.S. and Others, "Review of American and English Literature of Recent Years", Ninth Rheumatism Review, Medical Association of America.
of rheumatoid arthritis, has stimulated great interest in the study of all forms of arthritis, a study that in the past was not intensive. The main result of cortisone seems to be a relief of pain, swellings and inflammation of the joints, but it is not yet known why and how the hormone works. Freedom from pain usually lasts only so long as the medication is given and frequently side effects are produced.

In Canada research into rheumatoid arthritis and other rheumatic diseases has been emphasized by the Canadian Arthritis and Rheumatism Society. A comprehensive program of education and treatment has been envisaged including as one of its six stated objectives that of research, expressed simply as "assisting in examination of any proposed methods of prevention, treatment or cure".7 The British Columbia Division of the Canadian Arthritis and Rheumatism Society8 has been particularly interested in determining the usefulness of cortisone in the long-term treatment of the rheumatic diseases, and early in the year 1951 allocated funds for such a project, with one section directed to the intensive medical study of rheumatoid arthritis. The present study however is concerned only with one aspect of this project and the effectiveness of the casework services offered to the patients selected for it.

8 In subsequent references to be known as "The Society".
The Rheumatic Diseases Project: Rheumatoid Arthritis Series on Cortisone Therapy. 9

In deference to the fact that public money was being used it was decided by this Society that the patients selected to participate in the experiment would be chosen from two categories. The first was to be persons of low income receiving treatment through outpatient hospital clinics in Vancouver, and the second, those whom it seems possible to rehabilitate and return to useful employment. Rates of income are determined by the regulations governing the policies of hospital outpatients departments, since their facilities are used to provide necessary clinic examinations and medical treatment. To be eligible a patient may not have more than one hundred dollars per month as a single person, one hundred and thirty dollars per month as a married person with one child. The use of a sliding scale allows a maximum income of two hundred and fifty dollars per month including savings and bonds up to five hundred dollars. The Society has always emphasized need of treatment rather than ability to pay for it, so that a few patients are accepted directly on the recommendation of private physicians and in these cases slightly higher earnings are permitted.

A Clinical Research Committee (Cortisone and A.C.T.H. Committee) under the leadership of Dr. R.B. Kerr, professor at

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9 In subsequent references to be known as "The Project" or "The Rheumatic Diseases Project".
the School of Medicine of the University of British Columbia with the Medical Director of the Canadian Arthritis and Rheumatism Society in the capacity of secretary of the group was established to supervise the project. It consists of eight doctors who are also members of the British Columbia Medical Association Arthritis Committee and acting in an advisory capacity, it is responsible for the selection of the patients and the general policies with respect to the Rheumatic Diseases Project. Any doctor practicing in British Columbia, whether a private physician or a clinic doctor, may request the inclusion of his patient, but he must submit an application which is reviewed, and a decision made as to the patient's eligibility. For the sake of uniformity in assessing the experiment, a comprehensive set of forms concerning medical diagnosis, treatment and progress reports are maintained and issued to doctors whose patients have been admitted. Duplicate records of medical reports and social case histories are filed at the Canadian Arthritis and Rheumatism Society, British Columbia Division, offices in the interests of data for medical research.

Regular clinics are held by the doctors, and a procedure of frequent examination of patients is maintained with careful follow-up by physiotherapists and social workers. Medical treatment includes physiotherapy, hydrotherapy and the services of an orthopedic nurse provided from the staff of the Society to the hospitals of St. Paul's and the Van-
cooper General who allow space and equipment for these purposes. Facilities are also available at the Western Society for Rehabilitation for those patients requiring an extensive period of physical rehabilitation in residence, and often includes patients living outside the Greater Vancouver area. Each patient, when admitted to the Project, must sign a statement relieving the Society of responsibility for poor results or side effects produced by this hormone. The medical treatment and its doubtful aspects are carefully explained to him and he makes his own decision as to whether or not he wishes to undertake it. Once he has begun he is expected to continue for a twelve-month period of time, and may enter the experiment at any time on the recommendation of his doctor.

Case work services are considered an integral part of the treatment plan in many cases. In addition to the use of social workers from the Medical Social Service Departments of the hospitals for those attending outpatients clinics, a qualified social worker is employed by the Society to provide this aspect of treatment to those patients receiving care at the Western Society for Rehabilitation. The first patient was admitted to the Project, February 1st, 1951, and by May in the same year there were included a total of thirty-three patients, twenty-eight adults and five children. The adult group consisted of fifteen females and thirteen males whose ages ranged from twenty-three years to sixty-two years.

The evaluation of the casework services offered to
the patients participating in the Rheumatoid Arthritis Series of the project was limited to the study of twenty-three adult cases for the following reasons. Of twenty-eight referrals for casework services, two patients were referred to the Vancouver Family Welfare Bureau for specialized family service, one was assessed as having no problems requiring casework treatment, and two patients so recently entered the project that they could not be evaluated. The five children on the Juvenile Rheumatoid Arthritis Series were not referred for casework services by their doctors.

The Patients selected for the Project:

Chart I, Appendix B illustrates the age distribution, marital status, and average number of children belonging to each patient, as well as the duration of rheumatoid arthritis and the age of each patient at the onset of the disease.

Hard work all their lives as members of large, poverty-stricken families, necessitating their leaving school at an average age of twelve to fourteen years, appears with monotonous regularity among the case histories of this group of twenty-three patients. Before the onset of rheumatoid arthritis, however, they would seem to represent a fairly typical cross-section of the average "working-man" population. Occupations fall, in the case of the men, into the skilled labour group, and include electricians, farmers, an X-ray technician, and a university student. The average education
is grade eight for both men and women. The husbands of the married women fall, too, into the skilled labour group, with the single and widowed women doing domestic and waitress work, with one single woman being a stenographer.

The majority of these patients seem to have been severely dominated by one or other of their parents. They showed a marked desire to please, with a tendency to be overly respectable, and were very socially conscious of the good opinion of others. This very general picture would, of course, indicate a seriously undermined self-esteem which seemed to be well defended by the bright, courageous appearance presented by most of them. On the whole, the twenty-three patients superficially appeared to be an independent group, who had considerable conflict about authority and were resistive to a meaningful casework relationship which would help them change their present patterns of behaviour.

The female group had had rheumatoid arthritis for an average of nine years, with the duration of the disease distributed from three years up to twenty years. The male group averaged 6.9 years, with a range from two years to fifteen years. Since the average age at the onset of the disease would be 32.1 years for the women and 38.1 years for the men, it can readily be seen that the emotional effects of such a crippling and painful disease cannot be underestimated, since it occurred at an age when a man might reasonably be expected to be at his peak of productiveness, and a woman well estab-
lished in a career or marriage.

The precipitating causes of the rheumatoid arthritis condition could not be definitely ascertained from the recorded material on file, but a general survey of the patients receiving treatment seems to indicate early emotional and environmental deprivation having an accumulative effect, in conjunction with severe emotional trauma. In partial substantiation of this statement it may be noted that the two widows involved gave, as the cause of their arthritic condition, the death of their husbands; two of the separated women gave the shock of an unhappy marriage; the widower, the death of his wife and loss of his job; one male separated, the desertion of his wife; and one man his marital problem at home. It might also be pointed out that seven other members of the total group were given help with poor marital relationships, and the remaining patients were suspected of having marital difficulty.

It can readily be seen that the social problems and the medical difficulties of the rheumatoid arthritis patient are a challenge to a program of rehabilitation in view of the dearth of concrete knowledge as to cure and prevention. It is an area full of speculation, particularly in view of the characteristic personality patterns presented by these patients and, above all, one where medical research has long been overdue. The focus of the present study is an evaluation of the present program of case work services offered to those
patients selected to participate in the Rheumatic Diseases Project, essentially a medical experiment. There are encouraging implications in the fact that all available resources and services have been brought together in a combined attack on the medical-social problem of arthritis. There are discouraging aspects in the emphasis in the program upon purely physical rehabilitation to combat a disease which carries with it such serious social and economic implications, and where it is known that the psychosomatic aspects of arthritis cannot be ignored. The evaluation proposes to examine how the social worker is able to function as a professional person, and a member of a therapeutic team in a medical project, which is a major concern of caseworkers in a medical setting. Why she is expected to and does fulfill a certain role is of first importance in assessing the effectiveness of her services. There are indications of profound difficulties for the medical social worker because the nature of her contribution is not fully understood by her team-mates. It is reasonable to assume that what she does as a case-worker in the total approach to the rehabilitation of the patient will influence the future use of her services and her status within the team. The success of casework services must of necessity be determined by the psychosocial problem presented and the use made of available techniques.

In short, the use the patient is able to make of the services offered depends on the diagnostic skill possessed by
the caseworker followed by discriminate use of treatment
techniques. The opportunity to act on this premise must be
permitted if the caseworker is to be effective in the art of
helping people. The team members must recognize the limita­
tions of her profession and she must accept them. There is
good reason to believe that confusions existed within the
Rheumatic Diseases Project with the consequent wastage of
human and material resources. Poorly focussed services are
not only damaging to community understanding and appreciation
of a program but are also prejudicial to social work in the
effort to obtain rightful recognition from other professional
groups. Thus, the major concern of this evaluation is how
problems were met by the social worker and what the results
of casework treatment were within the limitations of this
particular medical setting and those of the profession.
CHAPTER II

The Team Approach to Rehabilitation.

The approach to the treatment of these victims of rheumatoid arthritis is basically team planning with each member of the team having a specific function. The doctor is the head or the director of the team, for he is responsible for the over-all plan of treatment. Under his leadership the physiotherapist, the social worker and any other staff members of hospital or society assisting in the patient's cure, contribute individual skills in the total plan of rehabilitation.

The physiotherapist carries out, much like the nurse, the physical remedial and preventive regimen prescribed by the doctor according to his diagnosis of the patient. Rheumatoid arthritis is a painful, crippling disease, and unless early remedial treatment is begun, serious deformity often results.

The Role of the Social Worker within the Team:

To the social worker, the doctor refers those patients whom he considers emotionally disturbed or to have problems which do not fall within the framework of physical care and yet may be impeding satisfactory progress. It is well known that tension and worry may be responsible for exacerbations of the disease and relief from such often causes remissions of symptoms.

The Rheumatic Diseases Project was primarily thought of as a medical experiment and the social worker, therefore,
has no part in the selection of patients for rehabilitation and does not participate in the conferences held by the Medical Committee for this purpose. It was considered that since every patient would not require case work treatment all admissions for the Rheumatoid Arthritis Series on Cortisone Therapy would not need to be referred. The individual case is referred by the doctor after he has undertaken the experiment, and screening is done at the point the physician recognizes his patient's need of case work treatment. Individual consultations between doctor and social worker are sometimes held, but, the usual procedure is that of a written report from the social worker to the doctor. It is assumed that the physician is responsible for the preparation of his patient for case work treatment. The social worker deals with many medical men since admissions to the project includes those patients recommended by private physicians and those receiving treatment through the outpatient's departments of the two hospitals. Cases are distributed among seven social workers according to the clinic attended and the Canadian Arthritis and Rheumatism Society's social consultant.

The social worker's role, within the setting of the Rheumatic Diseases Project, is governed by each individual doctor's concept of what she does as a member of the team in relationship to his patient. For the purposes of this study, however, her function as a case worker was determined according to accepted basic principles and practices of pro-
fessional social work. With the exception of one worker, who had had considerable experience in the field of medical social work, fifteen cases were carried by social workers who had completed two years of training at the University of British Columbia School of Social Work and six were carried under supervision by four students completing their second year of training. It is not unreasonable to assume that accepted professional case work methods would be followed and could therefore be evaluated according to certain standards of practice.

Preliminary analysis of the case recordings of the twenty-three rheumatoid arthritis patients studied, revealed that the case worker had been assigned one well-defined role. This may briefly be stated as, a provider of concrete services, including assistance in obtaining financial aid, contacts with regard to employment opportunities, obtaining hobby materials and small personal comfort allowances. It became apparent, however, that she had also accepted a second role, that of a dealer in emotional problems, recognizing as a professional person, the psychosocial nature of all problems. It is interesting to note, in this respect, that without exception every referral of the twenty-three cases was made on the basis of concrete services by the doctors, with the social worker recommending continuing treatment for emotional factors where such disturbances were worked with. Study of the social diagnosis of the problems, in terms of the techniques used in their
solution, made it obvious that the case worker was not only concerned with relieving the immediate problem brought to her attention, but where possible, because of the patient's recognition and participation, attempted to modify basic difficulties and complications.

