McGill University

Social Services Needed by Arthritis Clinic Patients

A Thesis Submitted to

The Faculty of Graduate Studies and Research

In Partial Fulfilment of the Requirements

for

The Master's Degree in Social Work

by

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Montreal, August, 1951

PREFACE

The writer would like to express her thanks to the physicians of the Arthritis Clinic, Royal Victoria Hospital, for the help they have given her in the preparation of this thesis. The exploratory study, on which it is based, was first undertaken in 1947 at the suggestion of Dr. Henry P. Wright, Chief of the Arthritis Service at that time. To Dr. Wright, Dr. Louis G. Johnson and Dr. S. Dworkin, members of the permanent staff, thanks are particularly due for their interest and encouragement. Since the original study, these three physicians have always been ready to answer further questions, or to give additional guidance to the writer when she needed assistance.

During the original study period, Mrs. Aline Paice, who was then Director of Social Service, was also most helpful. She not only gave consistent support to the writer, but it was owing to the special arrangements which she made that the study could be undertaken.

Grateful appreciation is also due to Miss Eva R. Younge, Assistant Professor and Director of Research at the McGill University School of Social Work, and to Mrs. C. H. Elledge, Associate Professor and Instructor in Medical Social Work, for their help in refocussing the original exploratory material. This help has meant that the present thesis gives a clearer picture of the problems involved, and is more suggestive of the kind of programme which might be developed to serve the social needs of arthritis clinic patients. Dr. F. R. Breul, Assistant Professor at the School of Social Work, who read the completed manuscript, also made

valuable suggestions for its revision.

The writer is very appreciative of the careful work of Mrs. D. E. Wilson who undertook the difficult task of typing the manuscript.

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CHAPTER I

INTRODUCTION

A recent publication on the rheumatic diseases points out that the term "rheumatism" has been used for centuries to designate all forms of painful skeletal disturbances, whether muscles, joints, fibrous tissues, or nerves were involved.[1] Present terminology makes use of the expression "arthritis and rheumatism" to describe these diseases.[1] They affect large numbers of people and cause loss of work and incapacity which may extend to complete disablement. However, they have only begun to attract serious attention during the past twenty-five years while recently there has been a growing appreciation of the magnitude of the problem.[2] For example, in the United States, the incidence of Rheumatism in 1937 was considered higher than that of any other chronic disease. It then had an estimated prevalence of six million eight hundred and fifty thousand cases in comparison with heart disease, which ranked second with three million, seven hundred and fifty thousand cases.[3] All forms of tuberculosis and diabetes, on the other hand, had a prevalence of six hundred and eighty thousand, in the former group, and six hundred and sixty thousand in the latter.[3]

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1. W. P. Holbrook and D. F. Hill, Manual of Rheumatic Diseases, (Chicago, 1950) p. 11.

2. Canadian Arthritis and Rheumatism Society, Arthritis, Plan for Attack, (Ottawa, 1950) p. 3.

3. E. Weiss and O. S. English, Psychosomatic Medicine (Philadelphia, 1949) p. 734.

In Canada the estimated number, either totally or partially disabled by rheumatic diseases, has been set at one hundred thousand with possibly fifteen to twenty thousand of these patients confined to bed or wheel chair. A further estimate of six hundred thousand has been made for all Canadians who suffer to some degree from arthritis and the rheumatic diseases.[1]

The problem of the study and treatment of arthritis and rheumatism is, moreover, complicated by the variety of forms which these diseases take, and by the fact that the exact causes of the most serious forms are not known. Besides these difficulties, there are no specific cures which can be relied on. Despite this, however, a positive statement by Lord Horder, Chairman of the Empire Rheumatism Council, reveals that a pessimistic view cannot be justified. He writes,

> Incomplete knowledge of causes results in incomplete knowledge of the best means of treatment and of prevention. Yet it must be insisted that, even in the present state of incomplete knowledge, there is available a range of efficacious treatments; sometimes, happily, obtaining complete cure; and, with few exceptions, bringing alleviation of pain and of the degree of disablement. Indeed, it may be said that, if all cases of rheumatic disease were diagnosed in their early stages and promptly submitted to the treatments which present medical skill can suggest, there would be a prompt and great reduction in the number of lives wrecked by its ravages. [1]

Similar thinking in Canada led the Canadian Rheumatism Association to call upon the Department of National Health and Welfare to hold a conference on the problem of the rheumatic diseases. This conference was held in Ottawa in November, 1947, and was attended by representatives of the

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1. Canadian Arthritis and Rheumatism Society, op. cit. p. 1.

Provincial Departments of Health, the Medical Schools, the Canadian Medical Association and other groups. As a result of this conference, the Canadian Arthritis and Rheumatism Society was incorporated in March, 1948. The Society, (with a National Office in Ottawa), then organized Provincial Divisions and developed plans for a concerted attack on the rheumatic diseases.[1] In summary, these plans proposed increased facilities for diagnosis and treatment, the encouragement of further professional education, the stimulation of research, and the consideration of other necessary provisions. Among such provisions have been suggested increased social and rehabilitation services, mobile physiotherapists to visit patients at home, and home maker services to give domestic assistance to housewives for whom rest has been prescribed.[2]

An understanding of the main types of arthritis will illustrate the problems which are involved. The two most serious conditions are Rheumatoid Arthritis, a disease of the whole system, as well as of the joints and Rheumatoid Spondylitis, which affects the spine. The first of these usually attacks women between 20 and 50 years of age. The victims of the second are, for the most part, young men. Pain, fatigue and stiffness, which gradually increase, are the results of these conditions. Joints may become swollen and painful, the patient loses weight, and finally, if there is no arrest of the disease, the joints may be destroyed, enlarged or fused, with a wasting of the surrounding tissues and muscles. Osteoarthritis, on the other hand, has been described as a mechanical disorder of the large joints, which is associated with the aging process. This may cause more or less pain, or

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1. Ibid. p. 16.

2. Ibid. pp. 6-12.

perhaps only mild discomfort. There are also forms of non-articular rheumatism, or rheumatism which does not affect the joints. These are conditions which have been described by such terms as lumbago, sciatica, bursitis and muscular rheumatism.[1]

A further group of patients may also attend a clinic devoted to the treatment of arthritis. These complain of pain, though no organic change in bone, muscle, or connective tissue can be demonstrated by x-ray or by any other procedure. Besides this, the interested physician becomes aware of the stresses and strains which may have affected any of these patients, with or without organic disease, and which are possibly affecting him now. Family tensions, financial worries, personal anxieties, will, it is recognized, influence any patient's response to medical care.

Such considerations as these, prompted the special interest of the physicians of the Arthritis Clinic of the Royal Victoria Hospital, when a study of some of the social aspects of arthritis was undertaken in 1947. It is the purpose of the present study to assess the type and intensity of the problems of those patients whose cases were reviewed at that time so that their needs for medical social service can be determined. At present, this clinic can only call upon a social worker for emergency requirements. It is proposed to discover how urgent the need is for a more extensive service which would afford the most comprehensive type of social care which might be made available to these patients. This study of one hundred patients attending the Arthritis Clinic of the Royal Victoria Hospital, includes eighty-three consecutive admissions to that clinic from November 20th, 1947, to December 30th, 1948, and seventeen patients referred during

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1. Ibid. pp. 2-3.

the same period, by their physicians or by community agencies, for specific reasons.

In order to determine the need for medical social services, attention will be focused on the social and emotional problems which these patients present. There is no agreement among physicians as to the relative importance of such factors as these in the etiology and progress of the rheumatic diseases, but many doctors agree that environmental and psychological stresses must be taken into consideration in treatment. Walter B. Cannon, writing on the effects of pain, hunger, rage and fear, emphasized the physiological mechanisms of emotional disturbance. He recommended that,

> The cortex, which is concerned with analysis of the outer world, should not, therefore, be the sole means by which treatment is attempted; the occasion for worries, anxieties, conflicts, hatreds, resentments and other forms of fear and anger, which affect the thalamic centres, must be removed. [1]

In a later article, he points out that modern life conditions increasingly involve strain on the nervous system which is all pervasive. The physician is therefore required to consider the organism as a "mind-body unity" with man as both an individual and as a member of a social group.[2] Turning from general considerations such as these, Bernard Comroe suggests that anxiety, worry and emotional shock may play an important part in the etiology of Rheumatoid Arthritis.[3] He also stresses that

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1. Walter B. Cannon, Bodily Changes in Pain, Hunger, Fear and Rage (New York, 1929) p. 264.

2. _____ "The Role of Emotion in Disease", Annals of Internal Medicine, Vol. 9, No. 11 (May, 1936) p. 1463.

3. Bernard Comroe, Arthritis and Allied Conditions (Philadelphia, 1947) p. 479.

the physician must never forget he is treating a human being and not merely a disease.[1] The significance of social factors was stressed by Gobb, Bauer and Whiting in a study of fifty patients with typical Rheumatoid Arthritis. They concluded that, "environmental stress, especially poverty, grief and family worry, seem to bear more than a chance relationship to the onset and exacerbation of Rheumatoid Arthritis."[2] Boland and Corr, on the other hand, do not believe that organic joint disease can result from psychic conflicts, but considered that a psychoneurotic state could be kindled by a chronic illness. They also agreed, with Halliday, that psychogenic complaints were frequently displayed in joints and muscles.[3-4] More lately, Selye has developed his concept of the General Adaptation Syndrome. He describes this as "an integrated syndrome of closely interrelated adaptive reactions to non-specific stress," but adds "... the process of adaptation may itself become the immediate cause of diseases...".[5] He states that the systemic defense of the body is possible through the endocrine and nervous systems and lists

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1. Ibid. p. 170.

2. S. Cobb, W. Bauer and S. Whiting, "Environmental Factors in Rheumatoid Arthritis", Journal of the American Medical Association, Vol. 113. No. 8 (August, 1939) p. 668.

3. E. W. Boland and W. P. Corr, "Psychogenic Rheumatism", Journal of the American Medical Association, Vol. 123, No. 13 (November 1943) p. 805.

4. J. L. Halliday, "The Concept of Psychosomatic Rheumatism", Annals of Internal Medicine, Vol. 15. No. 4 (October, 1941) p. 666.

5. Hans Selye, The Physiology and Pathology of Exposure to Stress (Montreal, 1950) p. 6.

the rheumatic diseases among those due to the excessive (or abnormal) responses of the organs of adaptation.[1]

In this study, an attempt will be made to explore the intensity of social need in relation to the specific diagnostic groups, as this seems to be variable. Those patients with osteoarthritis, for example, being, in general, in the older age group, are faced with problems of aging which, in a restricted environment, may make their disabilities and pain harder to bear. Their lives may even be affected out of all proportion to the organic change which is taking place in their bodies. On the other hand, patients with Rheumatoid Arthritis and Rheumatoid Spondylitis seem to present, in many cases, severe emotional problems, and may give a history of strains during childhood and adult life with which the individual was unable to cope in a satisfactory manner. As these forms of arthritis may disable men and women in their prime, it is of great importance whether these stress situations, or the individuals' reaction to them, can be relieved or modified so that there will be less drain on the physical and psychological energies of the patient. Rehabilitation of these patients would, therefore, not only include physical and perhaps environmental measures, but might imply help in reorientation to the life process, and an exploration of other means to satisfying experiences. Finally, the incapacities of those patients who show no organic change, but complain of constant or recurring pain, present a problem of understanding and management if medical science is to meet their needs. Such patients, if they feel rejected or belittled by the

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1. Ibid. p. 15.

physician of whom they ask help, go from clinic to clinic, or turn to patent nostrums and charlatans.

It will, therefore, be necessary to consider the effect of their illness on the lives of these patients, and the difficulties with which they have to contend. The extent of resources available to them in Montreal will be examined, and the services which medical social work has to offer will be explored.

The records available on the patients studied are of three types: first, the Royal Victoria Hospital Clinic record with which may be considered the indoor chart in cases of hospital admissions; secondly the record of the hospital Social Service Department, which frequently includes correspondence with outside community agencies; and thirdly, the admitting cards on each patient. These last are filed in the Registration Department and may contain details on family members and on the economic status of the patient which are of value. Besides this, the social worker who interviewed these patients in 1947 and 1948, is the present writer of this study. She therefore had the opportunity to become aware of the patients' needs from firsthand observation. At that time, patients were mainly referred for purposes of general assessment, but the interviews were not planned on a schedule basis. While this meant that interviews varied greatly in content, an attempt was made to assess the severity of the social and emotional problems involved by encouraging each patient to speak of his anxieties in his own way. These anxieties were often related by the patient to his life history, though the life history, as such, was not necessarily considered.

The method of the study will be a consideration in Chapter II of

the medical problems these patients presented. This will involve some explanation of the various types of arthritis and the methods of treatment. It will also illustrate the age and sex distribution of these patients in relation to their diagnosis, and the other medical conditions which were found among them. Chapter lll will further describe these patients in their civil capacity, reviewing their age and sex, marital status, number of living children, birthplace and religion. The occupations which they followed, their financial status before clinic admission, or when last employed, and the rents which they paid, will give some idea of their economic background. Chapter lV will illustrate the effect of their disability on their means of livelihood and the social and emotional problems found. An attempt will also be made to discover whether these problems bear any specific relationship to the patient's diagnosis. In Chapter V, the community resources needed by these patients will be considered, together with the availability of these resources in the Montreal area. Finally, Chapter Vl will examine the need for casework treatment of individual problems in the plan of patient care. This will be followed by a summary and general conclusions.

CHAPTER II

MEDICAL PROBLEMS AND TREATMENT

The extent of the problem of arthritis and the rheumatic diseases in Canada, and the present plan of attacking these problems have been considered. An attempt will now be made to show what the diagnoses involved for this group of 100 patients, as they illustrate some of the main types of disease which are likely to be found in an arthritis treatment centre. While complete medical records were available on these patients, an adequate assessment from a medical point of view could only be made by a physician. The description offered here will, therefore, be a general one of the situation as seen by the medical social worker in its effect on the patient. In order to do this Tables I and II, which illustrate the diagnoses from the point of view of age and sex, will be considered together.

TABLE I

AGE GROUPS ACCORDING TO DIAGNOSIS OF 100 PATIENTS ATTENDING ARTHRITIS CLINIC, ROYAL VICTORIA HOSPITAL.

Diagnosis	Age Groups							
	Total	Under 20	20-29	30-39	40-49	50-59	60-69	70 & over
Total	100	1	9	12	23	27	20	8
Infectious Arthritis (gc)	2		2					
Rheumatoid Arthritis	25		2	6	5	10		2
Rheumatoid Spondylitis	4		2	1			1	
Rheumatic Fever	1		1					
Osteoarthritis	39				8	10	18	3
Mixed Arthritis	2					1		1
Gout	1					1		
Traumatic Arthritis	1							1
Miscellaneous	4			1	1	1		1
No Demonstrable Arthritis	19	1	1	4	9	3	1	
Other Conditions	2		1			1		

TABLE II

DIAGNOSIS ACCORDING TO SEX OF 100 PATIENTS ATTENDING ARTHRITIS CLINIC, ROYAL VICTORIA HOSPITAL.

Diagnosis	Sex		
	Total	Male	Female
Total	100	31	69
Infectious Arthritis (gc.)	2	2	
Rheumatoid Arthritis	25	7	18
Rheumatoid Spondylitis	4	4	
Rheumatic Fever	1	1	
Osteoarthritis	39	8	31
Mixed Arthritis	2	1	1
Gout	1		1
Traumatic Arthritis	1	1	
Miscellaneous [a.]	4	2	2
No Demonstrable Arthritis [b.]	19	4	15
Other Conditions [c.]	2	1	1

a. Includes: Bursitis (2) Sacro-iliac Arthritis of undetermined origin (1) Senile Osteomalacia (1).

b. Includes: Diagnosis not completed or determined (11) Anxiety & Psychoneurotic Depression with Musculo-Skeletal Complaints (2) Menopausal Arthralgia (1) Myositis? (1) Potential Rheumatic Fever (1) Probable Psychogenic Rheumatism (1) Psychogenic Myalgia (1) Traumatic Synovitis? (1).

c. Includes: Multiple Myeloma (1) Pes Planus (1).

A. Diagnostic Groups.

1. Infectious Arthritis

Certain forms of arthritis are known to be caused by specific microbial agents. Among these are the organisms found in tuberculosis, syphilis and gonorrhea. This type of arthritis, called infectious arthritis, varies in degree with the severity and duration of the infection itself and may be either severe or mild in form. In some cases, joints may become very swollen and painful. More frequently these joints are the

hip, knee, elbow or shoulder, though others may be attacked. The prognosis in these cases depends on the nature of the original disease and its treatment. The aim is to halt the joint infection before the cartilage is destroyed, and to begin movement before adhesions and muscle atrophy develop.[1]

Among these patients, two young males had Infectious Arthritis of the gonorrheal type. These patients were treated in hospital and were afterwards advised to return to clinic which they failed to do. They were both restive and depressed during their time on the ward and one of them threatened to leave against advice. The fever treatment, which in itself involves a degree of great discomfort, had to be discontinued in the other case due to the patients' increasingly abusive and rebellious behaviour. While it is not known how often such reactions to this type of arthritis might be found, particularly as one of these patients also had a diagnosis of Psychopathic Personality with Paranoid Trends, the malaise, pain and disability involved cannot fail to have a disturbing effect on the patient. In both of these cases, the prognosis was uncertain, and, when the patients were last heard from, one was still complaining of being unable to work, while the other, according to his family, was "very ill" and under the case of the family doctor.

2. Rheumatoid Arthritis

The clinical picture of Rheumatoid Arthritis has been described as a combination of joint pains with swelling and evidences of constitutional

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1. American Medical Association, Primer on the Rheumatic Diseases, Prepared by a Committee of the American Rheumatism Association, (Chicago, 1949) pp. 9-11.

illness, weakness, atrophy of muscles, deformities and bony changes. The onset may be slow or acute and the disease may be characterized by spontaneous remissions or exacerbations. While patients tend to have cycles of being better or worse, once rheumatoid arthritis is established, complete remissions are rare. Various therapies have been tried, such as the removal of teeth, tonsils or appendix as supposed foci of infection, planning special diets or the administration of injections. Despite these therapies, however, rheumatoid arthritis may continue to follow a progressive course of crippling. Medical authorities now emphasize that no specific therapy will restore destroyed joints, and that a basic routine to prevent deformity should be planned from the beginning. This should include balanced rest and activity depending on fatigability and pain, nourishing diet and regular habits, correction of the anaemia associated with the disease by transfusions if necessary, and corrective exercises for both the ambulatory patient and the patient in bed.[1] Such exercises should be under the supervision of a physiotherapist and aid in maintaining motion and preventing muscle atrophy and consequent deformity. Bed rest, splints and plaster shells are also sometimes used to avoid strain or to rest affected joints.[2] In some cases injections of gold are given and research is being done with the hormones ACTH and Cortisone. While these two latter substances have produced some striking remissions, the patient usually relapses when the hormone is withdrawn. The treatment itself may also have some untoward effects. Research is, however, continuing in the use of both

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1. Holbrook and Hill, op. cit. pp. 15-49.

2. Ibid. pp. 117-149.

these substances.[1]

Rheumatoid Arthritis affected 27 per cent of the patient group. Twenty-five had a diagnosis of this condition, while 2 have been classified as having Mixed Arthritis, or Rheumatoid and Osteoarthritis combined. This does not give an accurate picture of the proportionate clinic admission rate, however, due to the inclusion of 17 specially referred patients as previously explained.[2] It is significant that as many as 14 of those specially referred were cases of Rheumatoid Arthritis, while only 3 had a diagnosis of Osteoarthritis. If the referred group is omitted, it will be found that only 13 per cent of the 83 consecutive admissions were cases of Rheumatoid Arthritis.

In this group of patients, 8 were male and 19 were female. The sex incidence has been reported as one man to 3 women in general, with 80 per cent of the cases occurring between the ages of 25 to 50 years. The peak has been placed between the ages of 35 to 40.[3] Among these patients, however, just under 50 per cent were under 50 years of age. This can probably be explained by the fact that some patients had been attending the Arthritis Clinic for several years, while others had a history of treatment elsewhere.

No attempt will be made here to assess the severity of the medical condition of these patients, as this would not be possible from a lay point of view. However, continuing to consider Rheumatoid and Mixed Arthritis together, 5 of the 8 males were unable to work, though in one case this was

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1. Ibid. pp. 105-116.
2. Supra, p. 4.
3. American Medical Association, op. cit. p. 24.

due to old age, and another worked only irregularly. Of the 19 females, 3 were wheel chair cases and one used crutches to get about. Seven others showed quite marked incapacities.

3. Rheumatoid Spondylitis

Rheumatoid Spondylitis is closely related to Rheumatoid Arthritis in its affects, but is considered by some to be a separate disease as the sex incidence is approximately 9 males to one female. Besides this, gold therapy is not effective, whereas x-ray therapy, which does not benefit Rheumatoid Arthritis, is. However, other joint changes similar to those in Rheumatoid Arthritis may develop. In this form of arthritis, the back becomes stiff, the head may poke forward, there may be a waddling gait, and hip and shoulder deformity with a limited chest expansion. The onset, again, may be insidious or acute, and weight loss, fatigability and fever may develop. X-ray therapy is of great value. Good nutrition, corrective exercises and the maintenance of normal posture and prevention of deformities are all important.[1]

There were 2 young males of 21 and 23 years in this group, as well as one male aged 37 and one of 68. The beginning of deformity was noticeable to the onlooker in the case of the 21 year old male whose chest expansion was limited, who bent slightly forward, and walked painfully with a cane. The anxieties caused to these younger patients by their condition was very marked.

4. Rheumatic Fever

Rheumatic Fever is not primarily a disease of the joints, but there is polyarthritis, or joint inflammation. Its most striking manifestation

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1. Holbrook and Hill, op. cit. pp. 50-58.

is its damaging effect on the heart after recurrent attacks. Sometimes it is confused with Rheumatoid Arthritis, but it responds to anti-rheumatic drugs. The joint involvement does not lead to permanent damage and the essential problem is its possible effect on the heart.[1]

There was only one patient, a young male of 22 years, with this diagnosis in the group. He had had a previous hospital experience and then came to clinic because he was not feeling well. He, also, appeared tense and unhappy, and did not return as recommended as he said he had difficulty in leaving his work.

5. Osteoarthritis

The chief group attending an arthritis clinic is usually composed of patients with Osteoarthritis. This has been called Degenerative Joint Disease and is a process beginning with the degeneration of joint cartilage.[2] It may affect the spine, knees, hips and other weight bearing joints, or cause enlargement of the end joints of the fingers. These patients are often overweight and the symptoms are found in persons past middle age. There is pain on movement, or stiffness of back or knees, or pain and swelling of finger joints. There may be a disabling hip involvement, or osteoarthritis of the spine, but pain in the back is often from other causes. Osteoarthritis is not crippling, and treatment aims at reassuring the patient and alleviating the "wear and tear" factors. Weight reduction is attempted if necessary, posture is corrected, and exercises advised. These measures, with aspirin to relieve pain, are among the forms

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1. American Medical Association, op. cit. pp. 22-23.

2. Ibid. pp. 40-43.

of therapy which are helpful as, with the exception of osteoarthritis of the hip, this condition has been described as "essentially benign".[1]

Thirty-nine per cent of the patient group had a diagnosis of Osteoarthritis and, as would be expected, all these patients were over 40 years with about 80 per cent being over 49 years old. These patients' incapacities, except in certain cases complicated by other conditions such as heart disease, seemed to be mainly due to their age. Another striking factor, however, observed particularly in 3 of the 8 males, was the disabling effect of their anxieties. Among the 31 females, concurrent anxiety was most noticeable in 23 cases. It is the writer's opinion, as will be illustrated later, that these anxious patients were more conscious of their pain and more worried about their health.

6. Mixed Arthritis

No comment will be made on the 2 patients with Mixed Arthritis, as they have been included for discussion with the Rheumatoid Arthritis group.

7. Gout

Gouty Arthritis is a disease in which there are high uric acid levels in the blood. The first attacks may be acute, with joint swelling and pain, and last a few days or weeks. Attacks may become more frequent until a chronic condition is established and the disease becomes as crippling as Rheumatoid Arthritis. The treatment of an acute attack is bed rest, protection of the joints with a cradle, footboard or cotton batting and colchicine medication. There is also a special diet and other measures for patients having repeated and severe attacks.[2]

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1. Holbrook and Hill, op. cit. pp. 59-73.

2. Ibid. pp. 81-89.

Though the usual sex ratio for gout is 3 women to 97 men, the only patient with this diagnosis in the group was a woman of 55 years. At this time she was a wheel chair case and could only be persuaded to attend clinic on two occasions. This was partly because she believed that nothing could be done to help her, but was probably also due to the difficulty of even getting in and out of the taxi which had been sent to bring her to the hospital.

8. Traumatic Arthritis

A form of arthritis due to injury is Traumatic Arthritis. This occurred in only one patient - a man of 73 years - and posed no unusual problem.

9. Miscellaneous Types

In the category of Miscellaneous Types, Bursitis, Sacro-iliac Arthritis of undetermined origin, and Senile Osteomalacia have been included. The first is a type of non-articular rheumatism and causes pain in the shoulder. It may be due to one, or a combination, of several causes and, if untreated, may result in a shoulder with extremely limited motion. X-ray treatment and physiotherapy, or diathermy and exercises when shoulder motion has been affected, usually result in cure.[1] Senile Osteomalacia is a softening of the bones which is attended with rheumatic pains.

Among these patients, there were two males of 42 and 52 years with Bursitis. The older of these men said that his pain had been so acute that he had not been able to help crying, yet this man failed to complete his medical recommendations. The condition of the 31 year old woman with Sacro-iliac Arthritis was complicated by an anxiety state, and the woman with

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1. Ibid. pp. 74-76.

Senile Osteomalacia was 72 years old so that little could be done for her.

10. No Demonstrable Arthritis

Nineteen of these patients have been grouped as having no demonstrable arthritis. These included 11 patients with incomplete or undetermined diagnoses, 4 with psychoneurotic or psychogenic conditions, 2 with questionable myositis and synovitis respectively, which is inflammation of muscle tissue or of a membrance, one with menopausal arthralgia, or pain in the joints, and one with potential rheumatic fever. Of these patients, 4 were male and 15 female. Three of the males were anxious and, in 2 cases in particular, disappointed about their lives, while 11 of the 15 women had varied reasons for distress.

11. Other Conditions

Finally, there were 2 patients who have been classified as having other conditions. A male of 22 with Pes Planus, or Flat Feet, seemed disabled out of proportion to his diagnosis, and a woman aged 59 had a diagnosis of Multiple Myeloma, which is a disease of the bone marrow with a terminal prognosis.

B. Associated and Other Conditions

It is not possible, in this study, to assess the effect of associated and other conditions of disease on these patients as only a physician could determine their importance to the individual concerned. It can be readily understood, however, that other diseases complicated the medical situation. The 25 conditions enumerated in Table III, were found 65 times among 40 of the total number of patients. The most frequently found were Cardiovascular Disease, Psychoneurosis and Anxiety State, and Diabetes. Fifteen per cent of these patients suffered from Cardiovascular Disease of various

types. Three of these were between the ages of 50 and 59 years and the remaining 12 were over 60 years of age. In 14 cases, Psychoneurosis or Anxiety State was either the diagnosis or diagnostic impression. Diabetes was diagnosed in 6 cases and there were 3 cases of Dermatitis. Other conditions were only found in one or two cases each.

TABLE III

ASSOCIATED AND OTHER CONDITIONS DIAGNOSED IN 100 PATIENTS ATTENDING ARTHRITIS CLINIC, ROYAL VICTORIA HOSPITAL.

Associated and Other Conditions	Number of Times Found		
	Total	Male	Female
Total	65	19	46
Bronchiectasis	2	1	1
Bronchitis	1	1	
Cardiovascular Disease (all Types)	15	2	13
Cervicitis (chronic)	1		1
Dermatitis	3	1	2
Diabetes	6		6
Epididymitis	1	1	
Gastric Ulcer	2	2	
Goitre (Colloid)	1		1
Haemorrhoids	1		1
Hammer Toes	1	1	
Hernia	1	1	
Menopausal Syndrome	1		1
Mental Deficiency (post traumatic)	1		1
Migraine	1		1
Nephritis (Gouty)	1		1
Pernicious Anaemia	1	1	
Pes Planus	2	1	1
Prostatism	1	1	
Prostatitis (Gc.)	2	2	
Pruritis ani et vulvae	1		1
Psychoneurosis including Anxiety State	14	3	11
Pulmonary Tbc. (arrested)	1	1	
Syphilis (latent)	2		2
Varicose Ulcers	2		2

The foregoing review of the various diagnoses of these patients, illustrates the diagnostic and treatment problems which the patients in

an arthritis clinic present. The possibly crippling forms of arthritis were found among 35 per cent of the patients. These included 25 cases of Rheumatoid Arthritis, 4 cases of Rheumatoid Spondylitis, 2 of mixed Rheumatoid and Osteoarthritis and one of Gout. Infectious Arthritis was found in 2 cases and Rheumatic Fever, which may result in permanent damage to the heart, in one. Osteoarthritis, which is associated with the aging process and does not necessarily result in disability, affected 39 per cent of these patients. A smaller group, less than one third of the total, had varied complaints. Among these patients were those with uncompleted or undetermined diagnoses, those with miscellaneous and other conditions, and those whose suffering seemed to have psychogenic components. All these patients complained of pain and would find their lives affected to a greater or less degree. This might be the pain caused by a disabling disease process, the discomfort due to inevitable aging, the suffering increased by psychological factors, or a combination of these three aspects of life.