Some Theoretical Assumptions of Casework Methods:

The two major methods of treatment used by the social worker consistently employed in varying degrees and stated according to Gordon Hamilton's definitions were:

1. Environmental manipulation or indirect treatment which includes "All attempts to correct or improve the situation in order to reduce strain and pressure, and all modifications of the living experience to offer opportunities for growth or change; the emphasis is on situational modification. Growth and change may be stimulated through any creative situation as well as through interviewing".  

2. Direct treatment, "a series of interviews carried on with the purpose of inducing or reinforcing attitudes favourable to maintenance of emotional equilibrium, to making constructive decisions, and to growth or change. The term also includes psychological support".

It was recognized at the outset that personality adjustment may be attempted by either method or a combination of both. The requisite conditions for treatment of any type,

however, were that the patient himself wished to change and that he would pursue whatever course of treatment would help him either to change, or to modify his attitudes and behaviour patterns. He had also, to a greater or lesser degree, to accept his responsibility to effect a change. The term treatment, then, was defined according to Gordon Hamilton's definition,\(^2\) "the sum of all activities and services directed towards helping an individual with his problem".

The techniques of case work are determined by the objectives of the case worker, which in turn, are affected by the problem presented by the patient. It was assumed, therefore, that the effectiveness of casework treatment could best be evaluated by the consideration of these components of the case work process in relationship to one another. Inherent in this approach is the concept of treatability. The degree to which the personality organization can be changed and how much modification of attitude and behaviour can be achieved, by working with the relatively healthy part of the patient's ego with respect to his real external situation, are always basic case work questions. Treatment to be effective must be based on a diagnostic evaluation, a professional judgement defined by Gordon Hamilton\(^3\) as "the understanding of the psychosocial problem brought by the client and his functioning with regard to his problem, his capacities and the availability of

outer and inner resources. It is this personality evaluation and characterization which determines treatability, success or failure, constructive and destructive factors in the prognosis of a case".

The accomplishment of the objectives of case work treatment is based on accepted techniques or practices evolving from the use of the case work relationship. This relationship is different from any other human relationship, in that it's purpose is therapeutic. The main characteristic of it is that there must be one in the experience who wishes to be helped - the patient-and one who wishes to help - the case worker.

The case work relationship is made up of acceptance, permissiveness and active support. The patient can be sustained and to a degree stimulated to change by its constructive use, but the extent depends upon the kind and quality of his emotional need and its place in the harmony of the personality. The problem must be defined and an estimate made of the patient's capacity to deal with it in fact. Its structure, etiology and the elements in relationship must be understood. From the outset the case worker must assess the kind and extent of help it is reasonable to offer or expect.

From the assumptions just expounded, two approaches were made to accomplish an evaluation of the effectiveness of the case work services offered to the twenty-three patients on the Rheumatic Diseases Project. Both were based on a diag-
nostic evaluation of each case and the premise that the suc-
cess of treatment depends upon the appropriate use of case
work skills in relation to the degree of treatability of the
patient. These methods are now considered under the heading
of "Methods of Evaluation".

Methods of Evaluation

Method I: Some Case Work Criteria of Treatability.

The first approach was concerned primarily with estab-
lishing the patient's capacity to make constructive use of
the case work relationship. An attempt was made to assess the
balance of destructive and constructive forces in the patient's
experiences, both past and present. The following factors
were taken into account with this objective in view.
(a) Emotional and physical stability in childhood and the
present family unit. (b) Negative and positive health fact-
ors. (c) Long illness. (d) General and special capacities.
(e) Emotional tone of family experiences. (f) Economic and
cultural influences. (g) Satisfactoriness of social exper-
iences. (h) Educational influences. (i) Self insight (in
the sense of understanding of self and problems with the abil-
ity to be responsible and self-critical.)

Because of the inadequacies of recorded detail it
was difficult, in better than half the cases, to obtain any
but the most superficial personality descriptions. An example
of a typical formulation of social diagnosis is the frequently
repeated phrase that "this patient is a rigid, unyielding person who cannot use a case work relationship". Little concrete information was recorded to substantiate such a statement. Early life experiences or histories of these patients were vague and inconclusive permitting little scope for accurate research and creating conjecture as to the precipitating causes of the present onslaught of the disease of rheumatoid arthritis and previous accumulative experiences leading up to it. Little concrete information could be gained from the recording concerning the patients former employers and the community.

Current problems, however, were more thoroughly dealt with by the case workers and for this reason criteria borrowed and adapted from Carl R. Rogers were established to determine not only the level of treatability of the patient but the focus of treatment. The following are the casework criteria selected:

**Criteria Indicating Direct Treatment:**

1. The patient is under enough stress or tension to talk about his problems and to try to find a solution to his conflicts.
2. The patient is able to cope with his situation.
3. There is an opportunity for the patient to express the conflicting tensions which have created his problem in planned contacts with the case worker.

4 Rogers, Carl R., *When is Counselling Indicated*, Counselling and Psychotherapy, Houghton Mifflin Company, 1942, Ch. III.
4. The patient wants help. He consciously recognizes his need for it. It is realized that help can be given without this condition being fulfilled but the likelihood of successful direct treatment is greater if the patient wants help.

5. The patient is reasonably emotionally independent of close family control.

6. The patient is reasonably free from excessive instabilities, particularly of an organic nature.

7. The patient possesses adequate intelligence for coping with his life situation, with an intelligence rating of dull-normal or above.

8. The patient is of suitable age—old enough to deal somewhat independently with life, and young enough to retain some elasticity of adjustment. In terms of chronological age this might mean roughly from ten to sixty years.

Criteria Indicating Environmental or Indirect Treatment:

1. The component factors of the patient's adjustment situation are so adverse that even with changed attitudes and insight, he could not cope with it.

2. The patient is inaccessible to case work in that reasonable opportunity and effort fail to discover any means by which he can express his feelings and problems.

3. Effective environmental treatment is simpler and more efficient than a direct approach.

4. The patient is too young or too old, too dull or too unstable for a direct type of case work treatment.
It was noted throughout the examination of methods of treatment, that while resources and techniques were employed in combination the preponderant emphasis in nineteen of the twenty-three cases was on direct treatment. Only four patients were treated exclusively by indirect methods, two because they had no need of relationship as a corrective experience, and two, because they were considered to have basic personality problems so severe that direct treatment was precluded. It is obvious that every patient does not require direct treatment and that the solution of problems brought to the attention of the case worker. Study of the balance of destructive and constructive forces in the patients experiences indicated that there was an overbalance of destructive factors in the patient's past experiences which would negate emphasis upon direct treatment except on an experimental basis.

Typical case material describing characteristic patients selected for the project and illustrating the criteria employed will be found in Chapter III.

Method 2: The Rating Scale for Measuring Movement. 5

Since process recording was not followed in the majority of the cases, the case worker - patient relationship was often unclear. Frequently it was difficult to learn, except on the basis of conjecture, how and why the problem arose and what was being done about it. It was at this point that

5 Appendix A., The Rating Scale.
The Rating Scale for Evaluating the Effectiveness of Case Work Services offered to Rheumatoid Arthritis Patients was envisaged as a more valid approach to the problems involved in working with the arthritic patient and the evaluation of the success of treatment services being offered. Recognition was made of the fact that lapses in recorded material did not necessarily mean a lack in services. Briefly, the Rating Scale had a dual purpose. It was designed to not only measure the patient's capacity to grow or change within the case work process but also attempted to measure the amount of such movement. As with the criteria previously described it was an effort to establish the ability of the patient to make constructive use of the case work process and on what level of service. This time however, the opinion of the case worker dealing with the patient was used.

The Rating Scale consisted of two sections, and a series of five point scales. Section 1 included the attitudes and reactions of the patient to his physical condition and Section 2 the behaviour patterns of the patient within the case work relationship. The objective was to establish the problem, concrete or basic, the patient's ability to accept help with it, and to obtain the case worker's opinion of the success or failure of her cases. Each individual scale was an attempt to measure the various factors in the patient's personality which made it possible or impossible for him to make

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6 To be known in subsequent references as "The Rating Scale".
effective use of direct treatment - a method based on skilled use of relationship since this case work service was emphasized in nineteen of the twenty-three cases.

The Rating Scale was distributed to the eight different social workers working with the cases to be completed. Three of the workers were master's students from the School of Social Work who carried a total of six cases with the remainder handled by regular staff members attached to St. Paul's Medical Social Service Department, the Vancouver General Hospital Social Service Department, and the Canadian Arthritis and Rheumatism Society. It was explained as fully as possible to each worker completing it and individual discussions were held with those who found difficulty in answering the various sections and assistance given when requested. It might be noted here that the greatest area of difficulty in completing the Rating Scale appeared to be in the Section concerning "Severity of the Problem" and in completing the chart on page 3. Discussion around this problem with the workers indicated that the majority felt that the life experiences of the patients suggested deep-rooted personality difficulties which could not be changed but did not preclude movement in the case in other areas such as improved environmental conditions. The chart was designed to suggest this. A further check was imposed by the correlation of the results of the parts "Degree

7 Appendix A, The Rating Scale, Part 2, Section A.
to Which Treatment Goals were Achieved" and "Degree to Which Casework is responsible for the Movement shown in the Case." In this way the progress of the patient with adjustments other than change in personality patterns was also indicated.

In the analysis of the amount of movement a case may show, factors such as, the over-all amount of effort the worker put into the case and the skill and techniques used were thought to be important in the evaluation of the services offered to the patient. Over-all effort was primarily thought of as the amount of time spent on the case and the number of areas of difficulty treated within a given social diagnosis to create a better adjustment of the patient. Skill was rated on the basis of the diagnosis by the worker of the problem dealt with and the methods or techniques used to reach her goal. It is recognized that this premise may not be valid in terms of accurate measurement of movement, but for the purposes of this study these aspects were considered important as part of the case work process in the success or failure of a case. The workers were also asked to scale their opinions as to the degree to which they felt case work was responsible for the movement shown in the case, in an effort to obtain some indication of whether or not physical improvement, since all the

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9 Ibid, Part 4, p. 4.
10 Ibid, Part 4, p. 4.
patients are on a course of cortisone treatment, may have been a factor in changing patterns of behaviour. Relief from the extreme pain and discomfort of rheumatoid arthritis after long years of almost continual suffering was thought to be a factor in movement which could not be discounted. The relief is sometimes so dramatic that some effort to evaluate this aspect had to be made. The answers to this part were correlated with the section on Health Evaluation taking into account the amount of improvement in the activity of the disease, how the patient followed medical instructions, his attitude to his illness and his desire to recover while undergoing case work services.

The nature of the relationship of the patient with the worker as an element in case work treatability was scaled in terms of the three factors, warmth, dependency and hostility as determinants in the patient's capacity to make use of the case work process. Warmth was considered as the quality of feeling, or feeling tone of the patient toward the case-worker, dependency and hostility as the way or manner the patient makes his decisions and handles his relationships within his given situation. The severity of the problem, the patient's awareness of it and his desire for help with his difficulty

11 Appendix A. The Rating Scale.
14 Ibid.
were considered elements that also entered into the patient's capacity to establish a case work relationship and therefore into the success or failure of the process.

With reference to the scale evaluating the severity of the problem, it may be noted that the problem is constant in many respects. For example, it is possible for a patient to have a severe emotional problem and yet, if he has the ability to form a case work relationship he is often capable of growth or change. Conversely, a superficial problem would show no movement with a limited capacity of relationship, indicating that deeper personality disturbances existed.

Whether such a difficulty would be dealt with by the case worker would depend on the patient's awareness of it and his desire for help. In short, diagnosis based on the patient's ego strengths and level of maturity would suggest the basis of treatability.

The interpretation of the material gathered by the methods described here are of necessity the thinking of the researcher and of course open to question. In an effort to achieve as much objectivity as possible in the evaluation of case work services the worker's ratings of their own cases were combined with the researcher's viewpoint to establish the conclusions finally arrived at. It may be argued that the workers had unconscious motivations in their responses.

and were subjective in the way they answered the questions posed, but this obstacle, if followed to its logical conclusion reaches absurdity. It can not be surmounted in view of the fact that the case work process is based on relationship, which in spite of the professional discipline of the qualified and experienced case worker always contains an element of the subjective.