The ages of these patients were chiefly of interest in their illustration of the incidence of the more serious and more benign forms of arthritis. About 50 per cent of the patients with Rheumatoid Arthritis were under 50 years old, while 80 per cent of the patients with Osteoarthritis were over this age. Two patients with Rheumatoid Spondylitis and the patient with Rheumatic Fever were in their early twenties. These patients have not been grouped according to the ages at which the onset of their illness occurred. If that could have been done the early onset of the more serious forms of arthritis would have been more striking.

As has been shown, the treatment possibilities for arthritis are still limited. For Infectious Arthritis the treatment is that of the

specific infection. X-ray therapy is used in cases of Rheumatoid Spondylitis. But for Rheumatoid Arthritis there is no specific cure. Gold injections are sometimes used, while rest, physiotherapy, adequate diet, and, in some cases, splints or plaster shells, are all measures of treatment. The general aim is to prevent deformity as far as may be possible. In April, 1949, the first reports on the effects of ACTH and Cortisone in inducing remissions in Rheumatoid Arthritis were made.[1] But these hormones are still the subject of research and cannot be generally used. Colchicine, on the other hand, has been used as a medication in cases of Gout for some time. In cases of Osteoarthritis, a regime to reduce "wear and tear" is planned, while aspirin is given to relieve pain in all these forms of arthritis.

It has only been possible in this chapter to give a simple presentation of some of the physical aspects of the disease processes found among this patient group. Our next consideration will be with the civil and economic status of these patients as this illustrates their position in the life of the community, and will influence medical and social planning on their behalf.

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1. Holbrook and Hill, op. cit. p. 105.

CHAPTER III

CHARACTERISTICS OF PATIENT GROUP

Chronic illness can be a particularly bitter experience for the young, though it causes reactions of fear at any age. It may also disrupt normally inter-dependent human relationships by creating dependency, or may further aggravate dependency problems which are already present. The chronically ill person may feel that there is no contribution which he can make to society. Instead, the burden of his care may be a drain on the courage and initiative of others. The individual may be young with the possible future of founding a family. Or he may already be a bread-winner or a housewife. Or else he may be aging and no longer very active. In all of these cases, however, there should be creative possibilities for his life as he lives it now. From this point of view, age and sex should not indicate limitation and deprivation as they often appear to do. Rather they should illustrate different phases of the life cycle which can be constructive and enjoyable. Considered in this way, life can always be a growth process, and have positive values, in spite of aging and disease.

1. Age and Sex

While the age and sex of these patients has already been noted, this was in connection with their relation to the disease involved. Here, rather, the question is one of the patient's relation to the community. Considered from the social standpoint, the age and sex of these patients give some indication of the individual's place in our present culture and thus reveal what he may expect of himself and what others may expect from

him.

Table IV shows that 31 per cent of the patient group was male and 69 per cent female. While 8 per cent of the patients were aged 70 years and over, 47 per cent were between the ages of 50 and 69 years, 23 per cent between 40 and 49, and the remaining 22 per cent were under 40 years of age. For these younger patients under 40, disease and disability may be particularly damaging both socially and psychologically. But, while they present the most urgent demand for rehabilitation, it is also a great loss to the community that individuals in their forties, fifties and sixties should become prematurely incapacitated.

Eighty-three patients, as previously explained, were consecutive clinic admissions, while 17 were already attending clinic when they were referred to the social worker for special reasons. There is no appreciable difference, however, in the proportion of males to females if these 17 patients are removed and the age groupings likewise remain the same.

TABLE IV

AGE AND SEX OF 100 PATIENTS ATTENDING ARTHRITIS CLINIC, ROYAL VICTORIA HOSPITAL.

Age	Sex		
	Total	Male	Female
Total	100	31	69
Under 20 years	1		1
20 - 29	9	7	2
30 - 39	12	2	10
40 - 49	23	8	15
50 - 59	27	6	21
60 - 69	20	5	15
70 & over	8	3	5

2. Marital Status and Number of Living Children

It seemed, in this study, that whether a patient were married and had living children, or not, was less important than his total adjustment to his spouse and children or to his single life. Presumably, a married patient should have been able to depend for some support on an affectional relationship with his spouse. This might also be the case in a common-law union. There were, however, 17 cases of current marital unhappiness and this will be again considered in Chapter IV in which the social problems affecting these patients are discussed. It will be sufficient to note here that 55 per cent of these patients were married, 2 per cent were living in a common-law relationship and 12 per cent were widowed. Six per cent were separated or divorced and 25 per cent were single.

While the significance of children in these patients' families will also be considered later, it seemed that two points can be mentioned here. First, it can no longer be taken for granted, as could perhaps be done in an earlier rural economy, that older children will be able to support, or even help, their aging parents to any extent. Secondly, any illness of father or mother will affect the lives of their children and medical and social treatment must endeavor to minimize the destructive possibilities involved. Of these patients, 38 per cent were childless, 47 per cent had from one to 3 living children and only 12 per cent had families of from 4 to 6 children. Three families consisted of 7, 8 and 11 children respectively. There was a total of 175 living children, but only 33 of these were under 16 years of age. This was most probably due to the average age of these patients as noted in Table IV. Of the 19 families with children under 16 years of age, there were 12 in which there were current conflicts or difficulties with regard to the children. The possibilities of these

children enjoying a normal and happy childhood were questionable.

TABLE V

MARITAL STATUS AND NUMBER OF LIVING CHILDREN OF 100 PATIENTS ATTENDING ARTHRITIS CLINIC, ROYAL VICTORIA HOSPITAL.

Marital Status	Number of Living Children												
	Total	0	1	2	3	4	5	6	7	8	9	10	11
Total	100	38	17	20	10	4	2	6	1	1			1
Single	25	24	1										
Married	55	9	13	15	7	4	1	5	1				
Widowed	12	3	2	3	2		1						1
Separated	5	1	1		1			1		1			
Divorced	1			1									
Common Law	2	1		1									

3. Birthplace and Religion

The significance of the birthplace and religion of these patients could not be determined for this study, though it is the writers' opinion that cultural influences during childhood, and adjustments from the old world to the new, are factors of importance. The need to learn, and live with, a language other than the mother tongue; the acceptance of methods of living unknown to, or only partially accepted by, parents; the parting from relatives, or later news of their loss in revolution or war; must inevitably have effected those patients who came from Europe. While 4 patients with a European background spoke of the deaths of relatives in war, the lack of data concerning cultural factors may be due, in part, to the fact that none of these patients were recent immigrants, as well as to the lack of focus on these factors.

TABLE VI

BIRTHPLACE AND RELIGION OF 100 PATIENTS ATTENDING ARTHRITIS CLINIC, ROYAL VICTORIA HOSPITAL.

Birthplace	Religion				
	Total	Protestant	Roman Catholic	Hebrew	Greek Orthodox
Total	100	41	37	20	2
Canada	50	18	29	3	
England	15	12	3		
Ireland	2	1	1		
Scotland	6	6			
British West Indies	2	2			
Czechoslovakia	1		1		
Estonia	1	1			
Italy	1		1		
Poland	5	1	1	2	1
Roumania	3		1	1	1
Russia	14			14	

Table VI shows that 50 per cent of these patients were born in Canada, 23 per cent in the British Isles, 25 per cent came from Europe and 2 per cent from the British West Indies. More than half the European group had been born in Russia and these Russian Canadian patients were all Jewish.

While 41 per cent of these patients were Protestant, 37 per cent were Roman Catholic, about half of this latter group being French Canadian. That as many as 20 per cent were of the Hebrew faith can probably be explained by the location of Royal Victoria Hospital which is the nearest English hospital to an old established Jewish community district in which 17 of these 20 patients lived. Only 2 per cent of the total group belonged to the Greek Orthodox faith.

Though no conclusions about religion and birthplace have been

possible here, the faith and country of origin of each patient are later noted in the case illustrations of the Chapter on social problems.

4. Occupation

The type of occupation in which a patient is engaged before illness or advancing old age overtakes him indicates his enconomic status and ability to bear the financial drain of ill health. It may also be an occupation which makes physical demands which can only be met by the healthy and vigourous person.

The occupation of these patients before illness or retirement reveals them in as normal a milieu as was possible to them. Nine per cent, only, were employed in clerical and sales positions with the highest salary at $130 a month. There were still fewer (5 per cent) who could be classified as skilled. These included a printer, a fireman, a machinist and a masseuse, though the extent of the training of the masseuse is not known and may have been quite limited. There was also a plasterer in this small group who had undergone an intensive European apprenticeship and was able to earn as much as $200 a month. This man would not ordinarily have been admitted as a clinic patient if he had not been an employee of the Hospital. Housewives comprised 49 per cent of these patients, and 13 per cent were occupied in cleaning and domestic services such as janitor, cook, cleaning woman or orderly. Wages in these cases were either very low, at about $70 a month, or more adequate when board and lodging were included. The semi-skilled and unskilled group of 20 per cent of these patients included day labourers, factory workers, sewing operators, tailors, a bench hand, elevator operator and truck driver. Tailors here are classified as semi-skilled since these men were employed on piece

work and the best paid among them only received $130 a month. They must, therefore, have been engaged in one of the less skilled tailoring processes and not, for example, as cutters who can command a higher wage.[1] The two unemployed women were living in the homes of relatives, there was one student dependent on his family, and one patient, whose former occupation is unknown, was over 70 years old.

TABLE VII

OCCUPATION ACCORDING TO SEX OF 100 PATIENTS ATTENDING ARTHRITIS CLINIC, ROYAL VICTORIA HOSPITAL.

Occupation [a.]	Sex		
	Total	Male	Female
Total	100	31	69
Clerical & Sales	9	4	5
Skilled Workers	5	4	1
Housewives	49		49
Cleaning & Domestic Services	13	5	8
Semi-Skilled & Unskilled Workers	20	16	4
Students	1	1	
Unemployed	2		2
No Data	1	1	

a. Occupation before illness or retirement.

When Table VII is considered in conjunction with Table VIII on the income of these patients and their families, it will be seen that the majority belonged to the low income, relatively unskilled category. These people cannot remain independent when faced with periods of unemployment

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1. Information obtained from Jewish Vocational Service, August, 1949.

and the expenses of illness, nor can they change from work which requires physical labour to sedentary type jobs which may require trained skill or abilities which they do not possess. This will be considered again in Chapter V on needed community services.

5. Income

An exact study of the income of these patients is not possible, as financial information was obtained from the cards made up at the clinic admission desk and details there are not necessarily complete. The number of persons living in a family group, together with the contribution of each, would have to be known, before a true appraisal could be made. Amounts which grown children might contribute by gifts or by a cash allowance, and whether lodgers were paying for food or rent, would also need consideration and this was not possible. Nevertheless, the details in Table VIII give as accurate a picture as could be obtained. As there noted, the income is based on that received before clinic admission or during the latest employment period. The number of persons in a family includes the patient, his spouse and dependent children. In three cases, older children supplementing a widowed mother's pension, or an old age pension, are included, but single persons, even though living at home, are considered alone.

As far, then, as can be determined, 34 per cent of these patients were earning, or living on, less than $100 a month. These included 19 single persons, 12 families of two, one of three, and 2 of four persons. Thirty-six per cent lived on over $100 and less than $150 a month. This group was composed of 9 single persons, 12 families of two, 9 families of 3, 5 of four, and one of eight. Finally, only 17 per cent earned over

$150 with no exact data on a further 13 per cent. It has already been pointed out that the single patient earning $200 was an exception due to being a hospital employee. With the further exception of the student whose allowance and family resources were not known, the 13 per cent with no exact data represented a group varying from destitution to comparative security.

TABLE VIII

APPROXIMATE MONTHLY INCOME ACCORDING TO THE NUMBER OF PERSONS PER FAMILY OF 100 PATIENTS ATTENDING ARTHRITIS CLINIC, ROYAL VICTORIA HOSPITAL.

Monthly Income [a]	Number of Persons per Family [b]								
	Total	1	2	3	4	5	6	7	8
Total	100	40	37	13	9				1
$ 30-$ 39	3	3							
$ 40-$ 49	5	4	1						
$ 50-$ 59	2		1	1					
$ 60-$ 69	5	4	1						
$ 70-$ 79	8	3	4		1				
$ 80-$ 89	6	3	3						
$ 90-$ 99	5	2	2		1				
$100-$109	9	4	3	1	1				
$110-$119	3		2	1					
$120-$129	11	4	2	3	2				
$130-$139	6		4	1					1
$140-$149	7	1	1	3	2				
$150-$159	6	1	5						
$160-$169	2	1		1					
$170-$179	4		3		1				
$180-$189	1	1							
$190-$199	3			2	1				
$200-$209	1	1							
No Data	13	8	5						

a. Income received before clinic admission or when last employed.

b. Includes patient, spouse, if living at home, and dependent children only. If patient is single, he is considered as one person. Older children are included in 3 cases where they supplement a widowed parents' resources.

To obtain some idea of the adequacy of these incomes, the budget allowance of the Jewish Family Welfare Bureau for 1948 and 1949 was taken as a guide.[1] The adequate nature of this budget, in comparison with that of the other Montreal family agencies, is explained in Chapter V on community resources.[2] Jewish Family Welfare budget, adjusted according to ages of the children and activity of the adults with regard to food and clothing, showed that no fewer than 21 per cent of these patients were probably living on budgets below the minimum for adequate nutrition. Of these 21, 9 were living on inadequate agency allowances, which, in 2 cases, supplemented pensions; 3 were living on pensions alone; 8 were affected by occasional unemployment or low wages; and, in one case, the amount of help which the children could give was unknown.

The two following cases illustrate the totally inadequate nature of those budgets which have been classified as below the minimum for proper nutrition.

> Case (33), a 44 year old man, his wife and six children were apparently living on $134.70 a month. The patient himself, with a diagnosis of Rheumatoid Arthritis, and with a personality disturbance, was only able to obtain occasional employment. His wife, therefore, took work as a night cleaner at $18 a week though she had an eighteen month old baby at home. The eldest boy of 16 found work but could only contribute $5 a week, while $35 a month was received from Family Allowance. Even though the eldest boy might be buying his own clothes, the minimum budget for such a family in 1948 was approximately $215 to $225 a month.

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1. Jewish Family and Child Welfare Bureau Montreal 1948 Clothing Budget.

Relief Allowance Budget, Family Welfare Department, Baron de Hirsch Institute, 1949.

2. Infra. pp. 69-72.

Case (35), a 58 year old widow, was incapacitated by Rheumatoid Arthritis. Her only regular source of income was her veteran's widows pension of $30.41 a month. She had a married son, who may have sent occasional help, but who lived out of the City and perhaps was not aware of his mother's difficulties. Her daughter, on the other hand, lived in Montreal but had been deserted and had a child of her own to support. When this patient was eventually referred to a family agency by her parish priest, she was living in a room alone and getting inadequate food.