The methods used to rate relationship and the factors involved in it may be questioned, but since authorities in the case work and research fields are still struggling with the difficulty of finding a valid measuring stick it can only be suggested that the methods of assessment used in this study be considered a reasonable approach to a new and almost unexplored area of social work. In any evaluation some standard of measurement must be postulated against which to draw conclusions, and all that can be stated is that certain inferences may be drawn from a given hypothesis within a prescribed set of circumstances. This is very probably as scientific as social work or any other profession can be at this time. Descriptive case material illustrating the use of The Rating Scale and the concept of movement is contained in Chapter IV. Patients characterized are typical selections from the group participating in the Rheumatic Diseases Project.
CHAPTER III

Treatability: Some Casework Criteria.

Treatability was examined on the basis of selected criteria and results point to the conclusion that treatment based on inadequate diagnostic evaluation does influence the success or failure of a case. Success or failure, in the sense the words are used here, means merely how much a patient was helped to make effective use of services offered to him having regard to his capacity to do so. A simple method of scoring was employed for the purpose of easy calculation. One point was allowed for each of the criteria fulfilled, and a zero score for a condition that could not be met. An inability to achieve a total score made it doubtful if the patient could be treated on that level of case work services. Criteria for direct treatment added up to eight points while indirect treatment totalled only four points. The total results for all the cases studied are summarized in Chart II, Appendix B. It should be noted that the conditions set up as criteria for treatability are merely tentative and do not cover all the conceivable situations which arose. Their purpose was to indicate the primary focus only. It is obvious that in many cases direct and indirect methods would be used in combination, but it was assumed that there would be a preponderant emphasis on one or the other techniques.

1 Rogers, Carl R., "When is Counselling Indicated", Counseling and Psychotherapy, Houghton Mifflin Company, 1942.
Mr. Z, for example, aged twenty-three years, was able to make effective use of indirect and direct treatment with the primary focus on the latter method. He participated in the case work process over a period of ten months with a total of forty planned weekly interviews of approximately one hour's duration each. Previous experiences of Mr. Z revealed that he had always felt rejected by his father, a hard-working, domineering man who drove himself and his family unmercifully to make his business a success. He presented a pattern of a rigid young man with terrific "drive", who deeply resented Mr. Z, Sr., but was unable either to admit his anger or express it, and who had struggled desperately for his father's approval but never received any demonstration of it. His mother controlled him too, but in an over-indulgent way, creating guilt feelings when he did not wish to accede to her demands upon him. His only sister related to him in much the same way as his mother, but he was able to express his resentment toward her more overtly.

His father's sudden death, and the fact that he was unable to reach his bedside before the event, deeply affected Mr. Z, particularly when it was reported to him that his father had called incessantly for him and seemed to want to let him know that he did care. The business his father had owned and in which Mr. Z had worked since the age of sixteen, became his, and he continued the pattern of strenuous labor at hypertensive speed laid down by the deceased. Marriage at the age
of twenty-one years to a dependent, rather frivolous nineteen year old girl who was deeply attached to her mother, and the birth of a baby soon after, continued to pave the way to illness.

Marital friction and interference from relatives on both husband's and wife's sides, (Mr. Z also being unable to break his ties to his mother who disapproved of his choice of a wife) ended in Mrs. Z's desertion while he was away on a trip. Reacting with emotional intensity to this news, Mr. Z drove continuously for several days and nights to reach his home. On arrival he began to feel ill, went to bed and found that he was so stiff and full of pain the next day that he was unable to get up. After a period of hospitalization, Mr. Z was offered case work treatment and accepted it, recognizing that he had a problem, although unaware of the deep-rooted nature of it. This case will now be described in illustration of the use made of criteria to establish the primary focus of treatment.

I. Criteria Indicating Direct Treatment. 2

The Case of Mr. Z.

1. The patient is under enough stress or tension to talk about his problems and to try to find a solution to his conflicts.

It is obvious that Mr. Z no longer had the ability

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2 Rogers, Carl R., "When is Counselling Indicated", Counselling and Psychotherapy, Chapter III, Houghton Mifflin Company, 1942.
to cope with the stress and strain of environmental and emotional pressures. He had undergone two traumatic experiences over a period of two years - the death of his father and the desertion of his wife after considerable friction both with her and her relatives. A controlled person all his life, he was rigid and unable to express his anger having learned to bottle up his resentment for fear of disapproval. His desire to continue his father's pattern of hard work and an exemplary life of stern discipline to obtain the love of his family and social approval, had ended in failure. The only recourse he had to express his inhibited aggression, when work failed, and to fulfill his deep dependency needs, was through psychogenic rheumatoid arthritis.

Mr. Z's anxiety and tension, created by his fear of crippling and being unable to carry on the physical activity he had always been accustomed to, the pain of the loss of his family, particularly his son with whom he indentified, the fear of domination by his mother who began to take over his life due to his illness and dependency upon her and the deterioration of his business, became great enough to enable him to begin to express his feelings about his problems within a healing case work relationship. His desire to continue his business was frustrated because of his physical incapacity and he gradually became aware that he was now unable to drive himself and must cope with his basic problems of maladjustment to achieve his goal of social approval and success.
2. The patient is able to cope with his situation. He has enough strength or capacity to take action to alter his life course and the situation is to some extent changeable. There are alternative satisfactions and alternative ways of dealing with the situation possible.

Mr. Z demonstrated good average ability. Through hard work he had been expanding an already adequate business, had some savings and was providing for his mother and own family on a decent level. He was a stable, rigid young person who had little time for leisure and rarely deviated from his goal of being a successful business man. At twenty-three years he had accomplished a great deal, was respected in his community, had no socially censurable habits and lived on an average social scale. Mr. Z's considerable drive and basic intelligence made it possible for him to alter his goals because of his illness when he recognized that he must. Free financially, since his wife did not demand support and assisted by his sister and mother who were oversolicitous it is true, but nonetheless interested and sympathetic, he had the power within himself and in his environment to cope with the situation and to control it.

3. There is an opportunity for the patient to express the conflicting tensions which have created his problem in planned contacts with the case worker.

Adequate facilities were available for regular weekly interviews which were carried on throughout a ten month
period. A course of treatment was planned with Mr. Z, with contacts directed to treatment of his emotional problems in relation to his marital situation, feelings around his father and mother in combination with specific help with regard to vocational retraining in view of some crippling, necessary intensive physiotherapy and finally job placement.

4. The patient wants help. He consciously recognizes his need for it. It is realized that help can be given without this condition being fulfilled but the likelihood of successful direct treatment is greater if the patient wants help.

Mr. Z wanted to talk about his problems and soon noted during case work contacts that when he discussed problems bothering him that his arthritic symptoms began to subside. Relief of tension with the attendant relaxation made him aware of basic personality problems with which he requested psychiatric help. He gradually became aware of dependency needs which he was expressing through his arthritic symptoms. Within the accepting relationship with the case worker he was enabled to express his resentment against his parents and wife, his fears of deformity and the loss of physical activity. A conscious desire for help at the beginning of case work treatment made it possible for him to follow through the course of treatment planned.

5. The patient is reasonably emotionally independent of close family control.

Spatially Mr. Z was independent of his family dur-
Emotionally he was still dominated by his mother and the carry-over of his father's patterns and deeply hurt by his wife's desertion. He was, however, resentful enough of the whole situation that he was able to express his anger and to make an effort to cope with these problems.

6. The patient is reasonably free from excessive instabilities, particularly of an organic nature.

As was noted previously, Mr. Z was a stable, capable person with a controlled but solid family background and suffered no organic instabilities in the sense of mental aberrations. The disease of rheumatoid arthritis with its pain and possibilities of crippling and inevitable exacerbations and remissions, created a difficult physical pattern, but under cortisone therapy he responded well, gradually learning to control his illness. The disease had not yet become a chronic condition and its duration was of one year at the time case work treatment was offered.

7. The patient possesses adequate intelligence for coping with his life situation, with an intelligence rating of dull-normal or above.

Mr. Z was obviously of good intelligence. He was able to complete his Grade XI at sixteen years in spite of after-school work in his father's business, and was able to complete a technician's course during case work treatment requiring above-average ability.
8. The patient is of suitable age—old enough to deal somewhat independently with life, and young enough to retain some elasticity of adjustment. In terms of chronological age this might mean roughly from ten to sixty years.

Mr. Z was twenty-two years of age when treatment began. With his drive, awareness of his problems and desire for help in accepting change, he was not yet rigid enough to preclude growth in making a better adjustment to his life situation. He was young enough to benefit by further technical training which made future profitable employment possible and to make new adaptations in terms of leisure and social relationships.

Viewed within his framework, it was found that of the twenty-three rheumatoid arthritis patients studied, nine were considered potentially treatable on a direct treatment level. It was noted previously that nineteen patients were given services with emphasis upon direct treatment, which would suggest either an experimental approach or that there was inadequate social diagnosis and evaluation of constructive and destructive forces in the patient's life experience. The latter view is favoured since the ten cases who were untreatable on a direct basis, but given such services, were found to have had life experiences of a crippling emotional nature, particularly with regard to factors\textsuperscript{3} 1, 2, 3, 4, and

\textsuperscript{3} Refer to Chapter II, p. 19, first paragraph.
5 with some doubt of number.

2. Chronologically, all were of suitable age. Emotionally they presented a picture of rigidity and psychological adaptation to the state of being ill.

A further check was imposed upon those cases where indirect or environmental treatment was indicated according to the following criteria illustrated by the case of Mrs. X.

This patient, a woman of forty years, had been ill with rheumatoid arthritis for six years. She was first referred for case work treatment over three years ago by her doctor, who considered that she needed help with a poor family situation which was aggravating her physical condition. Her husband was working at an inadequately paid job after being unemployed for a number of years. A backlog of debt had been built up which he, being a conscientious person, was reducing by small installments. He was resistant to his wife being admitted to hospital for treatment and suffered himself from asthma and ulcers. Mrs. X describes Mr. X as "selfish, demanding and mean". Relationships with her two adult children, living in the home, and two school age, were full of conflict and accentuated by her husband's poor attitude toward her, according to Mrs. X. The patient was also deaf and thought that her family took advantage of this. She had a fear of pregnancy and rejected sexual relations, which further aggravated the marital discord. The social worker had several interviews with Mrs. X at this time, but the case was closed
until she was referred again a year later by her doctor for case work help. Once more she was interviewed several times and the case closed. Mrs. X herself, upset and depressed, came back to the social worker a year later requesting help with her problems, saying that, "Someone had to do something for her—she didn't know what, but she had come to the end of her rope".

II. **Criteria Indicating Environmental or Indirect Treatment**

1. **The component factors of the patient's adjustment situation are so adverse that even with changed attitudes and insight, she could not cope with it.** Destructive experiences in the family or social group or a destructive environment, added to own inadequacies in health, abilities and competencies, make adjustment very unlikely, unless the environmental setting is changed.

Inadequate income, debts which her husband insisted upon paying, two adult children whom she resented, because she was unable to control them, and they did not provide the financial support so needed, two school-agers whom she was unable to manage physically and in terms of discipline, along with poor marital relationships made her environment impossible. Fear of leaving her children in another's care, a severe crippling arthritic condition, made it impossible for her to accept help and yet physically she was unable to manage a house-

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4 Rogers, Carl R., Phd. **Criteria; Adapted from Counselling and Psychotherapy**, Chapter III, "When is Counselling Indicated", "Some Basic Questions", Houghton Mifflin Company, 1942.
2. The patient is inaccessible to casework in that reasonable opportunity and effort fail to discover any means by which he can express his feelings and problems.

Over the three year period Mrs. X was interviewed eighteen times by two social workers. Eight of these interviews were concentrated over the latter six months. Excerpts from the case-record will illustrate this criteria. "While Mrs. X has an understanding between her difficulties at home and her illness, she has no insight into the part she plays in these difficulties. She projects all of the responsibility for these unto her husband and sees herself in a "martyr role." "While Mrs. X seemed to gain considerable release from tension in talking about these things, it is questioned whether she could use a case work relationship constructively. She appears to be a very disturbed person, but quite rigid, with no insight into the need for change in herself. She resisted the idea of regular interviews, perhaps because of this, but is willing to be seen from time to time. "She panics at the suggestion that her husband be seen. In short, Mrs. X did not want help with basic personality problems—she had settled for arthritis.

3. Effective environmental treatment is simpler and more efficient than a direct approach.

Environmental or indirect treatment was made available through the Family Welfare Bureau when Mrs. X went to
the hospital and home-maker service was provided. Necessary dentures were obtained for Mrs. X. Toward the end of the case work services a period of treatment at the Western Rehabilitation Centre was arranged which considerably improved Mrs. X's physical condition and strengthened the family situation.

4. The patient is too young or too old, too dull or too unstable for a direct type of case work treatment.

Mrs. X may not be considered too old at the age of forty, chronologically speaking, but emotionally her problems have been so long outstanding that direct treatment may be considered unfeasible. Psychiatric referral was made during the first year of contact with the social worker but such treatment was unsuccessful. Mrs. X was described as "an immature, dependent person demanding the undivided attention of the worker". Her husband was interviewed and found "capable of functioning quite well in regard to his wife and the home situation if he were supported in doing it". The marriage was considered to be one "of neurotic dependency". Both Mr. and Mrs. X "are basically deprived, immature and thus dependent people". Mrs. X when she did have flare-ups of her arthritic condition "insists that the social worker do something, but will not participate in planning". Mr. X is "hostile and uncooperative," but "when he was helped on the basis of his own needs he became more co-operative".

It becomes obvious throughout the case-record that
Mrs. X prefers to be thought of as a martyr, and says, "Life is so miserable that she doesn't even want to get well." The social worker described the relationship thusly, "Mrs X did not relate to me on anything but a superficial basis. She used me to meet her requests for physical assistance and support through acceptance, reassurance and warmth. She cannot tolerate limits or interpretation". Again the social worker records, "It is very difficult for her (Mrs. X) to accept the worker's relationship with Mr. X and his attempts to co-operate. She prefers to interpret him to the hospital staff as a punishing, depriving person, who is at the root of her illness".

It is apparent that Mr. X's resistance to his wife's receiving hospitalization was overcome very readily in one interview and it is to be regretted that he did not receive the direct treatment he could have accepted through a referral to a separate worker or different agency offering such services. It was noted throughout the case histories of the patients studied that the approach to treatment was predominantly patient-centred and exploration of the family unit for possible strengths seriously neglected.

Six patients of the total group were found to be capable of making effective use of indirect or environmental treatment. In one of these the social diagnosis suggested some doubt that this method would be constructive but an experimental approach was indicated. When it is considered that direct treatment was emphasized in every case it can only
be reiterated that inadequate social diagnosis and evaluation was consistently apparent. The following case is illustrative of those patients with personality disturbances so severe that neither type of casework treatment was effective.

Contra-Indications for either Direct or Indirect Treatment.

Miss A was an obvious example of those patients who were unable to make constructive use of either type of case work treatment but where services should probably be offered when and if requested by them. Seven patients stand within this category, according to the criteria applied. Again direct treatment was emphasized in four cases with three being offered indirect treatment on the level they were able to make use of it.

Miss A, age thirty-eight years, was referred to the case worker by her doctor for vocational guidance and was interviewed ten times over a period of six months. She made major improvement while on cortisone therapy, in spite of breaking physiotherapy regimes through an inability to agree with the physiotherapist. Beginning treatment as an active case of rheumatoid arthritis of ten years duration, she arrived at an arrested stage of the disease at the termination of this study. During the period of time Miss A, unapproachable in the extreme, was offered case work treatment, the case worker was not able to establish any more than a very superficial relationship and to obtain any information which would assist her in helping Miss A with her problem. This
patient was terribly threatened by any invasion of independ-
ence and responded to proffered services and interpretations
of the help the case worker could give her with polite but
firm rejection. She could not, however, express hostility
to the caseworker and having almost completely lost her abil-
ity to function within her environment because of her person-
ality problem, it was impossible for her to make any adapt-
ation which would improve her situation or to take employ-
ment.

It is interesting to note that Miss A is character-
ized as a "rigid, unyielding person with a schizoid person-
ality" who is "aware of her tendency to schizophrenia but
states that she does not wish help with her problem". There
is no doubt that Miss A is untreatable from the viewpoint of
her emotional problems because of her inability to involve
herself in a case work relationship, and to participate in
their solution. Because of her personality problem it is con-
jectural whether or not she will be able to make effective
use of concrete services offered. It could be said that
case work treatment in this case was ineffective since Miss
A was unable to obtain employment and the case worker was
unable to establish rapport, but, in view of the suspected
psychotic reaction which rejects all relationship, supportive
help, if and when she can accept it, is all that can be offer-
ed to this patient.

The over-emphasis upon direct methods of casework
treatment with patients unable to make use of such techniques points to two conclusions. One is that services offered to patients on the Project have been ineffective and the other that those services they are capable of using have not been made available to them. It follows that human and material wastage are the only results of such efforts and that there is an urgent need for sound planning on behalf of the patient and the community.
CHAPTER IV

An Approach to the Measurement of Movement

Perusal of the Rating Scale will make it apparent that a norm was established for each individual scale as a minimum criterion below or above which direct treatment was considered unwarranted unless on an experimental basis.

(A) Movement defined:

Movement was rated from the date of the beginning of case work treatment for each individual patient to the termination of this study May 20, 1952. Movement was defined essentially as change, in the sense of a growth process, either through the utilization of resources or relationship or both. It included improvement or change for the better in the social situation of the patient, physically or emotionally, and the modification of behaviour and attitudes to promote positive, healthful growth of personality. A movement score was conceived as upward movement or change, and downward movement or deterioration during case work treatment. Since rheumatoid arthritis patients present many of the aspects common to a chronic disease condition, (particularly that of weak ego structures) it was recognized that the chronicity of the illness in many cases may be found in the personality of the patient rather than in the environment. Accordingly, consideration was given to the case work aim of preventing

1 Appendix A. "The Rating Scale"
further breakdown or deterioration through environmental and emotional pressures by means of supportive treatment (a supporting of strengths and existing aims without the expectation of change.) Mrs. X and Miss A, described in Chapter III, represent those cases where further deterioration or breakdown was prevented.

It became apparent that such cases may demonstrate a no-movement score and for the purpose of determining the focus of treatment, in this respect, Section B of the rating scale, Parts 1, 2, 8 and 9 were utilized to establish this objective. The example of Mr. L to be elaborated shortly, is illustrative of those cases where no-movement occurred either physical or emotional. It was recognized that a patient may deteriorate or break down during case work treatment thus producing a downward movement score during the process. An effort was made to establish the reasons for deterioration through an analysis of the diagnostic evaluation of the case, in relation to the techniques used in the solution of the problems presented by the patient. It was assumed, in this respect, that the incompetence of the worker may be a factor, as well as the severity of the disturbance presented. The example of Mr. R to be presently described is the one patient who deteriorated under case work treatment and illustrates a downward movement score.

**Upward Movement:**

Mr. Z, previously discussed in Chapter II, demon-
strated the highest upward movement score of the twenty-three patients studied since he was able to make effective use of resources and relationship to change his behaviour patterns and to improve his social situation. He is characterized as presenting a long-standing neurotic pattern of behaviour which eventuated in almost complete personality disorganization and the precipitation of an attack of rheumatoid arthritis through the emotional trauma of his wife's desertion of him at the beginning of case work treatment. At the termination of services Mr. Z had been enabled to obtain suitable employment, his marital relations had improved, he was better able to cope with the domination of his mother and sister, and along with major physical improvement, with regard to disease, he was able to control exacerbations of symptoms. Most important of all, not only had he become aware of his basic conflict but he is able to take the initiative in requesting and accepting help with personality structure through psychiatric assistance. The case work techniques employed were environmental modification, psychological support and clarification indicating a high degree of skill on the part of the worker and a relatively strong ego on the part of Mr. Z.

Downward Movement:

Diagnostic evaluation indicated that Mr. R had long-standing basic problems of a psychoneurotic nature, having been characterized as such and hospitalized because of a psy-
chotic episode several years before case work services were offered to him, while a patient in the Rheumatic Diseases Project.

For many years deeply dependent upon his wife, he was unable to withstand the shock of her death and the loss of his employment occurring almost simultaneously, and deteriorated to irrationality and the beginning of rheumatoid arthritis which soon totally incapacitated him.

Several months of treatment based on environmental and psychological support enabled Mr. R. to make better adjustments to his sons and to begin to cope with his business affairs. This period of upward movement, however, did not continue and again this patient became psychotic, presenting a picture of complete regression physically and emotionally with a slight hold on reality. Examination of the techniques employed in relationship to the problems brought to the attention of the case worker suggested that through the use of interpretation of unconscious material in an effort to produce insight into his difficulties and an awareness of the nature and extent of his feelings, a psychotic reaction was precipitated.

A perusal of the background of Mr. R. reveals a dependent person with a weak ego structure already once diagnosed as psychoneurotic. It is known that the psychotic personality is unable to bear the pain of insight without a long period of ego strengthening, and then only, in a specially
structured relationship, usually in the domain of the clinical psychiatrist. It can only be concluded that the case worker had overstepped the limits which her professional equipment had prescribed for her.

No-Movement:

Mr. L, age forty-one years, is a character disorder verging on the psychopathic who finds in his illness, the answer to his unconscious desire to be dependent due to early childhood deprivations in the affectional area. Mr. L is characterized as a sullen, unrealistic, controlling, completely unresponsive person. He was referred for case work treatment because of his lack of response to medical therapy and his disagreeable personality which made it almost impossible for his Doctor and the Physiotherapist to continue treatment with him. Mr. L was unable to make adequate use either of medical or case work services being totally engrossed in the disease of rheumatoid arthritis. He was unable to form any but the most superficial relationships to either the case-worker, other patients, the doctor or any other members of the staff. This limitation was so pronounced that he was almost totally friendless in the community as well. Narcissistic in the extreme, he talked continuously on the topic of his arthritic condition and resented the medication given other patients for fear there might not be enough left to cure him.

A glance at his past history made it clear that Mr.
L had received so little affection and so few of his early basic needs had been met, that it was necessary for him to seek only satisfaction in himself. The fourth youngest of fourteen children of a poor Welsh fisherman living in a bleak, sparsely populated section of the country, he was early expected to shift for himself. At the age of twelve when he had reached the fourth grade, he was told by his harsh and domineering father, whom he greatly feared, that he was too stupid to continue at school and that he would have to go with him on fishing trips to row the boat. His mother, immersed in caring for her large brood of children, had little time for any of them and she is remembered as a weak, worn-out woman, too tired to care very much how her son was faring.

Mr. L worked for two years in close, but unpleasant contact with his father, who constantly undermined his self-confidence, and finally left home to be employed as a seaman. He was not happy in this work but continued on the boats until his first attack of arthritis made it necessary for him to leave. Soon after he began to recover, he married a woman much older than himself who mothered him as the spoiled boy she considered him to be. Such a marriage might have been the solution to Mr. L's effeminacy needs, since he enjoyed household tasks and his dependency upon his wife's financial support, but unable to relate on a warm enough level to satisfy her maternal need, either through children or himself, estrangement soon took place. Mr. L was unable to cope with any of
his problems and may be considered an inadequate personality. He can only revert to his arthritic condition for he has walled himself off from everyone because he feels that he can count on no one but himself and "what's the use anyway, for no one really cares".

In terms of relationship, he is able to give so little that he cannot be helped with his emotional problems on a direct treatment level and it is doubtful if psychotherapy would benefit him because of his basic inability to establish an enabling relationship. Direct treatment was attempted over a period of seven months with sixteen interviews, including one with his wife. The duration of the disease was six years, suggesting a chronic condition. Mr. L's severe personality problems and rejection of proffered case work services in any area over this length of time would seem to make regular face to face interviews with this patient, as was done in this case, completely unjustifiable. Diagnostic evaluation over several interviews should have indicated the possibilities of treatment and the patient's inherent right to self-determination respected.

Social diagnostic evaluation of Mr. R and Mr. L indicates that these patients are untreatable except on a limited level of concrete environmental modification, if even in this area in the case of Mr. L in terms of case work skills. Both are ineffective cases when the motive for referral by the doctor, that of gainful employment, is considered. Neither
patient had the prerequisites for direct treatment - the capacity for self-help, the wish to change and to improve their situation. These elements in Mr. Z made it possible for him not only to solve reality problems but to move on to help with his basic neurotic conflict. This may be called effective case work, since through a combination of environmental manipulation and direct interviewing treatment, Mr. Z was enabled to change his behaviour and attitudes within his social situation and therefore to function more constructively in all areas.

Authorities on the subject of human behaviour have generally agreed that every so-called normal person or mentally healthy individual, may, if unfavourable pressures are sufficiently numerous and persistent, display symptoms of abnormal or deviate behaviour. There are irreducible basic human needs which may be considered; (1) the need to maintain physical well-being, (2) the need to feel of worth and importance (the need for personal recognition), and (3) the need for security, for the love and affection of one's fellows, and for comfort and safety (a striving to have a warm and satisfying relationship with other people). No one of normal intelligence is able to confine his activities to the fulfillment of only one or two of these needs and maintain an integrated personality. Undue frustration or overbalance of

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these complementary needs produces neurotic, psychosomatic and other symptoms of maladjustment.