6. Rent

Table IX shows that the majority of these families were paying very low rents. Some of these rents may have been explained by length of tenure or by rental restrictions which, however, have since been removed. Apparently, 52 per cent of these patients paid rents of from $10 to $29 a month, 15 per cent paid from $30 to $39 a month and only 6 per cent paid over this figure. Details are not known for 12 per cent, and 15 paid no rent. This was due to living with their families, in 3 cases, to rent being included in wages, in 7 cases, or to owning property which, however, was mortgaged in 2 out of 4 cases. One patient, assisted by an agency, lived in a hostel. No generalizations can be made about the adequacy of this housing, as only 9 dwellings were seen when visits were paid for particular reasons. Of these 9, 2 appeared dilapidated and unsuitable, while 3 others were relatively so.

It is impossible to correlate rent and income from the following Table alone, but an individual analysis revealed that at least 18 patients in the lower income group, earning less than $100 a month, were paying more than a quarter of their income on rent. Of these, 8 were being assisted by agencies, 8 depended on low or erratic earnings and 2 were receiving inadequate pensions.

TABLE IX

MONTHLY RENT CLASSIFIED ACCORDING TO APPROXIMATE INCOME OF 100 PATIENTS ATTENDING ARTHRITIS CLINIC, ROYAL VICTORIA HOSPITAL.

Monthly Income	Monthly Rent							
	Total	$10-$19	$20-$29	$30-$39	$40-$49	$50-$59	No Rent	No Data
Total	100	26	26	15	4	2	15	12
$ 30-$ 39	3							3
$ 40-$ 49	5	3	1				1	
$ 50-$ 59	2		1	1				
$ 60-$ 69	5		1	2			1	1
$ 70-$ 79	8	3	1	3				1
$ 80-$ 89	6	1	1			1	3	
$ 90-$ 99	5		1	2			1	1
$100-$109	9	3	3	2			1	
$110-$119	3	2	1					
$120-$129	11	4	4	1			1	1
$130-$139	6	1	3	1				1
$140-$149	7	3	2		1			1
$150-$159	6	1	3		1		1	
$160-$169	2			1	1			
$170-$179	4	1	1		1		1	
$180-$189	1						1	
$190-$199	3	1	1			1		
$200-$209	1						1	
No Data	13	3	2	2			3	3

Two cases are given here to illustrate those 18 patients who paid a disproportionate amount of their income on rent. These patients had been unable to locate any of the low level rentals shown in Table IX.

Case (12), a 52 year old woman with a diagnosis of Rheumatoid Arthritis, was too ill to be able to work. Her husband of 66 years was also partially incapacitated. This couple received $75 a month from a family agency but, of this, $30 was required for the rent of their one room in a poor lodging house. In consequence, only $45 remained for food, clothes, and supplies for two persons in one month.

Case (47), a 71 year old single woman with a diagnosis of Osteo-arthritis, received a monthly pension of $60. Out of this amount, she was obliged to pay $26 for the rent of her single room. This patient's monthly pension was higher than that allowed by any family agency budget, yet she had only a monthly balance of $34 for her food, clothing and other necessities.

This chapter has described the civil and financial status of this group of patients. It was found that, while 22 per cent were under 40 years of age, 23 per cent were between 40 and 49 years and as many as 55 per cent were over 50 years old. Chronic illness is particularly destructive to the young and special planning is indicated in their case as so much of their life is still before them. However, there should be no pessimistic acceptance of the view that little can be done for the older group. Instead, a realization that there are creative possibilities for the older patients also, despite their limitations, means that they too require medical and social consideration.

Less than one third of the total group were males, while over two thirds were females. This is chiefly significant in considering possible employment. The work of a housewife, for example, which, in this group, was the more usual female occupation, is less physically demanding than employment outside the home would be. Psychologically, however, housekeeping is circumscribed and may lead an unhappy woman to withdraw further into herself and to concentrate on her complaints.

In this group, the marital status and number of living children do not appear to be significant in themselves. The family inter-relationships, however, are of importance, and will be considered in Chapter IV on social problems found among these patients. Birthplace and religion, as cultural factors, were not sufficiently explored for any conclusions to be drawn.

Forty-nine per cent of these patients were housewives and 9 had

been employed in clerical and sales positions. With the exception of one student, a patient on whom there is no data, and 5 who have been classified as skilled, the remaining 35 per cent belonged to the unskilled and semi-skilled group. This reflects both their low economic position and inability to find other work, if that should be recommended. The financial difficulties of these patients were illustrated by the monthly incomes per individual or family, and by the rents paid. About one third earned, or lived on, less than $100 a month, one third had from $100 to $150 a month and only 17 per cent earned over $150. The one patient earning $200 had been admitted to clinic as an exception. Twenty-one patients were unable to afford adequate nutrition. More than half these patients paid monthly rents as low as from $10 to $29 a month and only 6 paid from $40 to $59 a month. Property was owned in only 4 cases and in 2 of these it was mortgaged. These details again illustrate the economic status of these patients. Such a group is unable to meet the burden of unemployment or illness, even if these disasters are temporary in nature.

With this general introduction to the patient group, a consideration of the actual effect of their disabilities upon their lives and work will now be attempted. This should illustrate some of the social problems precipitated by illness in its disabling and handicapping aspects. The patient's own description of areas of anxiety in his life, in the past or present, will follow in the second section of Chapter IV. While the destructive effects of the severer forms of arthritis will be clearly seen, the possible relationship between the diagnoses and the social problems found will also be examined.

CHAPTER IV

SOCIAL PROBLEMS

In their book, "The Art of Ministering to the Sick", Doctor Richard Cabot and the Reverend Russell Dicks suggest that more should be known about a patient than his physical diagnosis. They write,

> If the sick man can eat and sleep, if he moves all his muscles and performs all his excretions, if he talks sensibly and does not cry, curse or complain, he will probably be taken for normal by his medical attendants. The huge total of what he keeps to himself, all that he cannot express, or fears may be ridiculed, what he dreads, what he depends on, what he takes for granted, what he loves and now misses, the hopes and affections that he lives by, the frustration and successes that have shaped him - these and many more, further or impede his convalescence. Wound, starvation or atrophy in some of his invisible powers may even destroy his desire for life, which is notoriously a factor in physical recovery.[1]

The patient must therefore be considered as an individual with a unique adaptation to life as this adaptation may be affecting, or may be affected by, his present illness. An attempt will now be made to evaluate some of these factors and to understand the lives of these patients who came to the Arthritis Clinic at Royal Victoria Hospital for help.

A. The Effect of Disability on the Means of Livelihood

The fact that these 100 patients came to a clinic places them in the category of those who are unable to afford private medical care. Furthermore it has been seen that, while 21 per cent were living on lower

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1. Richard Cabot and Russell Dicks, The Art of Ministering to the Sick, (New York, 1938) pp. 9-10.

than minimum budgets, the patient group as a whole was financially unable to meet the demands of illness or unemployment. While it can be acknowledged, then, that these patients' anxieties about their means of livelihood would be easily, and with reason, aroused, yet an originally more secure group might also find chronic illness jeopardizing its economic stability. Individual patients in more prosperous circumstances could likewise experience the destructive fears of dependency. They also, as members of the human family, would be equally subject to strained family relationships, to difficulties in adjustment and to situations of stress and strain.

During the period under review, 22 patients, who had formerly been wage earners, continued to support themselves. In this group, there were only 4 patients with Rheumatoid Arthritis, 2 women and 2 men. These patients' ability to handle their work was undoubtedly affected, and they also felt anxious lest they become more incapacitated. One, a tailor, said he could no longer work properly because of his hands; a maid in an institution complained of being tired and nervous; it was questioned how long a shop employee could continue; and a chauffeur valet thought he should move to a warmer climate. Of the 18 other wage earners, there were 12 whose earning capacity was reduced, or believed to be so by the patients, due to their condition of health. For 4 of these 12, this was undoubtedly true. One had Mitral Stenosis as well as Osteoarthritis, one was aged 60 with a diagnosis of Osteoarthritis and Bronchiectasis, which was complicated by the anxiety state he revealed in interviews, one had a diagnosis of Post Traumatic Mental Deficiency but no arthritis, and one had Rheumatic Fever. The remaining 8 patients, however, in this group of 12, were apparently mainly incapacitated by their psychological

attitude. But the fact that 5 were in their forties, and 3 in their fifties, is noteworthy. This leaves only 6 of the 22 wage earners able to carry on with minimal or no complaints. Two of these only had minimal osteoarthritis while the other 4 diagnoses were undetermined.

Forty-two per cent of these patients were normally supported by their families, but their work at home, or outside the home should that become necessary, would be affected by their condition of health. Of the 9 housewives with Rheumatoid Arthritis (including one with Mixed Arthritis) 4 were greatly incapacitated. Though one was mainly helpless because of old age, the other 3, aged 35, 50 and 57, were not able to handle normal household tasks, and these became the burden of husbands and children. The remaining 5 patients with Rheumatoid Arthritis, were variously affected, and 3 of these, at least, were probably less helpful as wives or mothers in consequence. It is very difficult to estimate the capacity of the remaining 33 housewives in all cases. Twenty were patients with Osteoarthritis, of whom 7 considered themselves more or less ill. One, of 56 years with her diagnosis complicated by Cardiovascular Disease and Coronary Sclerosis, had more basis for her complaints. The remaining 6 were mainly victims of their own unhappiness. Of 8 other patients, one with sacro-iliac arthritis of undetermined origin, and 7 with no demonstrable arthritis, this unhappiness and maladjustment might be considered the main factor in any incapacity they experienced. Only one patient, with a diagnosis of Multiple Myeloma, was very ill and a terminal case. The remaining 17 housewives were a varied group whose abilities did not appear to be affected to any degree by their complaints.

Three patients depended entirely, or mainly, on savings, due to retirement. This occurred in the natural course of events for 2, aged 70 and 71, but may have been premature for one, aged 58, because his Osteoarthritis was complicated by Pernicious Anaemia.

With the exception of 2 patients, both over 70, on whom there is no exact data, there remain 14 per cent of these patients receiving emergency family support due to illness, and 17 per cent supported by public or private agencies. The physical damage caused by the rheumatoid types of arthritis is most striking. Of the 13 dependent patients with Rheumatoid Arthritis, 3 were wheel chair cases, and 6 were definitely unable to work, though 3 were in their fifties, 2 in their forties, and one was only 27 years old. Two, a deserted wife and a widow, found it much more difficult to manage because of their condition. Only one, at 73, was necessarily dependent, and another, a man of 44, might possibly have worked had his personality difficulties not been so acute. During the period of this study, one of these 13 patients improved to such an extent that he was able to do light work.

Among the 4 dependent patients with Rheumatoid Spondylitis, one was 68 years old. Two others, aged 37 and 23, were able to return to their former occupations. But the fourth, aged 21 was still not able to work at the close of the study. The prognosis for the 2 patients with Gonorrheal Arthritis with regard to work cannot be considered satisfactory, as, in both cases, personality difficulties were acute and complicated the medical picture.

The 9 dependent patients with Osteoarthritis were mainly geriatric problems of over 60 years, as was the patient with Osteomalacia. But the

patient with Gout was incapacitated to the extent of needing a wheel chair though she was only 55. It is difficult to evaluate the case of the young male, aged 22, with Pes Planus, as the condition of his feet was complicated by his attitudes and work history.

In an attempt to summarize this necessarily tentative evaluation, it could be said that 22 per cent of these patients continued to be self supporting. However, 8 of these experienced a condition of health which might be a source of difficulty and later unemployment. In addition, 8 patients believed themselves to be more or less incapacitated, and only 6 seemed to be really confident of continuing independence. Of 42 housewives, 4 of 9 with Rheumatoid and Mixed Arthritis were very incapacitated, 14 with Osteo-arthritis, Sacro-iliac Arthritis and no arthritis were more affected apparently by their unhappiness than by any other cause, 2 were really ill, and only 17 appeared to be functioning in a normal, or relatively normal, manner.

Of the 31 dependent patients for whom there was adequate data, there seemed to be some possibility of 4 males aged 21, 22, 23 and 37, becoming self sufficient; the rehabilitation of 6 appeared doubtful, though 2 of these were young men still in their twenties; and 21 patients seemed likely to remain dependent either on family or agency. It must be stated, however, that, of these 21, 12 were over 60 years of age. The other 9 were incapacitated by the severer forms of arthritis, though 2 patients, a widow and a deserted wife, needed community help while they brought up their children in any case.

Further considerations, which will be left for Chapter V on needed community resources, would be the possible use of sheltered workshops for rehabilitation. Without some such provision, these patients become demoralized as their general uselessness is increasingly obvious. Their attitudes of dependency and anxiety then incapacitate them further.

Table X illustrates the foregoing discussion.

TABLE X

MAIN SOURCE OF LIVELIHOOD OF 100 PATIENTS ATTENDING ARTHRITIS CLINIC, ROYAL VICTORIA HOSPITAL.

Main Source of Livelihood While Attending Clinic	Diagnosis											
	Total	Infectious Arthritis	Rheumatoid Arthritis	Rheumatoid Spondylitis	Rheumatic Fever	Osteo-Arthritis	Mixed Arthritis	Gout	Traumatic Arthritis	Miscellaneous	No Demonstrable Arthritis	Other
Total	100	2	25	4	1	39	2	1	1	4	19	2
Wages	22		4		1	7				2	8	
Established Family Support [a]	42		8			20	1			1	11	1
Savings	3					2	1					
Emergency Family Support	14	2	3	3		5						1
Public or Private Agency [b]	17		10	1		4		1		1		
No Data	2					1			1			

a. Includes 40 housewives and 2 single women not working.

b. Includes patients receiving Veterans Pension, Old Age Pension, Needy Mother's Assistance and/or family agency assistance.

B. Varied Problems Revealed in Interviews

When a patient comes to a doctor to ask for help for the pain he is experiencing, he will also, with a little encouragement, speak of his personal life and of any difficulties which beset him. He is particularly ready to talk of his anxieties which may be causing him as much psychological suffering as the physical sensations of his body. It is for this reason that patients often speak of their problems and are referred to a social worker by their physicians during a first clinic visit. In the case of a review of a patient group, an early referral to the social worker is also the best procedure. This was the practice with regard to the 83 patients who were new clinic admissions, and these patients were seen as soon as possible after they had been medically examined. No questionnaire or schedule had been prepared, so that interviews were not focussed on any particular aspect of the past or present life situation. Instead, the social worker expressed the interest of the clinic doctors in their patients, and explained the conference procedure through which their cases would be studied. The patient was then usually able to talk about himself, and, if there were any areas where it seemed the social worker could be of help, these were considered together. The 17 patients referred by their physicians, or by social agencies for particular reasons, generally understood why they would see the social worker before they came to her office.

The foregoing explanation, and the fact that as many as 53 of the 100 patients were only interviewed on one occasion, means that the evaluation of the social anxieties of these patients which is here attempted cannot be a comprehensive one. But the significance of Table XI and of the illustrative cases which follow, will lie, not in the complete nature of

the survey, but in the intensity of the anxieties expressed by these patients. These anxieties were revealed so readily that their conscious presence was all the more apparent. It might be objected that frustration and disappointment, anxiety and grief, are part of the usual life experience. While this is true, these emotions may have a pathological effect on the organism and not be sufficiently couterbalanced by the positive feelings of affection for, and pleasure in, others. The satisfactions experienced in feeling necessary to the well being of one's family or friends may also be lacking. The effect of the emotions on health is now recognized, and the physician's opportunity to meet his patients' physical and psychological needs is an unrivalled one. In meeting these needs, he may use the resources of other persons on the medical team and in the community itself. It is the writer's opinion that the majority of the patients in the Arthritis Clinic needed social or psychological treatment, or both, as well as physical examination and care.

TABLE XI

FREQUENCY OF SOCIAL PROBLEMS DESCRIBED BY 100 PATIENTS ATTENDING ARTHRITIS CLINIC, ROYAL VICTORIA HOSPITAL.

Social Problems	Number of Times Found		
	Total	Male	Female
Total	228	76	152
Loss of Parents	19	9	10
Unsatisfactory Relationship with Parents	13	3	10
Marital Unhappiness	24	5	19
Anxiety or Conflict over Children	22	4	18
Death in Family	11		11
Illness in Family	29	10	19
Anxiety about Health	51	16	35
Fear of Old Age and of the Future	7	1	6
Financial Anxieties	39	17	22
Erratic Work History	13	11	2

In the following discussion reference will also be made to Table XII at the end of this section. This table illustrates the frequency of social problems found in relation to the patients' diagnoses.

1. Loss of Parents

Of the 19 patients who seemed to have been affected by the loss of parents during childhood, only one did not speak of this loss directly. While 3 patients lost both parents by death or separation, 11 lost fathers by death and 4 were similarly deprived of their mothers. The one patient who did not himself mention his father's separation from his mother, yet revealed some of the conflict this had caused. All but 2 patients spoke as if these losses had been followed by a sense of hardship, while as many as 11 indicated that they had been caused insecurity and suffering. A conclusion which seems to be valid for this group is that such a loss may not only affect the child directly but may also, in some cases, cause an unbalanced relationship with the parent who survives. The result of both factors appears sometimes to be a later difficulty in heterosexual adjustment. There was evidence of later unhappy relations with the opposite sex in 13 cases, 6 men and 7 women, in this group.

The diagnoses of these patients are of interest if an attempt is to be made to understand the effects of strain on patients with the more severe types of arthritis. In this group of 19, 11 patients had diagnoses of the infectious and rheumatoid types of arthritis. Five patients had osteoarthritis and 3 had no demonstrable arthritis or had other conditions.

The following 3 cases illustrate the possibly traumatic effects of parental loss. In the first, the patient felt her unhappiness was

due to her father's death. In the second, the patient's conflicts were never solved and she tried to find a father, rather than a husband, in her marriage. In the third, the patient's psychopathic development may have been due to his deprivation of parental care.

> Case (44), an unmarried French Roman Catholic girl of 24, born in Canada, and with a diagnosis of Rheumatoid Arthritis, was tense, timid and rebellious. She said her father had died when she was 15 and that, if he had lived, he would not have allowed her "to be pushed around". She still cried when she was alone in the evening and remembered him. She also felt resentful towards her mother who "had not taught her about life".

> Case (52), a 35 year old woman born in Poland of Greek Orthodox faith, with a diagnosis of Psychogenic Myalgia, gave an impression of grief. Her expression was sad and her eyes filled easily with tears. A chance remark led her to speak of her earliest memories of her father who had died when she was 5 years old. Patient remembered his punishing her for disobedience when she did not fetch the geese as he had told her to do. On the day of his death, she was playing at "weddings" when her aunt, angered by her apparent indifference, said, "Don't you care that your father is dead? Go and kiss him."

This patient also felt that her mother had not prepared her for her life as a woman. She married, at 19, a man 24 years her senior and a history of maladjustment followed. She was referred to Psychiatry Clinic but had to wait six weeks for an appointment and then failed to attend. On perusal of her medical and social record a psychiatrist's impression was, "anxiety state with conversion features at least".

> Case (45), a 26 year old Protestant man born in Canada (Diagnosis: Gonorrheal Arthritis, Gonorrheal Prostatitis, Psychopathic Personality and Anxiety with Paranoid Trends) was separated from his wife. His father had deserted when he was a year old and his mother then placed him so that she could work. At some period during his boyhood he was in a reform school where he reported being "brutally" treated. This patient said he could never keep his jobs as, sooner or later, he "always wanted to beat someone up". He expressed hostility to all "higher ups" and would threaten violence, instancing unjust and sadistic treatment of himself as an excuse. Nothing

could reassure this patient of the goodwill of others and his distrust and suspicion seemed to be part of his personality.

The effect of the desertion by both parents on this third patient when he was still a helpless infant can only be surmised. As the type of treatment which might help him is not available, his behaviour may eventually either result in commitment to a mental institution or to prison.

2. Unsatisfactory Relationship with Parents

In the 13 cases where an unsatisfactory relationship with parents was observed, 5 illustrated rejection by the mother of the daughter. Three of these 5 patients also complained of cruelty in their treatment. Three women and one man believed they had been unreasonably punished by their fathers and one woman tried to escape from her home by marriage. Two young males and an older woman appeared to be torn between their sense of dependency and their resentment toward the parent who seemed to be inhibiting their freedom. Somewhat similar results can be found here as in cases of parental loss as, of 9 of these patients who later married, 5 were unhappy and the adjustment of 2 was unbalanced.

Of these 13 patients, 6 had diagnoses of Rheumatoid Arthritis, Rheumatoid Spondylitis or Mixed Arthritis while 3 had Osteoarthritis and 4 no demonstrable arthritis.

In cases (17) and (92), the patients not only lost one parent but believed they had been harshly treated by the other.

Case (17), a 46 year old Roman Catholic man, born in Canada, Diagnosis: Rheumatoid Arthritis, Gastric Ulcer and, later, Epididymitis), had only known a broken home as a child and said his father had taken him away from his mother. He related that he had been "nervous" and "sensitive" ever since his father had

once punished him by shutting him in a dark cellar and terrifying him "with strange animal noises". This patient repeated his family history by later marrying a woman as unable to found a happy home as he was himself.

Case (92), a 62 year old Protestant woman of Scottish birth with a diagnosis of Osteoarthritis and Mild Coronary Insufficiency, responded with increased anxiety to medical reassurance that she was able to do light work. She lived with a married daughter who was able to support her and her attitudes of defeatism and insecurity could not be understood until she confessed that she had been illegitimate and felt she had had "no childhood". Her mother had apparently behaved in a punitive manner towards her "expecting so much" and "making her wash floors even when she was seven". This patient was later unable to adjust happily in marriage and records of social agencies mention her continual complaints of ill health and unhappiness. This finally culminated in her separation from a husband whom she characterized as "debauched" and to whose level she had felt she could not sink "because of her conscience".

In case (22), on the other hand, the patient just seemed to have no happy memories of her relationship with either parent.

Case (22), a 38 year old Jewish woman born in Russia (Diagnostic Impression: Anxiety with musculo-skeletal complaints), felt deprived and insecure as a child. Her mother was "always pregnant and having miscarriages" so that she was needed at home and "missed camp and school". She was "ashamed she knew so little" and "held it against her mother". This patient married to escape the constant parental bickering at home. She had determined that her married life would not resemble her mother's but, as soon as she mentioned her husband to the social worker, she began to cry and would not continue. This patient was also afraid of being called "neurotic" and of the doctors disbelieving her pains.

3. Marital Unhappiness

Of the 24 cases of marital unhappiness, 10 complained of infidelity and 11 of the unreasonable behaviour of their partners with lack of affection and care. One wife was lost in fantasies of what she might have become if unencumbered by her husband and children and one patient was psychopathic and might not have been able to adjust in

any marriage. For another patient, reasons for complaint are not known. There had been 10 separations among these 24 patients and, while the husbands of 8 female patients were either dead or of whereabouts unknown, only 2 of these women appeared to be somewhat indifferent about the past. It seemed that rather hasty marriage, lack of knowledge about the partner, and erroneous conceptions about the physical side of marriage on the part of certain of the women, were some of the factors in these unhappy unions. Eleven of these patients had diagnoses of Rheumatoid Arthritis, one of Gonorrheal Arthritis and one of Gout. Five had Osteoarthritis, one arthritis of undetermined origin and, in 5 cases, there was no arthritis but there was anxiety and unhappiness.

Among these 24 patients, there were only 2 who had no children. An important consideration in trying to help such patients would then be the well being of children who were still at home. There were children under 16 years in 10 cases, though, in one family, they had been taken from their mother, who was considered incapable of handling them, and placed in a boy's institution and a boy's reformatory school. In 5 other cases there was evidence that the children had suffered because of parental anxieties and conflicts, in 3 the effects on the children were unknown, and in one the girl of 13 was a cretin which introduced other difficulties.

In the following case, the patient blamed his wife for his loneliness and disappointment.

> Case (21), a 46 year old Roman Catholic man, born in Czechoslovakia (Diagnosis not determined) said he had married without much thought, hoping to found a family. His wife had not told him she suffered from deafness and "attacks" and, when his only daughter was 4 years old, he had deserted her. Now the daughter was "a fine girl of 15" who lived with her mother and saw him secretly, but his wife had

recently beaten her and patient said that if this happened again he would have his wife arrested. His daughter, however, "loved her mother and didn't want trouble". Patient felt bitter and defrauded about this situation and blamed his faith which made divorce impossible. A social agency, which had been involved, reported that patient's wife actually did not appear to be normal but that patient, though well able to do so, had refused to support his wife and daughter saying his wife "had caused him too much trouble".

Case (12) describes a woman who had submitted with bitterness to her fate.

Case (12), a 52 year old Protestant woman, born in England, and with a diagnosis of Rheumatoid Arthritis, married at 17, despite her mother's warnings, to escape from[a] poor and overcrowded home. Unprepared for marriage, as that part of life appeared "disgusting" to her, patient found that her husband drank so that she left him several times and returned home. A "diseased ovary" was removed some years later and patient remained childless. At the time she was seen, her husband, now 66 years of age and with a crippled hip, was unable to work. Patient felt she must serve and cater to him while he never felt concerned about her. She appeared to be in a state of continual tension, hostile and embittered, "keeping her worries to herself and crying when they became unbearable". She said her husband "sat in his chair from morning to night" and "got on her nerves". He "watched and criticized" her so that she "hurried her meals" and could not sleep. The doctor in Gastro-Intestinal Clinic, who diagnosed Entero-Spasm, felt that this patient's unhappiness was affecting her physically. Other factors here were a minimum social agency budget, sordid living quarters and patient's own physical pain, but much of her despairing restlessness seemed to be due to her sense of being trapped by her marriage into an unsatisfying life.

Case (46), also describes a patient with Rheumatoid Arthritis who was grieved and bitter about the failure of her marriage.

Case (46), a 57 year old Protestant woman born in England, with a diagnosis of Rheumatoid Arthritis, also married "against her mother's advice" and was deserted in 4 years. The marriage showed evidence of weakness from the start as there were periods when patient and her husband, or patient alone, stayed in the maternal home. Patient claimed that her husband had been "spoiled" by his own mother and that a married woman, 15 years his senior, was to "blame" for his desertion. This patient had also been "shocked" by the physical side of marriage. While all this history occurred before the onset of Rheumatoid Arthritis, patient still spoke of it with unhappiness and seemed in a chronically anxious state. Now, living with her elderly mother of 81, and dependent on a social agency, her sense

of defeat is difficult to modify and small disappointments provoke tears. This patient once said that she "never looked forward to anything for fear of disappointment".

4. Anxiety or Conflict over Children

Closely related to the unsatisfying marriages described, are the 22 cases in which there was anxiety about, or conflict because of, children, though in 8 cases there was no evidence of parental disagreement. Among these 8 patients, 3 were widowed, 4 did not describe any maladjustment, and, in one case, the relationship between husband and wife was unknown as it seemed the wife accepted her hardships as inevitable. Of the total 22 cases, 9 patients seemed to be chiefly worried about the health of their children, and 13 about their behaviour, though there is a combination of these factors in 13 cases. In 2 families, the children became delinquent and in 17 others the homes were unstable in various ways. At the time of this Study, however, there were only 12 families in which the children were under 16 in this group.

The diagnoses of these patients included 9 with Rheumatoid Arthritis and one with Gout, 6 with Osteoarthritis and 6 with no arthritis.

In the following case the patient's past had been tragic in her eyes due to the illness of her husband and children. Now a daughter was again ill.

Case (31), a 56 year old Hebrew woman born in Russia, with a diagnosis of Osteoarthritis and Hypertensive Cardiovascular Disease with Coronary Sclerosis, was tearful and anxious. She said she had felt ill ever since her eldest daughter's death 7 years previously. She "did not want to remind herself of it" nor of the death of her husband. Now she was upset because her youngest girl, Ruth, was "sick with arthritis and could not work". All this patient wanted was reassurance about Ruth who was seen in Medical Clinic where the diagnosis was "Chronic Nasopharyngitis, Psychoneurosis and Anxiety". A family agency had formerly assisted for 10 years as

the real problem had been tuberculosis, which patient and her daughter now never mentioned. The children in this family had always seemed "delicate and undernourished" while patient herself was subject to "tears and brooding".

Another patient had placed her children by a former marriage and felt that the mental deficiency and difficult behaviour of her husband's two children was an intolerable burden.

Case (41), a 35 year old French Roman Catholic woman born in Canada (Diagnosis: Rheumatoid Arthritis and latent syphilis), spoke of "her greatest worry," the children of her husband's first wife who had died in a mental hospital. The girl of 13, who had also been placed in this hospital, had been brought home by the father against advice where she drove patient distracted as "she had no ideas and couldn't understand anything". Patient said this had upset her to such an extent during her latest pregnancy that she "nearly had a miscarriage". After a year or so, patient's husband placed this child in a reformatory. Patient felt uncomfortable about this with good reason considering the punitive and repressive nature of the institution in question, but her husband's suggestion that he bring the girl home for the summer holidays made her say that she would miscarry her latest pregnancy. The 14 year old brother of this girl, in an orphanage previously, had also been brought home by the father and was "difficult" and troublesome. Two children of the patient's own by a previous marriage were with relatives in the country, and her youngest child, of 13 months, was at home and apparently a source of pleasure and pride. Patient and her husband were not willing to consider applying for transfer of the mentally affected child back to the hospital where she would have received understanding care, nor would patient decide on mental testing for the 14 year old boy. Instead she solved her problems by persuading her husband against a summer vacation for the girl, and by placing the boy in the country. Her pregnancy was also terminated by a miscarriage.