Rheumatoid arthritis creates concrete problems for the individual afflicted with it since it is a disease usually of long duration, often creating severe deformity and occurring as it does, generally, at the productive years of life. There is no doubt that such illness, with its real threat of dependency with consequent loss of self-esteem and the inevitable new adjustments that must be made, such as change of employment, often a realignment of familial roles and curtailment of physical and social activity because of the very nature of the disease, superimposes a considerable burden upon the adaptative mechanisms of the personality. Dr. Weiss states that, "emotional stress under such conditions may so deplete the arthritic patient's normal defences that his capacity for adaptation to usual environmental stresses is lost. It is not to be wondered at that, in many advanced crippled cases, there is a chronic psychological adaptation to the state of being crippled."

Medical treatment often includes hospitalization at the onset of the disease for a period of weeks or months and surgical procedures, and physiotherapy is instituted for the prevention of deformity or its correction. It, therefore, becomes important for the patient to establish within himself

3 Weiss, Edward and English, O.S., Psychosomatic Medicine, Saunders, 1943.
emotional adjustment to the requirements imposed by the disease. Being compelled to suffer cannot help but arouse anger but the expression of it may also be the outlet for long-standing grudges that the patient may otherwise have kept to himself. The almost universal stoicism and optimism noted throughout the twenty-three cases studied would suggest a chronic state of inhibited aggression or control of hostile impulses which would indicate a general predisposing personality factor. Emotional factors are expressed through attitudes, behaviour and verbalization, so that it is possible for the case worker to see the patient in his situation, as well as his problem, through these unconscious feelings, needs and drives. The patient gives the meaning which the situation holds for him and this becomes the starting point for treatment.

The Concepts of the Rating Scale:

In order to obtain a more precise description of the patient's reaction to his illness than was available in the case recordings, Section A, Health Evaluation of the Rating Scale was devised to embrace a series of questions, with an extreme attitude at each end of each scale, for the purpose of arriving at the meaning of illness to each patient and his feelings around it. It was assumed in this regard, that the patient would very likely reveal a pattern of behaviour in re-

4 Appendix A. The Rating Scale.
relationship to his illness similar to that which he adopted in meeting other reality situations or problems. This assumption was substantiated. Since relief from the symptoms of rheumatoid arthritis is often dramatic, due to cortisone therapy, the amount of improvement in the activity of the disease was considered of possible importance as an ally in the strengthening of ego structure with the attendant result of a greater capacity to cope with confronting problems because of a new constellation of events.

Section B, Evaluation of Casework Service, parts 1 and 2, was designed to formulate essentially, the treatability of the patient or client in terms of his capacity to make effective use of the case work relationship. In this respect the patient's ability to relate to people, to make decisions to alter his situation and to express his resentment at his situation enough to want to change or alter it, were all considered factors which made it possible for him to make use of a case work relationship in the solution of his problems. It included basically an evaluation of the strengths and capacities of the personality to accept help and some indication of the resistances to assistance.

To help a patient express his feelings is a test of the case worker's skill in creating an enabling atmosphere.

5 Ibid., page 54
6 Appendix A. "The Rating Scale"
since, it is possible to overcome resistances and to enable the patient to accept help. Skill, however, may be futile if the inner and outer resources of the patient are meagre. Thus, an effort was made to measure the severity of the problem presented and the prognosis for the success of direct treatment insofar as the patient consciously recognized his problem and wanted help with it.\(^7\)

Problems within the skills of the case worker were considered concrete problems requiring practical services, such as, information, job placement and other environmental situations. Also included were those where the patient was aware of personality difficulties creating problems for him, which could be modified through a case work relationship, such as difficulty in obtaining employment because of conflict with authority, marital discord etc., feelings around illness and in relationship to necessary medical regimens. Problems outside the limits of case work techniques were considered those requiring psychotherapy for movement defined as "any interviewing procedure carried out by a psychiatrist".\(^8\) Suspected psychotic reactions were also assumed to require the services of a psychiatrist for movement.

Treatment sometimes may be successful without a

\(^7\) Ibid, Section B, Part 2, Subsection A, B, and C., page 55.

\(^8\) Coleman, Jules V., M.D., "Distinguishing Between Psychotherapy and Casework", Principles and Techniques in Social Casework, Selected Articles, 1940-1950, Family Service Association of America.
conscious desire for help, but, there is much more chance of its success if the patient is under stress, eager for help and able to talk about his problems. Treatment is powerless to deal with problem-creating forces which are not in some way brought into the case work relationship. Basic minima indicating the patient's capacity to make effective use of a case work relationship with regard to direct treatment were established by the researcher, below which, this method was considered inappropriate.

Tabulation of the results of the Rating Scale was done numerically for the purposes of simplification, the total score of both sections yielding the amount of movement for each patient and his capacity to make effective use of direct and indirect methods of case work treatment. The norm at point three on each scale represented a total of thirty-eight points.

The Patient's Ability to make constructive use of a casework relationship: Groups 1, 2 and 3.

The twenty-three patients participating in the Rheumatoid Arthritis Series on Cortisone Therapy, Rheumatic

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9 Appendix A, Section B, Page 2, Subsection 1, A, B, C.

Basic Minima:
A. WARMTH: A relationship warm enough to permit generally relaxed discussion around concrete problems.
B. DEPENDENCY: The patient is comfortable enough with his own dependency needs to be able to share and accept the case worker's participation in making decisions and resolving problems which arise around the provision of concrete service.
C. HOSTILITY: The patient is secure enough that he is free to express hostility overtly when circumstances arise which give him good reason to be angry.
Diseases Project, studied, were divided into three groups according to the severity of the problem presented and the case work relationship established with them for the purposes of treatment at the termination of case work services.

The three divisions were designated as Group 1, those patients having a "good relationship---generally relaxed discussion around illness and service," whose problems were rated by the case worker as "rooted in defense mechanisms but capable of change with intensive (direct treatment) case work relationship"; Group 2, those with a "very close relationship---discusses most problems freely and whose problems were rated as "very deep-rooted, requiring psychotherapy for movement, including suspected psychotic reaction"; Group 3, represented those patients who had a "very superficial relationship" and whose problems were considered "superficial due chiefly to lack of information", and "chiefly reaction to unusual environmental stress".

Considered from the viewpoint of the primary focus of the two methods of treatment employed in the services offered to these groups the following conclusions were arrived at:

The Effectiveness of Direct Treatment:

In nineteen cases direct treatment was emphasized

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10 Refer to Chart II - Comparative Scores of Movement, Achievement of Goals and Criteria - Appendix B.

with the Rating Scale, indicating that only six patients had the capacity to make effective use of this service. It may be noted that, according to criteria of treatability previously outlined, in Chapter III nine patients (including Group 1) fell within this category, although latitude in determining treatability accounted for three doubtful diagnostic evaluations, according to the conditions applied. These patients averaged a total of sixteen interviews over a period of eight months and ranged from two interviews over a period of two months to forty interviews during a ten month period. Considering the small degree of movement achieved, it may well be wondered at, in view of the diagnostic evaluation, why this group of patients was not given a more intensive course of treatment.

More service was given to Group 2 than either Group 1 or Group 3, who averaged thirty interviews over a period of ten months, with a scatter from three interviews to forty-five interviews over a twelve month period.

It is difficult to understand the emphasis upon face-to-face interviewing, direct treatment, with these patients, obviously considered by the case workers beyond their scope of treatment, except on an experimental basis. Movement according to the Rating Scale was so small that it could be barely rated.

Group 3, presented a more realistic approach to treatment aimed at basic change within the personality struct-
ure of the individual patients. This group averaged sixteen interviews over a period of seven months, with a scatter of two interviews over a two month period to forty-two interviews over a twelve month period.

Physical improvement was made in all cases, exclusive of three patients each, in Group 2 and Group 3 respectively. Average ages and duration of the disease of rheumatoid arthritis for each group was as follows:

**Group 1** - ages 23 years to 49 years, included four males and two females. Duration of disease 8 years.

**Group 2** - ages 29 years to 44 years, included five males and two females. Duration of disease 7 years.

**Group 3** - ages 33 years to 49 years, included four males and six females. Duration of disease 9 years.

The long duration of rheumatoid arthritis in each case would suggest a chronic state of illness with all the psychological implications of any chronic condition. Physical improvement seemed to make no appreciable change in the patient's capacity to make effective use of case work services, in spite of the fact, that seventeen patients were physically rehabilitated enough to be employable, eight on a full-time and nine on a part-time basis. Five of these patients were housewives enabled to care for their homes. It is self-evident that these patients had to be redirected to lighter physical and less skilled labor than hitherto performed.

It can only be concluded, therefore, that the sev-
erity of the problems presented by seventeen of the twenty-three patients participating in the Rheumatic Diseases Project, were such that they were unable to make constructive use of a corrective case work relationship. There is no doubt that treatment is powerless to deal with problem-creating forces which are not in some way brought into the casework relationship. It is, indeed, questionable, if the primary focus of the case worker should continue to be direct treatment but rather that her skill and effort should be redirected to a group of patients who have the capacity to make use of such methods.

The Effectiveness of Indirect Treatment:

Included in the indirect method of case work treatment is the goal of rehabilitation as defined by the Clinical Research Committee responsible for the Rheumatic Diseases Project, "physical rehabilitation and gainful employment".

The treatment of case work goals listed on the Rating Scale\(^\text{12}\) fell into five categories, and the number of patients receiving concrete services and help with reality problems were as follows:

1. Job placement and vocational counselling - 9 patients.
2. Help in accepting illness, its limitations and medical treatment - 15 patients.
3. Help in relieving anxiety and tension in relation to illness and fear of financial and personal dependency - 10 patients.
4. Help in the resolution of marital conflict or the family situation or problems - 8 patients.

\(^{12}\)Appendix A. Section B, Part 1, and Section B, Part 2.
5. The development of self-awareness in its relationship to illness and personality difficulties - 3 patients.

As can be seen, this group received help in various combinations of service, with the greatest amount of assistance being given in the first three categories. The percentile average scores according to the degree to which treatment goals were achieved as rated by the case workers were as follows:

1. Job placement and vocational counselling - 29% achievement.
2. Help in the acceptance of illness, its limitations and medical treatment - 57.3% achievement.
3. Help in relieving anxiety and tension in relation to illness and fear of financial and personal dependency - 48% achievement.
4. Help in the resolution of marital conflict or the family situation or problems - 50% achievement.
5. The development of self-awareness in its relationship to illness and personality difficulties - 71.6% achievement.

The degree to which the workers felt that case work was responsible for the upward movement shown in these areas, as averaged, is 22.74%. This would indicate, again, that the severity of the basic emotional problems encountered by the case worker in this group of patients, were such, as to preclude a high rate of change in any area where service was offered. The seven cases indicating a primary focus of direct treatment made the largest gains, in terms of the goals of treatment aimed at by the case worker, averaging 68.1% achievement.
ment of goals, with case work responsibility averaged at 37.8%. Goals 1, 2 and 3 were emphasized by case workers with nine of the patients in this group, with one falling within goals 4 and 5 as well. Ten of the thirteen cases requiring psychotherapy for movement had goals 1, 2 and 3 as the case worker's aim, with two suspected psychotic reactions falling within these goals, indicating the use of social and supportive therapy. One of the latter had goals 4 and 5 as his case worker's aim.

Since no consideration was given by the Clinical Research Committee responsible for the selection of patients for the Rheumatic Diseases Project, to personality factors, as determinants in the level of rehabilitation of each patient, the results of the program, from the viewpoint of gainful employment, are discouraging, in contrast to the physical improvement made. The case worker in her role of vocational guidance assisted five male patients to obtain employment out of a total of thirteen physically able to work. Eight of these men made major physical gains. When it is remembered, however, that diagnostic evaluation demonstrated that sixteen patients were able to make possible use of indirect treatment, with only a possible maximum of nine patients able to make effective use of such services, such results are understandable. Seven of the twenty-three cases were incapable of making effective use of either type of treatment according to the criteria applied.
It can only be concluded, when it is noted that in twelve of the sixteen cases direct treatment was the primary focus, that the role of the case worker as a provider of concrete services has been neglected. This is illustrated by the fact, that of the eight cases where marital problems were listed as a goal of case work treatment, only seven interviews were held with relatives, and in only two cases, were referrals made to other agencies offering family services. Contacts by the case worker with employers or agencies offering specialized employment services were negligible. It is obvious throughout, on one hand that the caseworker has attempted to deal with emotional problems beyond the scope of present social work techniques and neglected the problems she is equipped to work with. This accounts for the general lack of upward movement of the patients on the Rheumatic Diseases Project. On the other hand, it is apparent that emotional difficulties beyond the scope of casework skills have been referred to her by the doctor. The lack of understanding and the awareness of the contribution she has to make by the medical profession and the social worker herself is demonstrated by the ineffectiveness of the case work services offered to the Rheumatoid Arthritis patients on the Project.