5. Death in Family

Deaths occur in all families and affect all individuals, but this group of 11 female patients seems to have been particularly distressed by their losses. Four had been anxious about the health of their husbands for a period of time prior to death. Two lost husbands unexpectedly. Four lost a sister, a foster child, a father and both

parents respectively. While one said she had recently heard that her family had been practically exterminated in Europe. Only one of these women had Rheumatoid Arthritis, 7 had Osteoarthritis and 3 had no demonstrable arthritis. It seems to be important to note that these 11 patients were all suffering from anxiety caused by factors other than the loss itself.

The first case given here illustrates a grief reaction in a dependent woman who seemed unable to reorient her life.

> Case (84), a 41 year old Hebrew widow born in Canada, with a diagnosis of Osteoarthritis, said that her husband, 13 years her senior, had "always taken care of her". She said he had been "ill and having operations" for 6 years before his death but nevertheless had died "unexpectedly" from a heart attack. Patient had been affected to such an extent that, even though the Orthodox year of mourning was over, she still wore black, "could not help remembering", and missed him from his place with the family in the synagogue. This patient's brother had also died at about the same time from "cancer", and patient used the word "dependent" when describing her relationship with both husband and brother.

Case (18) reveals the patient's identification with her lost father but also her unconscious resentment against him.

> Case (18), a 48 year old Roman Catholic woman, born in England, (Diagnosis: Osteoarthritis, Obesity, Menopause), continued to complain that her treatment did not help her pains though x-ray showed only minimal arthritic changes. She was referred to the social worker as she seemed to be generally upset. During her first interview she talked mainly of her father who had died about 3 months before. He had written to her regularly every fortnight for 20 years since she first came to Canada. Patient had always "admired" him and believed he had "the same nature" as she. He had been a mining engineer who had taken lower paid jobs "because of his great principles" in his work for trade unions. She felt that he had "sacrificed his family" but, at middle age, he withdrew from union work "disgusted with the rottenness of men who were traitors to the cause" and "with his health broken". Patient felt her mother, with 12 children, "would have liked comfort", while she herself, due to the struggle to manage, had to work at the age of 13.
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> As patient talked, she seemed to feel driven as her father had been. She became extremely tense and began to cry. She said

she could never relax at home, "she had so much to do". Another cause of anxiety was her 16 year old daughter who was playing truant from school and "telling lies".

6. Illness in Family

Illness in the family as a cause of distress was described by 29 per cent of these patients. Two spoke of past rather than present strains due to illness and 24 were caused financial anxieties because of it. It seemed that 15 of the 29 patients were chiefly anxious because of their responsibilities for the ill relative, while 14 showed more clearly their own insecurity and fear of illness in themselves.

Of these patients, 11 had Rheumatoid Arthritis, Rheumatoid Spondylitis or Rheumatic Fever, 10 had Osteoarthritis, 3 miscellaneous or other conditions, and 5 no arthritis.

The three illustrative cases used here show the strains and anxieties which family illnesses provoke.

Case (93), a 58 year old Hebrew woman born in Russia (Diagnosis: Diabetes, Diagnostic Impression: Psychoneurotic Depression with Musculo-Skeletal Symptoms), had a diabetic husband who had also suffered from "ulcers". She felt he "had not had the same nature since his illness but kept everything inside" and then got upset "like a match". Patient's only sister, after much marital unhappiness, had recently been committed to a mental hospital. Patient visited her weekly only to be met by tears and reproaches as she begged to be taken away. After such scenes, patient continued to imagine, for two or three days, that she could see the mental ward with patients tied to benches. This patient was intensely distressed and said she "would have to be born again not to worry". "God forbid" that she herself ever be sent to an "incurable hospital" if she became "paralysed".

Case (25), a 48 year old Protestant woman born in the British West Indies and with a diagnosis of Rheumatoid Arthritis, linked her period of greatest anxiety over her family with her most acute suffering. Her husband and daughter had been ill at home with tuberculosis and patient said she "could have screamed with pain" herself. There was "no one to help her", "friends were scared to

come around" and "she had to manage from day to day" as best she could.

Case (37), a 50 year old Protestant woman born in Canada (Diagnosis: Osteoarthritis) was worried about her husband who had been on sick pay for about 7 months. He had eye trouble and insisted she go everywhere with him, always calling "Anne, Anne", and following her around. She feared he was "at the end of the line" with his "heart and nervous stomach". He was also becoming impatient with his high school age son. A doctor's letter about this man's employability in a more protected job relieved this situation appreciably.

7. Anxiety About Health

The 51 patients in this category were chosen because their anxieties about their own health seemed particularly acute. In 33 of these cases, distress caused by the patients' life situation was a concomitant factor. In 15 cases such relationships are not clear as too little is known about them and only 3 were relatively uncomplicated. One patient had been badly frightened at being checked for possible tuberculosis and only needed medical reassurance, another was aged 71 and felt very much alone but was helped by her doctor in the same way, while the third, with Multiple Myeloma, was afraid she would die.

It is interesting to note that, in this group, there were as many as 20 with Osteoarthritis and 12 with no demonstrable arthritis. Fifteen were in the rheumatoid and infectious arthritis group and 4 had miscellaneous and other conditions.

The following two cases show the genesis of anxiety in childhood history. The second, in particular, exemplifying the same tragic pattern in three generations.

Case (42), a 37 year old man of Greek Orthodox faith born in Romania, with a diagnosis of Rheumatoid Spondylitis, was very

depressed about his physical condition. He said he "felt like sixty", was "tired and could not eat" and "did not trust himself or his health". There was only "me and my hands". He had wanted to marry and have a home but had refused a girl "because of his health" and this "broke his heart". He felt he "had to suffer because he must care for his health". This patient, as a child of 7, had seen his home looted by Russian soldiers. When his mother resisted she was about to be shot but "dropped dead from her heart". His father had been in Canada at the time and returned to his home but "had no heart to continue" and died of tuberculosis. It seemed that this patient's nervous unhappiness was due to his life history as well as to his physical complaints.

Case (80), a 42 year old Hebrew woman born in Russia, (Diagnosis: Probably Psychogenic Rheumatism), was afraid of "cancer" and "imagined she would die". Patient traced the unhappiness which "choked" her, to her mother who had been in an orphanage herself and "was only happy for a few years" when she married. Patient's father died and her mother then "didn't want to live and was always crying". Patient herself married because she felt "lonely", but now her husband paid her no attention and "didn't even care when the children were sick". He only said, "You are just like your mother - always complaining". Patient said she "screamed at her children, though she knew it was a crime", and made them "miserable" by saying she could not afford things. The eldest girl of 12 would get upset and once had said, "I wish I wasn't born". This unhappy woman, who goes from one clinic to another in her anxiety, had been further distressed by hearing that all her family, with one exception, had been killed in Europe during the war.

8. Fear of Old Age and of the Future

It is difficult to separate fear of the future and of old age from generalized attitudes of anxiety. It is also probable that many of these patients were concerned about what would happen if they were to become more ill or helpless. The 7 cases here chosen were ostensibly anxious about health and finances. Six were over 58 years of age, but one, who seemed very insecure,was only 47. Six of these patients had diagnoses of Osteoarthritis and one of Rheumatoid Arthritis. The latter became greatly relieved when assured that she would be cared for by a social agency.

Insecurity about the future was clearly shown by a 60 year old patient.

> Case (39), a 60 year old Protestant man born in England, with a diagnosis of Osteoarthritis, Bronchiectasis and Hammer Toes, was thin, nervous and worried. He was upset about the health of a brother "deformed by Rheumatoid Arthritis", a sister "who looked a wreck" and a son whose job had "folded up". He had been employed for 27 years by the same company but there was no pension plan and he had saved only $1500. Now he felt he was "too old for an operation" though his pains were "crucifying" him. He felt he was losing time through illness and that his wife was worried. "What if anything should happen to me?"

That there was "no one to care" as patient grew old, seemed to be another woman's chief complaint.

> Case (51), a 69 year old Protestant woman born in Newfoundland, (Diagnosis: Osteoarthritis, Arteriosclerotic C.V.D.), had lost her husband, "her only friend", two and a half years previously. She had then worked for a time but had felt in poor health and gave this up. Now, with some small capital only, she was "afraid of getting old with no one to care". Some of the reasons for her distress seemed to be due to her disappointment in life. As a child she had been "a general servant all the way through" and "the unlucky one". She "always had to work and save", "never had trips or clothes" and "only one vacation". Now she was living in conflict with an adopted daughter, Cecilia. This adoption of an illegitimate child had not given her the satisfaction she hoped for. Cecilia had "cried and cried" as a child when told about her adoption and now was "irritable, nervous and rough". She "didn't give a damn and told lies" and would not follow the proper regime for her diabetes. Patient felt that living with Cecilia was "killing" her, but could not decide whether to go to her family in Newfoundland, to let the social worker apply to an available church home, or to accept help in finding some sheltered and quite possible work. Some 4 months later it was found that patient had finally decided to go to Newfoundland. Cecilia was seen at this time and it was noted that her slacks, cigarettes and breezy ways were a contrast to patient's attitudes of propriety.

9. Financial Anxieties

The financial insecurities of these patients have already been considered. An attempt to analyze their economic status shows that at least 30 per cent needed financial assistance at this time while[a]/further

20 per cent were also probably in need, making 50 per cent of the total group.[1] In interviews, however, only 39 per cent of these patients expressed particular anxiety about finances. Twenty-five appeared chiefly concerned because their own health or that of a spouse resulted in reduced income. In only 8 cases did the financial difficulty appear to be the one of primary importance. In all the others it was combined with other factors provocative of strain.

Of these patients, 14 were cases of Rheumatoid Arthritis, one of Gonorrheal Arthritis and 2 of Rheumatoid Spondylitis. In these cases it would seem that it is extremely important to relieve the patients, if possible, of worries about finances, as such anxieties add to others which are already reacting unfavourably upon their condition. There were 16 patients with Osteoarthritis who could, for the most part, be called geriatric problems and 6 patients with miscellaneous diagnoses, no arthritis, or other conditions.

The first illustrative case which follows is one in which an insecure common law relationship was the most acute problem. The second seems to be purely a financial difficulty. However, this patient's life history was never understood due to the barrier of language which could only have been surmounted had more personal attention been given to him.

> Case (5), a 62 year old Hebrew woman born in Russia and with a diagnosis of Osteoarthritis and Arteriosclerosis, was overtly distressed because her husband would not give her enough money for her physiotherapy treatments. Besides this, the independence of her youngest daughter, Bessie, upset her. A widowed son-in-law was courting Bessie unsuccessfully, yet patient desired this

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1. Infra pp. 72-73.

marriage as her son-in-law had always helped her financially. She believed he would cease to do so should Bessie continue to refuse him and prefer her own choice of a "poor" boy "with no prospects". It was only during a third interview that patient confessed that the basic reason for her insecurity was the common-law relationship in which she lived. She said she had brought up 4 stepchildren and her own child for her husband but he would not even give her adequate clothing. When she protested that even a hired girl in his home would cost something, he had answered that she could keep someone else's house if she wished.

Case (9), a 45 year old Roman Catholic man born in Poland, (Diagnosis: Rheumatoid Arthritis), had been in Canada for 22 years but had never learned to speak English easily and had only done unskilled jobs. Patient had no relatives here, so that when he became incapacitated he had to depend on the help of friends and, after more than 6 months of this, was discouraged and in despair. Through the necessary social agency, and with a medical certificate, the maximum public assistance allowance of $45 a month was obtained for him. Patient's relief was very apparent and he said he could manage. There is no solution, however, to the problem of finding light work for him when his physical condition improves. This lack in community resources will be discussed in the following chapter.

10. Erratic Work History

Work history was only discussed with 13 of these patients. Of the 11 males who had worked sporadically, 6 had apparently had no adequate apprenticeship to any trade, and 3, with some training, were restless and dissatisfied. One patient felt he could no longer adapt to change and that his age of 52 was against him. Reasons for the frequent changes of work by another patient are unknown. Of the 2 women, one, a restless girl, moved from one institutional position to another hoping to find happiness, while the other experienced periods of depression and incapacity. Four of these patients had Rheumatoid Arthritis and 2 Gonorrheal Arthritis. The remaining 7 were divided about equally among the diagnoses of Osteoarthritis, no arthritis and miscellaneous and other conditions.

Sometimes it would seem that psychiatric help is needed as in the following case.

> Case (89), a 22 year old French Roman Catholic man born in Canada, with a diagnosis of Pes Planus, had not worked for nearly a year due to "joint pains" after a gonorrheal infection. There was no proof, however, that this had been Infectious Arthritis. There was difficulty in this patient's home as his father had been partially paralyzed after a stroke and the family barber shop had been recently sold at a loss. Meanwhile, patient's step-mother complained that if he were well enough to go out in the evening, he was well enough to work. Patient said he had left school at Grade VIII to take messenger jobs. Later he was employed by two different companies as a bench hand but had left these positions to work on the summer lake boats. He was very withdrawn and depressed and implied that his inability to settle down was due to his mother's death from cancer when he was 15 years old.

The older man in Case (17), however, could not be given psychiatric treatment as his organic disease was too far advanced and his history of social disorganization was of too long standing.

> Case (17), a 46 year old Roman Catholic man born in Canada, Diagnosis: Rheumatoid Arthritis, Epididymitis, Gastric Ulcer, was first known to an agency at the age of 26 when he applied for day nursery care for his young son as he was out of a job and his wife was working. Patient was reported to be of an "unkempt" appearance at that time. Unemployment or erratic work continued with patient's wife complaining of cruelty or non-support and retaliating by infidelity. Patient's odd labouring jobs, such as snow removal, became impossible after the onset of Rheumatoid Arthritis when he was 35. On one occasion an elevator job was found for him in an institution, but he gave it up saying he had not liked the food. It was reported, however, that he could not adapt himself to night work and fell asleep while on duty. Other attempts to find employment for this patient were failures and he is now considered both physically and psychologically unemployable. His unhappy childhood, which has been previously noted, probably laid the foundation for his aimless life.[1]

Before summarizing the findings of this section, Table XII can be briefly considered.

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1. Supra, p. 47.

TABLE XII

FREQUENCY OF SOCIAL PROBLEMS DESCRIBED BY 100 PATIENTS ATTENDING ARTHRITIS CLINIC, ROYAL VICTORIA HOSPITAL, RELATED TO DIAGNOSIS.