Such breakdowns in the team approach to rehabilitation are responsible for the patients inability to make constructive use of those services they are capable of responding to in the majority of cases. Characteristic personality
patterns described have clarified the difficulties of a chronic disease, with all that that term implies, in conjunction with severe emotional problems. There is a real need for the social worker to determine her area of competence on the solid foundation of social diagnostic evaluation if she is to make her services appropriate and effective.
CHAPTER V

Toward Maximum Helpfulness

The patient sets the pace for his rehabilitation and in this study it cannot be emphasized too strongly, that where case work treatment goals were current problems and concrete services, their achievement was relatively high. The case of Mrs. C exemplifies a realistic approach to treatment and the use of indirect methods.

The Case of Mrs. C.

Mrs. C, a young married woman of thirty-six years, with two school-age children, was able to respond to case work treatment when it was offered to her and to take initiative in requesting help with concrete or practical problems, she became aware of, through an enabling relationship. She did not believe in talking about her feelings "for fear people would consider her a bore", had exaggerated feelings of duty and a nagging sense of responsibility. With an acute conscience, she was a controlling person with many nervous mannerisms, so full of tension and anxiety that during interviews she was often on the verge of tears and was extremely guarded in discussion. Her husband, a salesman, was away from home a great part of the time so the total responsibility for her children fell upon her shoulders and she nagged at them consistently, creating within her family an atmosphere of tension and unhappiness.
Vaguely aware, at first, that something was the matter with her attitudes, she was able to move toward an understanding of the emotional factors in her illness and to try to work through her problems.

Mrs. C's first attack of rheumatoid arthritis had occurred at the birth of her second child. She did not wish added responsibility and dependency but felt guilty because of her rejection of this little girl. An aged aunt who had raised her whom she deeply resented, complicated the situation again. The old lady needed care and further emotions of guilt were aroused because Mrs. C did not wish to have her aunt in her home; thus were created more inner tension and a second arthritic attack. Her own unmet needs for dependency had stirred up conflict which had long ago become deep-rooted in defence mechanisms noted in her exaggerated sense of responsibility and extreme control, with illness again a protection.

Her past history illustrates the accumulative effect of many factors eventuating in chronic disease.

Mrs. C was the second child in a family of four and had taken responsibility for her sisters and brothers at an early age. Her father was alcoholic and after considerable marital conflict deserted the family when she was about six years of age. Her mother was bedridden for the last three years of her life, dying when Mrs. C was ten years of age. Thereupon, she was sent to live with the aunt previously mentioned, who was very strict and overworked her considerably. She left
her aunt's home at seventeen years of age, and was employed as a domestic until her marriage.

Supportive therapy enabled Mrs. C to express her hostility towards her Aunt and to accept her feelings around this area. She has been helped to be more comfortable with her dependency needs and to move from relating on a very superficial and well guarded level to a good relationship with the case worker and generally relaxed discussion around illness and service. Treatment has enabled her to be less anxious to the point of giving up some nervous mannerisms, and to make a beginning in the direction of more satisfying adaptations within her environment. Mrs. C's basic personality problems have been untouched, but she is more comfortable within her illness, and because she has the capacity to relate she is able to accept help in other areas of current problems with her children and her finances and to reach for it as her awareness increases. Case work has continued with Mrs. C over a period of twelve months and sixteen interviews. She has made major physical improvement within this time under medical treatment, the duration of the disease being six years.

This case along with the others previously described exemplify patterns of personality which appear typical of the rheumatoid arthritic patient. The need to control, the rigidity of defences and the deep dependency needs which cannot be admitted to consciousness result in an almost compulsive person. The seventeen patients who were listed as requiring
psychotherapy for movement fell between Mr. L's personality characteristics and Mrs. C, again forming the patterns outlined, but in varying degrees. Many did not have the capacity to relate or the desire for help that Mrs. C had and yet were not so extreme in their rejection of people as Mr. L was. It can readily be seen that case work must be a long term, continuing process with these patients, for defences are so well established, and ability to relate so limited that a strong supportive relationship is necessary for even the most superficial upward movement, quite apart from basic change in personality structure. It is doubtful if available casework resources can go beyond assisting the patient to be more comfortable within his illness and the provision of concrete environmental services and help with practical problems.

Limitations of the Treatment Role of the Social Worker:

Limitations are placed upon the treatment role of the case worker by the nature of the mental or psychological dysfunctioning. Psychoses for the most part present an absolute limit, while neurotic maladjustments can be influenced under general criteria such as the severity of the disturbance, the length of its duration and the client's age.¹

It was evident that the younger patients whose personalities were basically healthy showed the greatest capacity to use case work services to make better adaptations, and

¹ Appendix B. Refer to Chart III, Mr. Z; Chart IV, Mrs. B; and Chart V, Miss M.
offered the best possibilities for rehabilitation. Those whose ego structures were weak, such as prepsychotic, psychotic, infantile character structures and severe neurotics, could be protected from undue pressure which could contribute to a breakdown, and were sometimes helped to grow through the experience of more adequate functioning. This, of course, raises the question whether case work treatment should be geared to a program of the prevention of breakdown or to that of dynamic rehabilitation. Both concepts are valid from the viewpoint of social work, but with limited services the necessity for a definite goal with a well defined agency function would seem to be appropriate.

It may not be amiss to stress the point that the largest amount of effort and the greatest number of face to face interviews were concentrated upon those seventeen patients whose basic personality problems were severe enough to require psychotherapy for upward change or movement. It is obvious that supportive therapy, rather than a deeper level of relationship aimed at change in behavior, is the only justifiable process with these cases since it is a limited treatment and designed to maintain present strengths.

The six patients whose problems were severe but who came within the scope of intensive case work may well have benefitted from the use of direct treatment, but it is noted that to less than half was this treatment made available. This group was accorded, on the average,
little better than two interviews per month over a period of seven months. It would seem, therefore, that if selective case work must be practiced, as is indicated, then greater emphasis should be placed on those patients able to use a greater depth of relationship to change behavior than on those whose basic personality problems cannot be modified except by the specialized services of a psychotherapist. This is most glaringly apparent in the total lack of case work treatment offered to the children or their families participating in the Rheumatic Diseases Project, Juvenile Rheumatoid Arthritis Series. The fact that none of them were referred by their doctors would indicate a serious dearth of interpretation by the social worker and of understanding of the emotional complications of illness on the part of the physician.

It cannot be denied that the majority of the twenty-three patients studied fall within the climacteric age group where the instincts might be expected to stimulate a new but last climax and where the ego has less chance to prevail and has difficulty in keeping balance. The generalized picture obtained from recording on file would lead one to believe that the current distress has its roots in long-standing maladjustments, not just in present reality pressures. This in turn suggests that the Rheumatic Diseases Project patients are poor prospects for rehabilitation in any sense but the physical.

The problem of case work is some personal or environmental unsettlement, and its aim a new settlement. From this
viewpoint only six patients of the twenty-three were able to make a new settlement, while the remaining seventeen patients have yielded to unsurmountable barriers to the realization of their desires.

Vocational Guidance and the Social Worker:

"Return to useful employment" was part of the social thinking of the Clinical Research Committee who envisioned the Cortisone experiment with rheumatoid arthritis patients selected from the low-income brackets. Job placement or vocational counselling was considered the case worker's function, and it may be noted in this respect that all those who were medically fit to work, either full time or part time, including eight men and two women, were referred to the social worker on this basis. Of the eight men, four were able to work part time with jobs available for two of them; and four were able to work full time, with jobs available for two. The two women both had employment, and since the remaining eight women were housewives with families they would not be taking gainful employment in any case. Five of these were able to do their housework part time, while three women had improved enough to do it full time.

It should be stated at this point that vocational guidance of the rheumatoid arthritis patient is a particular problem for the social worker because of the deformities suffered by the majority of them which requires redirection into lighter employment, with few resources available for retrain-
ing in the community. The social worker is, consequently, dependent upon the individual employer for job placement, and he usually sees his prospective employee in terms of dollars and cents and whether or not it is profitable to employ a handicapped person. The social worker must also take into account the disease itself, which imposes limitations in planning for the patients who are often subject to remissions of symptoms while on cortisone and exacerbations when off medication, which may mean they are not ready for employment at the time the job is available for them. Thus she must wait to be certain of the physical improvement before she begins to find a suitable placement for the patient. The age factor also enters into the total picture; since most of the patients in the male group are between forty-one and forty-nine years and have been totally unemployed over a period of several years. Only those few employers who have types of business where an older, partially disabled man can be satisfactorily fitted in, will consider them.

Competition, with the preference given in most industries to the handicapped Second World War veteran, also, makes vocational placement more difficult for the social worker. Emphasis has been placed upon the use of the resources of the Special Placement Division of the National Employment Service by the Society, which would seem to be a sound method of coping with the problem. Even so, the employment of five men and two women out of a total of thirteen employables, in view
of the added efforts of the social worker, is a matter of concern. Sheltered workshops geared to vocational training may well be the answer in this respect, in combination with pressure exerted upon governmental departments and industry.

Expansion of the program to include case work services to children with rheumatoid arthritis and their families, taking into consideration their potential employability and the prevention of human wastage, may well be one step toward easing this situation in the future.

It is obvious that the emphasis of the program has been to "get the arthritic patient back to work". There is a pressing need for a dynamic philosophy of rehabilitation in the sense of Kenneth Hamilton's definition which includes gainful employment. The ultimate aim of rehabilitation should be, "the restoration of the handicapped (individual) to the fullest physical, mental, social, vocational and economic usefulness of which they are capable."²

It might be said that six patients of the group studied are well on their way to being rehabilitated. The

² Hamilton, Kenneth A., Counselling the Handicapped in the Rehabilitation Process, Chapter 1, A General View, Definition of Terms. "Rehabilitation is creative. It aims to define, develop and utilize the assets of the individual. Its purpose is to restore competitive ability, independence, and self-determination. It seeks to utilize all the available resources, both within the individual and within the community, toward this end." Ronald Press, New York, 1946.

remaining seventeen may have been prevented from further
deterioration through the provision of services and a strong
supportive case work relationship. It therefore becomes ap­
parent that from the aspect of social rehabilitation the Rheum­
atic Diseases Project, has been unsuccessful. From the view­
point of medical research and an experiment in the limitations
of case work treatment with a select group of patients it has
been an unqualified success.

There is no doubt that the prevention of family dis­
ruption and individual breakdown is a social economy, compared
with institutionalization and the placement of children. These
patients are well enough to live in the community and part­
cipate in certain aspects of adequate social functioning.
There is, however, a strong case for a preventive program for
children and young adults, rather than the present concentrat­
ion on the chronic older adult patient.

A concrete philosophy of rehabilitation is necessary,
if the goal is thought of in the total sense, and not merely
from the physical aspect. The decision has to be made as to
whether the program is to be the prevention of social and fam­
ily breakdown in the chronic case, or directed to improved
functioning of the individual patient through changes in basic
personality patterns. Adequate social diagnosis of the prob­
lems presented by the patients should be made before they are
taken on the Project. Such an evaluation would include the
severity of the emotional disturbances, their duration, an
evaluation of ego strengths, the stage of maturity of the patient and his ability to grow through a casework process.

**Team Planning for Maximum Helpfulness: Some General Conclusions:**

Since the social worker is a specialist in this field she should be included, at least in an advisory capacity, on the Clinical Research Committee selecting the rheumatoid arthritis candidates for cortisone therapy. The social worker has a real contribution to make with the chronic patient who has advanced to a stage of rigidity, in both disease process and emotional attitudes, so that the condition has become irreversible. Her understanding of the emotional elements can assist the physician to distinguish these patients from those who are more treatable, and to determine the appropriate level of medical and social treatment.