Social Problems	Number of Times Found											
	Total	Infectious Arthritis	Rheumatoid Arthritis	Rheumatoid Spondylitis	Rheumatic Fever	Osteo-Arthritis	Mixed Arthritis	Gout	Traumatic Arthritis	Miscellaneous	No Demonstrable Arthritis	Other Conditions
Total	228	8	67	9	2	80	3	2		10	41	6
Loss of Parents	19	2	7	2		5					2	1
Unsatisfactory Relationship with Parents	13		4	1		3	1				4	
Marital Unhappiness	24	1	11			5		1		1	5	
Anxiety or Conflict over Children	22		9			6		1			6	
Death in Family	11		1			7					3	
Illness in Family	29		8	1	1	10	1			2	5	1
Anxiety about Health	51	2	8	3	1	20	1			2	12	2
Fear of Old Age or of the Future	7		1			6						
Financial Anxieties	39	1	14	2		16				3	2	1
Erratic Work History	13	2	4			2				2	2	1

References have been repeatedly made to the incidence of the social problems found and the diagnoses of the patients involved. There were proportionally more instances of parental loss, unsatisfactory relationship with parents, marital unhappiness, and anxiety about children, among those patients with the more severe and rheumatoid types of arthritis than among those with osteoarthritis only. For example, among 27 patients with Rheumatoid Arthritis, these disturbances in family relationships occurred 32 times. Whereas they were mentioned in 19 instances only by the 39 patients with Osteoarthritis. Such evidence as this, however, cannot be considered conclusive owing to the tentative nature of the study of these aspects of the life history. Nevertheless, it was the writers' impression that those patients with the more serious forms of arthritis had experienced greater difficulties of life adjustment and were faced with more intense conflicts in their inter personal relationships.

It must be remembered that a long continued experience of pain - which is more severe in the more serious forms of arthritis - has an exhausting and demoralizing affect. This is increased by the uncertain prognosis and possibility of crippling. From whatever causes lay behind the manifestations observed, it seemed to be more difficult to gain the confidence of these patients. In some cases, also, their attitudes, often overtly timid and submissive, later revealed a resentment which they had at first been unable to express. Such attitudes were observed among 18 of the 27 patients with Rheumatoid Arthritis, with submission generally the more apparent. There also seemed to be some relationship between attitudes such as these and the early life history.

A review of this section on the social problems revealed in

interviews, shows that 19 per cent of the group had experienced the loss of one or both parents. This appeared to result in increased difficulties of life adjustment. Thirteen per cent spoke of unsatisfactory relationships with parents. Such unhappy experiences, as well as parental loss, may mean that, in adult life, it will be more difficult to form balanced relationships with the opposite sex. This was found to be the case among 7 of 9 of these patients who later married. Marital unhappiness was described by 24 per cent, which is about one third of those who were, or had been, married. It would appear to be of particular urgency to try to find means of alleviating the family conflicts in this group for the sake of the children involved. This consideration is important also when noting that 22 per cent of these patients expressed conflict or anxiety over their children in any case. In 12 of these families, the children were under 16 years of age.

Deaths in the family, which were mentioned with particular distress by 11 per cent of these patients, seemed significant because of the resulting feelings of loss, insecurity and helplessness. All these patients were, however, suffering from anxiety due to other factors than their bereavement alone. Twenty-nine per cent were concerned because of illness in their families, and, among 14 of these patients, this factor increased their fears about their own health. Fifty-one patients expressed such fears overtly. While financial anxieties and fear of old age were closely related to concern about health, actually only 7 patients spoke of their fear of the future, and only 39 mentioned their worries about money. However, as far as could be discovered, at least 50 per cent of these patients experienced financial anxieties. Work history was only considered in 13 instances.

These patients described frequent employment changes or disatisfaction with their work.

The situations of stress, which have been described, appeared to be of great importance as 47 per cent of these patients, comprising 14 males and 33 females, exhibited a generalized state of anxiety. As many as 27 per cent, 3 males and 24 females, were in tears as they spoke of their difficulties. While the incidence of social problems in relation to the various diagnoses can only be considered suggestive, it seemed that those patients with the more serious forms of arthritis had experienced life stresses of a more severe nature. However, the long continued experience of pain in these cases must not be forgotten, as pain is necessarily a phenomenon which concentrates the attention of the organism on itself. It thus exhausts, or diminishes, those energies might might otherwise be used in establishing relationships with other people and in adjusting to the vicissitudes of life.

Just as each individual diagnosis must be both medical and social, so methods of treatment will need to be applied to meet physical, social and emotional requirements. In the following chapter, possible methods of social treatment will be considered, as well as the community resources which should be available if such treatment is to be successfully attempted.

CHAPTER V

THE EXTENT OF NEEDED COMMUNITY RESOURCES

When a patient has a chronic disability and complete restitution to normal can no longer be expected, the physician's chief aim, according to Dr. Ernst Boas is, "to arrest the progress of disease, and to enable the patient to maintain or resume his accustomed place in society and in his family." This study is chiefly concerned to discover how this adjustment to society and family can be accomplished. While it is generally accepted that human life is profoundly affected by its social milieu, it is now apparent that, among these patients, social conditions were, in many instances, complicating the treatment of their disease. However, just as medicine explores every avenue of research in trying to find solutions for physical suffering, so it must now consider how to alleviate and redress those conditions of living with which the individual is unable to deal unaided. Some of these conditions, as will now be seen, are part of our imperfectly developed society and illustrate the need for further social planning.

There are many community resources and services which might be needed by patients attending an arthritis clinic. It was only possible here to list those which were most obviously and most immediately required. Their availability and adequacy in Montreal at the present time

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1. Ernst P. Boas, The Unseen Plague Chronic Disease (N.Y. 1940) p. 22.

(May - June 1951) is considered in Table XIII, which also illustrates the frequency of need found among these patients.

TABLE XIII

FREQUENCY AND EXTENT OF COMMUNITY RESOURCES NEEDED BY 100 PATIENTS ATTENDING ARTHRITIS CLINIC, ROYAL VICTORIA HOSPITAL.

Resources [a]	Frequency and Extent			
	Total	Available		Not Available
		Adequate	Inadequate	
Total	112	51	20	41
Outside Medical Planning [b]	10	9		1
Financial Assistance	30	4	15	11
Recreation	9	1		8
Vocational Service	4	4		
Employment	4	4		
Sheltered Shop and Employment Training	11			11
Family Agency Service	27	24		3
Special Home Care	13	2	4	7
Other Needed Resources	4	3	1	

a. This includes community resources known to, and used by, Social Service Department, Royal Victoria Hospital.

b. Cooperative planning with other hospitals or psychiatric agencies.

The community resources here described were needed by 49, or just under half, of these patients. However, this estimate of need is not a complete one as a more comprehensive evaluation of the social factors involved might have resulted in a recognition of other specific needs. From the available records, it would seem that 112 services were required. Of these, 71 were available, and 41 were not available. The available resources were, however, inadequate in 20 instances.

1. Outside Medical Planning

The treatment of patients in a clinic or treatment centre may vary according to the medical resources available. In the case of the Royal Victoria Hospital, the treatment facilities are extensive. Admission to the ward is possible, the clinic treatment of ambulant patients can be carried on, and a physiotherapy department carries out the physicians' recommendations for supervised exercise and other special procedures. As the extent of planning with other medical and psychiatric agencies depends on the services which the original treatment unit can give, the medical needs of this patient group did not often require the cooperation of other institutions. Contact with such agencies was, therefore, mainly due to the fact that other family members were being treated elsewhere. These contacts only became necessary when the well-being of such family members vitally affected the patient himself.

Of the 10 patients for whom planning with other hospitals or psychiatric agencies was needed, one only could not be helped. This patient, case (45), had a diagnosis of Psychopathic Personality and Chronic Anxiety with Paranoid Trends. He required, according to the consulting psychiatrist, a disciplinary institution in which the therapist would have no authority over the patient, or responsibility for his behaviour, but would act in a purely psychotherapeutic capacity. During this patient's admission and his clinic attendance in 1948, no such resource was available for him, and it was not considered feasible to attempt treatment either in Psychiatric Clinic or at Allan Memorial Institute. Nor was it felt that committment was justified at that time, though it was possible that patient might become involved with the police. Suitable facilities for the treatment of this

type of patient are still not available in the Montreal area.[1]

For 9 patients, however, available services were adequate. One required convalescent care and 8 had family members known to other medical or psychiatric agencies. When transfer to another hospital or institution is required, it is not only necessary for the patient to agree to the plan of transfer and to feel satisfied with it, but an interpretation of his particular needs must be made, and the cooperative understanding of his family must frequently be gained. For those patients who are connected, through their families, with other hospitals, concurrent plans of treatment may be worked out. Cooperative solutions of social problems, which would not otherwise be understood, may then be attempted. The following cases illustrate these two types of need.

> Case (50), a 65 year old Hebrew man, born in Russia, with a diagnosis of Osteoarthritis and Hypertensive Cardiovascular Disease, was recommended for convalescence as there was probable disk involvement and rest was impossible at home. Patient, however, wanted hospitalization and did not seem able to understand about the need to rest. As there were also language difficulties, the social worker visited his home. There, his daughter-in-law explained that patient "fussed around" his bed-ridden wife, though she was adequately cared for. She said he was "studdorn but could be persuaded like a child." With her encouragement, he finally agreed to recommendations and applied to his union insurance for payment of the bill.
>
> During convalescence, this patient became upset as he had been moved to a room alone because he moaned at night. This distressed him, as he and his family thought he had been moved because he was Jewish. The social worker, to whom the patient's daughter-in-law had reported, was able to explain and thus remove a possible source of misunderstanding. At this time the daughter-in-law also said that the patient had formerly been under the supervision of another hospital clinic but had left in dissatisfaction about his care.

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1. 1. Confirmed by telephone by Dr. Baruch Silverman, Director, Mental Hygiene Institute, Montreal, May 29, 1951.

Case (67), a 49 year old French Catholic married woman, born in Canada, had, as yet, an undetermined diagnosis but was anxious and distressed. She said her husband had been changed by his service overseas and now became violent when drunk and might smash things in the house or beat the family. The daughter, aged 21, had been given shock treatment for schizophrenia at the Allan Memorial Institute. There the psychiatrist reported that the father's behaviour had undoubtedly affected his children. The son, aged 11, was attending the Children's Memorial Hospital where the Social Service Department had sent him to Laurier Mental Hygiene Clinic. Psychiatric examination of this boy, "strongly suggested a pre-psychotic condition with schizoid and paranoid traits."

As this patient thought that her children would be helped by summer holidays at the family farm in Gaspé, the social worker consulted the physicians interested in them, and assistance was given with arrangements. The following Autumn, when the patient became worried about her son's return to school, due to his former experience of being strapped and playing truant, she was encouraged to find a special school placement for him which she was later able to do. An attempt was also made to secure the cooperation of the Department of Veteran's Affairs on behalf of this patient's husband who was eligible for treatment at the Queen Mary Veteran's Hospital. Meanwhile the daughter, who had been too "terrified" to accept convalescence after her shock treatment, had also failed to return to psychiatric clinic. With encouragement, she was able to do so and a long term supportive contact was established with her psychiatrist. While this patient required a more prolonged service than she was given, since there were destructive elements in the family relationships, this case illustrates the necessity of understanding the family situation of clinic patients as their physical condition is only one aspect of the total problem.

2. Financial Assistance

The provision of financial assistance to persons in need in Montreal, is complicated by the unique pattern of organization for health and welfare in the Province of Quebec. This system is a combination of private charity and state assistance in which government aid to private hospitals, institutions, and welfare agencies, is channelled through grants-in-aid and the Quebec Public Charities Act of 1921. By this Act, in principle, the provincial government, the municipality, and the private agency, each bear one third of the cost of care given to needy persons

in institutions.[1] Due, however, to the lack of available beds, grants were given to social agencies as "institutions without walls", so that the needy might continue at home. In 1948, these grants were at the rate of $24 a month for an ambulant or aged person unable to work, or $45 a month for a chronic invalid who would have required chronic hospital care if such had been available. These inadequate allowances, which have not been increased, are administered, in the Montreal area, chiefly by six organizations which belong to the four philanthropic federations of the French and English Catholics, the Jews and the Protestants. There is no documentary source for these policies which, conceived as temporary measures, are likely to remain permanent.[2]

The above organization of public welfare will explain the inadequate nature of relief and the burden placed on private agencies, whose budgets for assistance vary according to their financial condition and the success of yearly appeals. For example, Family Welfare Association, which assists those of Protestant and Greek Orthodox faith, has a present food allowance of 42¢ per person per day for families on relief. This agency is unable to increase its budget[3] though the most recent study of food costs by the Montreal Diet Dispensary noted that 58.3¢ per person per day was the minimum for adequate nutrition.[4] Family Welfare

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1. H.M. Cassidy, Public Health and Welfare Reorganization, (Toronto, 1945) pp. 364-366.

2. Confirmed by telephone by Mr. G.A. Aubertin, Social Welfare Department, City of Montreal, May 29, 1951.

3. Confirmed by telephone by Miss E. Barnstead, Casework Supervisor, Family Welfare Association, Montreal, May 30, 1951.

4. Confirmed by telephone by Miss N. Garvock, Director, Montreal Diet Dispensary, May 29, 1951.

Association, however, assists persons in need from the time of referral, according to the accepted budget plan, and supplements the Quebec Public Charities allowance when this is later obtained. On the other hand, Bureau d'Assistance Sociale aux Familles, which serves French and European Roman Catholics, cannot afford to do this. This agency must have recourse to the non-professional society of St. Vincent de Paul until the Municipal grant is received, which may be a matter of three months. Augmentation of this $24 or $45 grant is then only possible in certain very limited cases.[1] The only exception to this restricted service, is the budget of the Family Welfare Division of the Baron de Hirsch Institute for Jewish clients. This agency, with the highest relief budget in Canada, made a study of its August 1950 allowance in January 1951. It was then found that the August allowance had been generous enough to be able to absorb the rise in the cost of living during that period.[2] This, no other Montreal agency has been able to do.

Table XIII, in its description of financial assistance, will now be understood. Of 30 patients who could be said to need such help, only four could have been adequately helped, 15 were eligible for inadequate assistance, and 11 were ineligible for any relief. Of the 4 placed in the adequate category, one was assisted with hospital expenses by his union insurance, one was granted an increase in the usual agency budget, for reasons unknown to the writer, and two were eligible for Jewish Family

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1. Confirmed by telephone by Mlle. F. Marchand, Director, Bureau d'Assistance Sociale aux Familles, May 30, 1951.

2. Confirmed by telephone by Mr. Benjamin Goldman, Supervisor, Jewish Family Welfare, May 30, 1951.

Welfare assistance though, when first seen, they were anxious to remain independant despite their difficulties. The 15 patients for whom adequate help was not possible, comprised 13 for whom agency budgets would not be sufficient to meet minimum food requirements, and 2 cases where a sheltered workshop plan, with adequate remuneration, as will be described later, might have been used in rehabilitation. There were 11 patients for whom assistance was not available. In 8 cases, the family income was above the inadequate agency budget allowed; in one the required certificate that the patient was completely incapable of work was not considered justified; and in another, there was no out of town agency to administer relief. Case (64), the last in this group, could not be assisted as the agency concerned was unable to gain the cooperation of the patient's daughter who supported her psychopathic male friend in her mother's home.