For patients with neurotic tendencies, the concentration upon physical ills, examinations, frequent clinic visits, may produce greater rather than less disability. A more directly palliative and alleviative type of treatment would often, not only be the most appropriate treatment for such patients, but would also release effort for work with more hopeful cases where treatment must be more limited and to contribute a medical-social perspective to the program of medical care.

These contributions that the social worker is able to make, however, must rest on a firm base of sound practice in individual cases. The social worker must be clear as to
her appropriate scope and focus. Specific conclusions to be drawn from this study are that more emphasis should be placed on social diagnosis, screening out those patients unable to be rehabilitated and concentrating effort upon those who are able to benefit by the program offered. Evaluation of the patient's problem over a period of three to five interviews should indicate the inherent possibilities of the primary focus of treatment where difficulties are apparent. Preliminary survey of the group problems that can be dealt with within the resources available, in combination with individual assessment much on the lines followed in psychiatric screening, would cut down on the numbers taken on the Rheumatic Diseases Project whose maladaptations are untreatable by the case worker.

The Case of Mrs. D. A Planned Approach to Treatment:

An example of realistic diagnostic evaluation may be found in the case of Mrs. D, age thirty-five years, recently referred from an outside point to the Society by her doctor for further medical treatment under the Rheumatoid Arthritis Series. His referral suggested that poor home relationships were contributing to her illness.

Plans were made in conference between the medical director and the social counsellor to have Mrs. D admitted to the Western Rehabilitation Centre for therapy. These were carefully explained to this patient by the Medical Director and the total treatment program was interpreted, not only from the viewpoint of the physical aspects but including in the etiology of
rheumatoid arthritis the effects of stress and worry upon the
course of the disease. The suggestion was made that case work
services were available to assist her in the solution of
problems with which she wished help.

Several interviews with Mrs. D confirmed the tenta­tive diagnosis of the case worker that this patient was full
of anxiety, strongly defensive and reacting negatively to
pressures and heavy responsibilities at home, with four young
children to care for and an ailing husband unable to provide
adequate economic resources for his family. Marital conflict,
overwork at a job beyond her physical strength to assist finan­cially to pay for the home and provide for the children, had
all conspired to break down Mrs. D's health. Over compensation
through a cheerful smiling front, had kept her at work, in
spite of intense suffering. During first contacts with the
case worker she was only able to relate on a superficial lev­el, but demonstrated a capacity to move toward warmth with a
desire for help with concrete problems concerning future plans.
Positive feelings toward her family and a real determination
to get well indicated a fundamentally healthy personality.

Reassessment of the case after three interviews with
clarification of the services case work could offer verified
the fact that Mrs. D could accept and wanted help. In her own
words she expressed herself as follows: "You get too close
to a problem when you are thinking about it yourself. It
helps to have another person's viewpoint and to know what some-
one else thinks. You get thinking you’re about the size of an nickel, and then when you talk it over with someone you get reassured.”

It was apparent that the case worker had focussed on immediate problems and evaluated the ego strengths that Mrs. D had to accomplish their solution. Severe environmental stress along with illness had weakened Mrs. D’s considerable strengths. The case worker, however, using supportive techniques did establish an enabling relationship, which resulted in a positive reaction to total treatment and Mrs. D’s recognition of part of her basic personality problem, an unconscious need to suffer, and self sacrifice expressed simply by her, "I know I've always kept up longer than I should have".

It need not perhaps be pointed out that a well prepared referral for case work services from the Doctor, a team approach, with realistic diagnostic evaluation of social problems has made it possible for Mrs. D to be rehabilitated within her maximum capacity.

**Planning the Reality of the Team Approach:**

Because of limited resources, it is obvious that it is impossible to treat everyone, and a team approach is necessary for the most effective use of the time, effort and skill now utilized. Emphasis upon diagnosis before the patient is taken on the Project, and if this is impossible, then at least, regular conferences with the doctor before the case is referred for case work services is necessary. This would enable the social worker to interpret her role and the functions
she can implement in relation to the problems presented. Evaluation after a period of time, in conjunction with the doctor, would reinforce his understanding of the impact of emotional difficulties as they affect the giving and receiving of casework services, whether they be on a concrete problem level, or with deeper personality difficulties. This of course, would presuppose an awareness on the doctor's part of his role as head of the team, and his willingness to have regular conferences with the social worker to consider the patient as a whole person.

Another great gap in the team approach is found with the physiotherapist, who plays a major role in her relationship to the patient, and should be encouraged to make more imaginative use of her skill in terms of varying monotonous routines through creative use of methods. She sees him regularly and gives him much support in his battle with remedial and preventive regimens. She works closely with the doctor, but with the use of rigid routines may reinforce the patient's already rigid personality patterns which the case worker may be helping him relax as part of her treatment plan. The physiotherapist should be included in the total team planning for she has much to offer in terms of knowledge of the patient's attitude to his illness. Conferences made up of the three members of the staff who are carrying out the program of rehabilitation seem essential to make effective use of the various skills involved.
Apart from regular conferences concerning individual cases within the Vancouver General Hospital, St. Paul's Hospital and the Canadian Arthritis and Rheumatism Society, a pooling of knowledge and experience would be of benefit in periodic meetings of the total groups involved in working with the arthritic patients, including the doctors and all staff members contributing their services to the program. Such meetings would not only stimulate interest, but solutions to common problems could be co-operatively worked out. Individual interpretation to individual doctors and physiotherapists by the social worker is valuable, but there is still a need for concerted action so that all may function to capacity for the benefit of the patient.

It might also be suggested, (in view of the seventeen members of the Rheumatoid Arthritis Series who are unable to make effective use of direct treatment) if it is felt that help with their problems should be included in the program set up by the Society, that the case worker limit her time and effort to social and supportive therapy. The necessary skill to work with these patients might be obtained through the services of a psychiatrist psychoanalytically oriented. Consultative services are valuable, but unless such cases are carried by the social worker under the psychiatrist's regular supervision upward change can be expected to be nebulous. It is recognized that resources in this field are extremely limited, and again the common problem would have to be worked out
through conferences designed toward a solution of such difficulties with the psychiatrist. The ideal situation, of course, would be to have these cases undertaken by a staff psychiatrist, but in lieu of this, cases carried by the social worker under his continuing supervision and consultation would make services more effective. The inclusion of a psychiatrist in an advisory capacity on the Clinical Research Committee selecting candidates for the Rheumatic Diseases Project would facilitate the choice of those able to benefit to the greatest extent in a program of total rehabilitation.

From the caseworker's viewpoint, it is obvious that the burden of interpretation of the needs of the patient to the doctor and the physiotherapist, is hers. With current problems of understaffing and heavy caseloads it is important that she be given the opportunity to be more selective in the cases carried. This implies more skillful diagnostic techniques, and the ability to see the program as a whole rather than from the viewpoint only of the individual patient. With the distribution of patients throughout three separate centres it is necessary to provide some means of getting together for the purpose of making more effective use of casework skills. Regular conferences of all the social workers would assist in this respect, for it is important to share a common philosophy and understanding of what the caseworker has to offer the arthritic patient within the medical setting. The time of a social worker employed for the purpose of co-ordinating efforts
in this direction would be well spent.

It is noteworthy that in only eight cases of the twenty-three studied were relatives, husbands and wives of the patients interviewed, with whom there were a total of thirteen interviews, varying from one to three. It has also been indicated throughout the material analysed that concrete problems and practical services have not been the case worker's major consideration. Since patients indeed have families, it is suggested that the family rather than the single patient should be the unit of focus. More emphasis upon family diagnosis might assist the patient to be more comfortable within his dependency, particularly in view of the marital problems presented by the group. Again this means that the patient must be seen as a whole person in all his human relationships, for support extended to other members of the family unit often leads to healthier family relationships.

It may be assumed, also, that physical improvement does account for superficial upward movement in the ability to accept services, since case work does not take the total credit. Because it is noted that effort has chiefly been directed to services relating to the illness itself and its acceptance, it is obvious that the disease becomes a chronic factor which cannot be ignored in the case work process. The illness imposes certain limitations which must be given priority consideration, and demands from the social worker a function essentially that of enabling the patient to use what the doctor has to offer and
to focus upon effecting change in the environment, as the patient's opportunity to maintain his balance may be either enhanced or seriously limited by the influence of factors within it. The chronic nature of the disease of rheumatoid arthritis and its often long duration with all the implications of reduced ego strengths, feelings of inadequacy and lack of self-esteem which a chronic condition presents, makes it essential that the social workers should consider that they are making a significant contribution to the well-being of the patient through skillful manipulation of the environment, rather than feeling that such services are of lesser importance because they are focussed upon effecting change in the environment.

Understanding the problem of basic adjustment with which the patient is dealing is a responsibility in order that such services, around employment, for example, may bring maximum helpfulness to the patient. The dynamic significance of such environmental services are unquestionable, and need not be relegated to a minor position among the various ways of giving help. Many patients, as has been shown in this study, do need help in mobilizing their inner and outer resources in order to accommodate themselves to the real threat to security which illness brings. Emotional support, although the patient may not consciously be aware of his need for it, to help him maintain his total economy on a basis less costly to himself and others, is indeed a significant contribution of the case worker.
Equally important, however, is a thorough knowledge and use of material resources available. There is a need to hold the patient within the appropriate area in which he and the social worker can fruitfully work together, and if he is unable to make progress there, to realize that the problem is beyond medical social case work.

This again brings in the problem of referral which has already been dealt with, but it should be pointed out that fourteen cases out of twenty-three did not know that they were being referred to the case worker, nor why. The other nine cases had a vague idea that it was in connection with job placement and other practical services. Preparation by the doctor in all but three cases indicated his lack of awareness of the total functioning of the social worker. He sees her role as a vocational counsellor and the provider of concrete services, and there is a necessity for a better understanding of case work treatment on his part. Knowledge of her skills would also be facilitated through round table discussion and a co-ordination of effort on behalf of the patient. It is suggested that a total treatment plan should be worked out for each individual at the point he is considered for the Project with enough flexibility allowed to suit his varying needs as treatment progresses. Revaluation of the plan in regular conferences when needed would be of value.

To recapitulate, it can only be said from the viewpoint of this study of the rheumatoid arthritic patients part-
icipating in the Rheumatic Diseases Project, that the great lack has been the team approach to the problem of their rehabilitation. The social worker has a philosophy and techniques to accomplish this goal, not shared for the most part by the Clinical Research Committee sponsoring the experiment. There is a need for a more clearly focussed program, based on a well-defined goal of rehabilitation, approached through concerted action by staff members. The doctor must assume his full responsibility as head of the team, for the patient is his client, to make most effective use of the services the case worker has to offer as a member of the team. She has demonstrated that she has much to contribute, both from the aspect of concrete services and deeper emotional distress. However, in order to make the most effective use of her treatment skills it is necessary for her to have the co-operation and understanding of the medical profession, to make a co-ordinated effort to give total service to a whole patient. Structuring the program cannot be her complete responsibility within this medical setting, and there must be mutual agreement as to the goal to be achieved and the methods of accomplishment. The team's dilemma as how best to serve the patient, can be resolved by team work. Case workers, however, must accept the philosophy that case work is indeed "the sum of all activities and services directed towards helping an individual with his problem".  

APPENDIX A.
A RATING SCALE FOR EVALUATING THE SUCCESS OF CASE WORK SERVICED OFFERED to RHEUMATOID ARTHRITIS PATIENTS

<table>
<thead>
<tr>
<th>File No.</th>
<th>Sex</th>
<th>Age</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>Age</td>
<td>Sex</td>
<td></td>
</tr>
</tbody>
</table>

A - HEALTH EVALUATION
1. Date of onset of arthritis, or duration of illness
2. Dates of hospitalization, if any, or duration of stay in treatment centre

On scales below, indicate by "X" the status of the patient at beginning of case work service, and by "O" status of the patient at end of case work service. "X/O" means no change.

3. ACTIVITY:

<table>
<thead>
<tr>
<th>Inactive</th>
<th>Arrested</th>
<th>Active</th>
</tr>
</thead>
</table>

4. DEGREE OF INCAPACITY OR HANDICAP: PARTS OF BODY AFFECTED:

(1) Bedridden
(2) Wheel Chair
(3) Able to walk about
(4) Able to work: Full time (Housework or job) Part time
(5) Is there a job available to go to? - Yes No

5. FOLLOWING MEDICAL INSTRUCTIONS:

<table>
<thead>
<tr>
<th>Follows rigidly</th>
<th>Generally follows</th>
<th>Constantly breaks routine</th>
</tr>
</thead>
</table>

6. ATTITUDE TO ILLNESS:

<table>
<thead>
<tr>
<th>Extremely unrealistic (e.g. denies, exaggerates, extreme anxiety or rage)</th>
<th>Moderately realistic (e.g. generally satisfactory in one or two areas)</th>
<th>Quite realistic</th>
</tr>
</thead>
</table>

7. DESIRE TO RECOVER:

<table>
<thead>
<tr>
<th>Determined to recover regardless of difficulties</th>
<th>Some ambivalence generally healthy attitude</th>
<th>Seems determined to kill himself or herself</th>
</tr>
</thead>
</table>

B - EVALUATION OF CASE WORK SERVICE

Number of interviews with patient....................................................
Number of months treated.................................................................
Number of interviews with wife, husband or relatives............................
Date of change of case worker (if any)................................................
1. Nature of relationship with case worker. (Indicate separately for father, mother and social worker) "X" indicates status at beginning of service, "O" indicates status at end of service.

A. WARMTH:

| Very superficial relationship | Good relationship generally relaxed discussion around illness and service | Very close relationship, discusses most problems freely. |

B. DEPENDENCY:

| Leaves all decisions to case worker | Participates in making decisions on flexible basis | Terribly threatened by an invasion of independence. |

C. HOSTILITY:

| No overt expression | Free expression of hostility on realistic basis | Continuous barrage of hostility |

2. In the chart following, you are asked:
   a. to indicate ALL MAJOR problems given casework consideration,
   b. to designate as client, each person with whom the problem was discussed,
   c. to estimate the seriousness of the problem to that particular client,
   d. to evaluate numerically the progress made in the solution of each problem.

A. SEVERITY OF THE PROBLEM:

| Superficial, due chiefly to lack of information | Chiefly reaction to unusual environmental stress | Rooted in defence mechanisms but capable of change with intensive case work relationship |

B. CLIENT'S AWARENESS OF THE PROBLEM:

| Quite aware | Able to face with case work help | Completely unaware even when brought to his or her attention. |

C. DESIRE FOR HELP:

| Takes initiative in asking for help | Able to accept help when it is offered | Quite unable to accept help in any area. |

D. MOVEMENT:

| Client completely immobilized or disorganized by problem | Problem not basically resolved, but under control | Problem completely resolved. |
### AREA OF DIFFICULTY

<table>
<thead>
<tr>
<th>Client</th>
<th>Severity</th>
<th>A From</th>
<th>B To</th>
<th>C From</th>
<th>D To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reaction to illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reaction to limitations of service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship with S. W.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child-parent relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personality disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Please list treatment or case work goals:

2. Check off the technique you used to achieve them (please add if necessary)

#### TECHNIQUES.

1. **Environmental modification**: (modification of physical or social and human environment, modification and modifying attitudes) by DIRECT ACTION.

2. **Psychological support**: (client-worker interview - encouraging client to talk freely and express feelings, relieving anxiety and feelings of guilt, promoting client's confidence in his ability to handle his situation adequately). SUPPORTIVE TREATMENT.

3. **Clarification**: (counselling - helping client to understand himself, his environment and/or people with whom he is associated - intellectual understanding with some emotional content, client becomes aware of his own feelings, desires and attitudes.)

4. **Insight**: (On a therapy level, client relives his current and past emotions; deep level feelings which are not deeply repressed).

3. **DEGREE TO WHICH TREATMENT GOALS WERE ACHIEVED**:

<table>
<thead>
<tr>
<th>/0</th>
<th>/25</th>
<th>/50</th>
<th>/75</th>
<th>/100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not achieved</td>
<td>Partially achieved</td>
<td>Half achieved</td>
<td>Achieved in most areas</td>
<td>Fully Achieved</td>
</tr>
</tbody>
</table>
4. **DEGREE TO WHICH CASE WORK IS RESPONSIBLE FOR THE MOVEMENT SHOWN IN THE CASE:**

<table>
<thead>
<tr>
<th>0</th>
<th>25</th>
<th>50</th>
<th>75</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not responsible</td>
<td>Partially responsible</td>
<td>Half responsible</td>
<td>Mostly responsible</td>
<td>Totally responsible</td>
</tr>
</tbody>
</table>

5. **OVER-ALL AMOUNT OF EFFORT EXPENDED ON THE CASE.**

   (Increasing amounts of effort).

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Slightly more than minimal</td>
<td>Average amount</td>
<td>More than average amount</td>
<td>High or full amount</td>
</tr>
</tbody>
</table>

6. **Difficulty of the client's problem from the technical standpoint of getting success in treatment.** (Increasing difficulty of problem).

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>No difficulty</td>
<td>Slight difficulty</td>
<td>Difficult</td>
<td>Very difficult</td>
<td>Impossible difficulty</td>
</tr>
</tbody>
</table>

7. Is this a case where the change in the client would have occurred without case work BUT casework has increased the rapidity of the change? Yes No ________

8. Has deterioration been prevented without evidence of upward movement? Yes No ________

9. Have services (such as financial), environmental, etc.) been rendered without evidence of movement? Yes No ________

**REFERRAL:** (Please check off).

1. Did the patient know he was being referred for case work treatment? Yes No ________

2. Did the patient know why he was referred for casework service? Yes No ________

3. Who prepared the patient for referral? Doctor Social Worker ________

4. Are cases referred in conference or consultation with the Doctor? Regularly Occasionally Not at all ________

5. Did evaluation of case work treatability come BEFORE or AFTER ________ Referral? ________
APPENDIX B.
<table>
<thead>
<tr>
<th>CHART #1</th>
<th>MALE PATIENTS (13)</th>
<th>FEMALE PATIENTS (10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE DISTRIBUTION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41 TO 49 YRS.</td>
<td>MAJORITY</td>
<td>33 TO 41 YRS.</td>
</tr>
<tr>
<td>9</td>
<td>MARRIED</td>
<td>5</td>
</tr>
<tr>
<td>1</td>
<td>SEPARATED</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>WIDOWED</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>SINGLE</td>
<td>2</td>
</tr>
<tr>
<td>2.2.</td>
<td>AVERAGE NUMBER</td>
<td>3.6</td>
</tr>
<tr>
<td>29 YRS. TO 70 YRS.</td>
<td>AGE RANGE</td>
<td>5 YRS. TO 25 YRS.</td>
</tr>
<tr>
<td>15 YRS. TO PRESCHOOL</td>
<td>AVERAGE AGE</td>
<td>SCHOOL AGE</td>
</tr>
<tr>
<td>6.9 YRS.</td>
<td>AVERAGE DURATION</td>
<td>9 YRS.</td>
</tr>
<tr>
<td>38.1 YRS.</td>
<td>AVERAGE AGE AT ONSET OF DISEASE</td>
<td>32.1 YRS.</td>
</tr>
</tbody>
</table>
Appendix B

Chart II: Comparative Chart: Movement, Achievement of Goals & Criteria

Group 1 (6 Patients)  Group 2 (7 Patients)  Group 3 (10 Patients)

Points of Movement  Achievement of Goals  Points of Movement  Achievement of Goals  Points of Movement  Achievement of Goals


Suspected Psychogenic Arthritis Due to Emotional Trauma, Mr. Z. Aged 23 years

Direct Treatment Indicated as Primary Focus.

<table>
<thead>
<tr>
<th>I Health Evaluation</th>
<th>Beginning of Casework Services</th>
<th>Stipulated End May 20/52</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity of Disease</td>
<td>Active</td>
<td>Arrested</td>
<td>2</td>
</tr>
<tr>
<td>Following Medical Instructions</td>
<td>Follows Rigidly</td>
<td>No change</td>
<td>0</td>
</tr>
<tr>
<td>Attitude to Illness</td>
<td>Moderately realistic</td>
<td>Quite realistic</td>
<td>1</td>
</tr>
<tr>
<td>Desire to Recover</td>
<td>Determined to recover regardless of difficulties</td>
<td>No change</td>
<td>0</td>
</tr>
</tbody>
</table>

II Nature of Relationship with Caseworker

A. Warmth

Superficial relationship | Very close relationship, discusses most problems freely | 4

B. Dependency

Leaves most discussions to caseworker | Participates in making decisions | 2

C. Hostility

No overt expression | Almost free expression on realistic basis | 2

III Severity of the Problem

Rooted in defence mechanisms but capable of change with intensive casework relationship

A. Client's Awareness of Problem

Able to face with casework help | No change | 0

B. Desire for Help

Able to accept help when it is offered | No change | 0

C. Movement

Client almost completely immobilized or disorganized resolved by problem | 2

Number of interviews - 40.
Number of months treated - 10 months.
Duration of illness - 18 months.

15 points
### Neurotic Personality - Mrs. B, Aged 41 years

**Indirect Treatment Indicated as Primary Focus**

<table>
<thead>
<tr>
<th>I Health Evaluation</th>
<th>Beginning of Casework Services</th>
<th>Stipulated End May 20/52</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity of Disease</td>
<td>Active</td>
<td>Minor improvement</td>
<td>1</td>
</tr>
<tr>
<td>Following Medical instructions</td>
<td>Generally follows</td>
<td>No change</td>
<td>0</td>
</tr>
<tr>
<td>Attitude to illness</td>
<td>Moderately realistic</td>
<td>Quite realistic</td>
<td>1</td>
</tr>
<tr>
<td>Desire to Recover</td>
<td>Determined to recover regardless of difficulties</td>
<td>Some ambivalence, generally healthy attitude</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II Nature of Relationship with Caseworker</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Warmth</td>
</tr>
<tr>
<td>B. Dependency</td>
</tr>
<tr>
<td>C. Hostility</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III Severity of the Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Client’s Awareness of Problem</td>
</tr>
<tr>
<td>B. Desire for Help</td>
</tr>
<tr>
<td>C. Movement</td>
</tr>
</tbody>
</table>

**Number of interviews - 18**

**Number of months treated - 7 months**

**Duration of illness - 5 years**
Psychoneurotic, Infantile Personality Structure, Miss M, 37 years. Indirect Treatment Indicated as Primary Focus

### I Health Evaluation

<table>
<thead>
<tr>
<th></th>
<th>Beginning of Casework Services</th>
<th>Stipulated End May 20/52</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity of Disease</td>
<td>Active</td>
<td>Active, minor improvement</td>
<td>1</td>
</tr>
<tr>
<td>Following Medical Instructions</td>
<td>Constantly breaks routine</td>
<td>Breaks routine less</td>
<td>1</td>
</tr>
<tr>
<td>Attitude to Illness</td>
<td>Extremely unrealistic</td>
<td>Less extremely unrealistic</td>
<td>1/2</td>
</tr>
<tr>
<td>Desire to Recover</td>
<td>Seems determined to kill herself</td>
<td>Seems less determined to kill herself</td>
<td>1</td>
</tr>
</tbody>
</table>

### II Nature of Relationship with Caseworker

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Slight improvement in very superficial relationship</th>
<th>1/2</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Warmth</td>
<td>Very superficial relationship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Dependency</td>
<td>Leaves all decisions to caseworker</td>
<td>No improvement, leaves all decisions to caseworker</td>
<td>0</td>
</tr>
<tr>
<td>C. Hostility</td>
<td>Continuous barrage of hostility</td>
<td>No improvement</td>
<td>0</td>
</tr>
</tbody>
</table>

### III Severity of the Problem

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Client's Awareness of Problem</td>
<td>Completely unaware, even when brought to her attention</td>
<td>No improvement</td>
<td>0</td>
</tr>
<tr>
<td>B. Desire for Help</td>
<td>Quite unable to accept help in any area</td>
<td>No improvement</td>
<td>0</td>
</tr>
<tr>
<td>C. Movement</td>
<td>Client completely immobilized or disorganized by basic problem</td>
<td>No improvement</td>
<td>0</td>
</tr>
</tbody>
</table>

Number of interviews - 42. 4 points
Number of months treated - 12 months.
Duration of illness - 12 years.
BIBLIOGRAPHY

Books


Family Service Association of America, Principles and Techniques in Social Casework, Selected Articles, 1940 - 1950.


Richardson, Henry B., Patients Have Families, Commonwealth Fund, New York, 1945.


Articles and Pamphlets.

Articles and Pamphlets.


Canadian Arthritis and Rheumatism Society, British Columbia Division, Miscellaneous mimeographed material.


Upham, Frances, A dynamic approach to Illness, American Association of Medical Social Workers, "A Statement of Standards to be met by Medical Social Service Departments in Hospitals and Clinics."