If these 30 patients are considered from the point of view of age and diagnosis, two main reasons for dependency become apparent. One of these is the problem of age, and the other the result of the disabling effects of Rheumatoid Arthritis, Rheumatoid Spondylitis and Infectious Arthritis. For example, of 17 patients with these diagnoses, only 2 were over 60 years of age, 5 were aged 50 to 59 years, 4 were between 40 and 49 years and 6 were under 40 years old. On the other hand, among the 11 patients with osteoarthritis in this category, 9 were over 60 years of age and the medical conditions of the two who were aged 54 and 56 respectively were complicated by heart disease. The 2 other patients needing assistance in this group of 30, had diagnoses of Gout and Osteomalacia.

But, besides these 30 patients who, it seemed, were in obvious financial need, there were 20 who have not been included in the table

whose financial position appeared to be precarious and unsatisfactory. These included 3 cases of the patient's husband being unemployed, 11 cases of low wages or irregular employment, and 6 of inadequate pensions or savings or assistance of unknown amounts contributed by children. Only more detailed knowledge of the financial situation of these individuals and families, could supply grounds, however, to state that this further 20 per cent of the patient group needed immediate assistance.

The two illustrative cases have been chosen to show the efforts which must be made to supplement inadequate budgets which do not, even then, allow a manner of life with minimum satisfactions. They also reveal the short sighted nature of a community policy which insists on means tests rather than basing services on human need. It must be remembered, however, that the lack of a public welfare program to meet subsistence needs, imposes an intolerable burden on the private agencies concerned.

> Case (34), a 69 year old Protestant woman born in England, (Diagnosis: Osteoarthritis, Hypertensive Cardiovascular Disease and Obesity), seemed tired and depressed. Twenty-three years previously her husband had experienced a head injury for which he had received no compensation due to returning to work too soon after his accident. A later diagnosis, at the Montreal Neurological Institute, was Traumatic Epilepsy which necessitated low paid jobs and the patient's supplementation of the family income. This patient described the period of strain which followed when she said, "Nobody knew how I felt - I kept it to myself". Finally, in 1946, when the patient was aged 67, she felt she was no longer able to work and so asked for assistance from a family agency. At the time of this study the budget of this couple, who had no living children to assist them, was $72.60 a month. Of this amount, $30 went for the rent of the small apartment which they called "home". While the patient spoke of her increasing anxiety due to her husband's "fits", after which he might wander around and turn on the gas, the family agency found that she and her husband were eating too much bread and that their diet was monotonous. They also lacked any opportunities for recreation. Only limited ways of relieving this patient's strain could be found, however. An arrangement was made for a supplementary diet

for her, library memberships at Young Women's Christian Association were secured, and extra car fare was given for visits to flower shows. While the dietary supplementation could not be continued for more than a period of 6 months, this patient lost some weight and said she felt considerably better.

Case (63), a 27 year old Roman Catholic man, born in Canada, (Diagnosis: Rheumatoid Arthritis), was no longer able to work. He had become so disabled that, despite all efforts by him, and on his behalf, no suitable part time or protected employment could be found. During his disability, he was entirely dependent on his family, which subjected him to great strain. This patient's father, formerly a man of robust constitution, was now partially paralyzed and patient spoke of him with uneasy admiration and also with fear. On one occasion, taunted by his father's comments about his inability to find work, he told the medical social worker that he had felt like walking in front of the traffic on the street. The patient's mother, who had "sacrificed" herself for her children, according to patient, meant much to him, but he feared the effect of his father's moods on her. Patient's siblings were healthy and athletic and were a continual reminder of his own incapacity. To relieve this patient of the constant strain he was under at home, sheltered workshop facilities, as will be discussed later, should have been available to him. But a living allowance, to restore his self respect and allow him to live elsewhere in an independent manner, was also necessary. This could not be granted, as the combined income of the earning siblings was considered sufficient to support the patient at home. That his condition has since become progressively worse, may, in part, be due to the continuation of the environmental stresses to which he is subjected.

3. Recreation

The active individual who finds satisfaction in his work, his family and his friends, may have no difficulty in also finding the type of recreation which meets his needs. It is not necessary to emphasize, however, that economic restrictions affect recreation as they affect housing and nutrition. A holiday in the country, going to a concert, a play, or the cinema, belonging to a club for games or social gatherings, may cost varying amounts. It would not be possible in this study, however, to consider how many activities were available to all these patients. For though the medical records noted in a number of cases that these

patients enjoyed very little recreation, it was observed that such notations might be made on a patient who was able to exert himself both in work and play but was too unhappy to do so. Such patients as these cannot be considered here as presumably, with medical and social treatment, they would be capable of achieving a more satisfying life. Instead, a relatively small group of 9 patients, who were particularly lonely or handicapped and needed special resources, have been chosen for discussion.

Of these 9 patients, only one, a young man of 27, could find suitable recreation at the Young Men's Christian Association. The other 8 were women. Five were over 50 years old, 2 were over sixty and one was over 70 years. The question arises as to why recreational activities were not available to them.

In a study on recreation lacks for older persons in Montreal, the Montreal Council of Social Agencies reported that there were too few recreational groups for the elderly in the City. While in theory there should not be segregation, in practice this section of the population was neglected unless special provision was made.[1] A pamphlet on the organization of clubs for older people was produced this year which also states "... with the rapidly increasing proportion of people over sixty years of age in our population, there becomes apparent a serious lack of clubs, programmes and centres geared to the recreation needs of older people."[2]

Besides this interest of the Council, Women's Voluntary Services, Montreal,

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1. Montreal Council of Social Agencies, "A Proposal for the Development of Recreation Programmes for the Aged in Montreal", April 24, 1951. pp. 3-4.

2. _____, "Old Age Can be Fund", unpublished, Montreal, 1951. p. 1.

has, by distributing lieterature to men's and women's organizations since November 1950, been encouraging the formation of "Darby and Joan Clubs" for the elderly.[1] Several such clubs have now (June 1951) been started, though, at present, the only one with professional leadership is the "Golden Age Club" of Young Men's and Young Women's Hebrew Association.[2] The eventual aim of these clubs is that members and volunteers will visit home bound members or that transportation for them will be provided.

Such resources and services as these were undoubtedly needed by the 8 women over 50 years of age in this group. Three were wheel chair cases and one required crutches. Of the 4 who could get about by themselves, only one appeared to be free from any real strain other than that of being too much alone. Six of these 8 patients subsisted on minimum agency budgets, while 2 were supported by their families in financially restricted situations. No such resources as here described were available for them in 1948 and, while a beginning is now being made, many small neighbourhood groups will have to be established before needs are met. Services to the home bound, while envisaged for the future, are still entirely lacking. The following two cases illustrate these community needs and reveal the restricted lives of two patients. One of these was a fairly usual situation and the other lived in a pathological environment.

Case (27), a 73 year old Protestant woman, born in Estonia, had a diagnosis of Rheumatoid Arthritis. Her father had been an architect, but the family had always been poor and her life had been full of

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1. Information obtained from visit to Women's Voluntary Services, Montreal, May 21, 1951.

2. Interview with Mr. Ben Stein, club leader, Young Men's and Young Women's Hebrew Association, May 17, 1951.

vicissitudes and hardships in Europe. In 1948, settled in Canada and with no relatives here, she lived in a room alone supported by her old age pension of $30 a month augmented by $14 which was granted her by a family agency. Patient had recently been in hospital and told the social worker that her joints had formerly been so stiff and painful that she had had to climb the stairs in her lodging house on her hands and knees "like an animal". Now, physically better, able to get about, and feeling almost gay with relief, she wondered whether there might not be something she could do. The family agency had suggested Occupational Therapy Centre, which the doctor approved, and which was therefore arranged. This centre could, at that time, provide little but the occupation of weaving, belt making, or such similar crafts, and had not been established, as a club would be, to foster the warm inter-relationships which lonely people need. At this time, (June 1951), even this resource is lacking, as the Centre is to be available in the future only to those who can be rehabilitated in an active manner.

Case (15), a 50 year old married Roman Catholic woman, born in Canada, and with a diagnosis of Rheumatoid Arthritis also, was forced to use crutches to get about. Patient's husband earned only $82 a month, one son had been on his own for some time and was married, while the younger son of 18 was still at home and was apparently working in an erratic manner. Patient's marital relations seemed to be irreparably strained. She said her husband threatened her with an asylum and called her a "Nova Scotia bastard" and a "damned old crippled up witch". Her reactions of anger and helplessness made her body feel weak and her chest oppressed. Patient said she felt as if everyone were threatening her. A neighbour's child had even said she was "only a hag - all crippled up and ugly." This patient also had an intense fear that her youngest son would leave her. This fear was increased as he tried to free himself from her domination, but she provoked his rejection by going, for example, "to fetch him home" when he stayed out at night. He would return cursing, while his mother was in tears. Patient's physician felt that no help could be given to her in clinic while this situation at home continued, and the social worker attempted to drain off some of this patient's anxiety. It was found that the family agency, to which the patient was known, believed that nothing could be done, while the patient's older son felt resentful about his mother's earlier rejection of him and could not be helpful to her.

As the medical social worker was unable to visit, patient telephoned the hospital whenever she felt in need of reassurance. She made real efforts to be accepting of her son's desire for independence and said to the worker, "Nothing can happen while I'm talking to you". The psychiatrist, who was consulted, recommended a continuation of this supportive treatment. An attempt was also made, without success, to secure a visiting occupational therapist and to encourage patient to invite her friends to the house. It was probably the truth that she had few friends who could be tolerant of her complaints. After a three month period, when conditions

were a little improved, this case was closed, and the patient became as unhappy as before. This patient might have been helped could she have been driven regularly to a recreational centre. Visiting at home in her case, however, could only have been undertaken by a professional worker, as a volunteer could not have been exposed to the family problems.

4. Vocational Service

As the infectious and rheumatoid types of arthritis may handicap the young and force them to change their type of work, vocational service and suitable employment are necessary resources for rehabilitation. Among patients attending an arthritis clinic, there may also be those who have related complaints and who are maladjusted in their occupations and require help in changing them. At the time of this study in 1948, the only agency which was staffed for vocational guidance by professional psychologists, and which offered a free consultation to the public, was Jewish Vocational Service. This agency, a member of Jewish Federation, still accepts clients of all faiths, and is in touch with a large number of employers with whom placements are arranged.[1]

For French Catholic single men, the Societé d'Orientation et de Réhabilitation Sociale offers special testing, if considered necessary, by a psychologist or psychiatrist. Placement in work is then arranged through National Employment Service. Handicapped men are directed for physical treatment to the Rehabilitation Society for Cripples which began active work in April 1950. A somewhat similar, but more limited, English Catholic agency has also been recently organized.[2]

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1. Interview with Miss Ruth Stein, Supervisor, Jewish Vocational Service, May 16, 1951.

2. Interview with Mr. Evariste Choquette, Director, Societé d'Orientation et de Réhabilitation Sociale, May 16, 1951.

It seemed that 4 of the total group of these patients needed vocational services to assist them with future planning. These included one case each of Infectious Arthritis, Rheumatoid Arthritis, Rheumatoid Spondylitis, and Pes Planus, with 3 patients in their early twenties and one aged 34. None of these patients, however, could have been helped by Vocational Service alone, as they all appeared anxious and strained. This was partly due to their pain and disability but was also the result of other factors as well.

Case (83), a 21 year old Protestant man, born in Canada, with a diagnosis of Rheumatoid Spondylitis, had had periodical attacks of pain in his right hip since the age of 12. This evidently interfered with his boyhood sports and he was sensitive about being perhaps considered a "sissy". He continued with golf, swimming and badminton, and also went on long canoe trips during vacations, until he was forced to use a cane in March 1948 and later to stop work altogether. When patient finally attended the Arthritis Clinic at Royal Victoria Hospital in September 1948, he complained of persistent and severe pain for 8 months which interfered with his walking. There was also pain in his right knee, his left arm, and his back, and a muscular ache in his chest which had limited expansion. Patient could not stand erect but was stooped slightly forward.

The medical plan of treatment was a series of three monthly courses of x-ray therapy with three and six month intervals between courses. Physiotherapy twice a week was also advised. The doctor at first recommended that patient should not work for nine months, but, when patient said this was not possible, he was permitted some part time employment.

Patient's physical condition was not the only problem. His parents were separated and his father did not contribute. Patient's mother and an older sister both worked, while a younger sister of 18 was a nurse-in-training. When this patient was first seen by the social worker, it was noticed that he had a slight stutter. He said he was reticent and had formerly been apprehensive about doctors who had told him nothing could be done, that his disease would "burn itself out", and that he must concentrate on his work and forget his pain. When his plans for the future were discussed with him, he was interested in going to Jewish Vocational Service, but said he wanted work "with some excitement and interest" which would distract his mind from his pain. He said he did not want to be "pampered" and wanted no "compromise" because of his disability.

Jewish Vocational Service reported that patient had implied that he had disliked his former office work, that his interests were vague, and that he seemed to think he would like an advertising or newspaper position for which he had no special training. He had his matriculation and tests showed first year college ability. It was considered he might like work in a library, or for a publishing company, and clerical training was recommended as a beginning. In an adjustment test, patient was frank, saying he had problems at home but felt he could solve these himself. He had also borrowed a book on the psychology of everyday living.

It seemed to the social worker that this patient was somewhat disappointed that the Vocational Service was exploratory only. He visited Sir George Williams College and Montreal Technical Institute and enquired there about a possible course in construction. Finally he began a secretarial course in his home district, which was just outside the City and would thus spare him from too much travelling. Patient would not consider an application to Rotary Club for financial assistance towards his training.

It was the social worker's opinion that this patient did not receive adequate help for his adjustment. He needed a sheltered workshop where his employment might have been adjusted, under medical supervision, to his capacities until he had completed his treatment. Then, after undertaking the necessary training he might have been directed to a suitable job. It was not helpful for him to feel that he was a burden on his mother and working sister, and a maintenance allowance or adequate wage, regardless of what he was able to accomplish, should have been available. Finally, he had never confided in the social worker who felt that he needed the help of a supportive and sustaining relationship. While he might have established this type of relationship with his physician, he needed more time than can often be given in a busy clinic.

Case (71), a 21 year old Protestant man, born in Canada, had a diagnosis of Gonorrheal Arthritis and Chronic Prostatitis. Patient became known to the social worker while he was on the ward for treatment. His brother reported that his illness had "demoralized" him and that a former hospital had just "let him out to suffer". Patient said little at first but gradually expressed great anxiety and resentment. He said his illness was a "nightmare", his treatment a last resort, and that he might as well leave against advice. Reassured by his doctor, he decided to stay and told of loosing his mother when he was 11 and of being brought up by a succession of housekeepers. At 15 he began an International Correspondence School course and was a "qualified machinist". Now, however, he could no longer lift the heavy weights required and disliked his work. Patient said he would like to be a salesman and travel around like his elder brother. But he was afraid his vocabulary was lacking and that he did not have "what it takes". He did not accept the idea of referral to Jewish Vocational Service, but wanted, instead, a letter to his employer asking for his transfer to some sedentary type of work. Patient was

not reemployed, however, as he apparently had an unsatisfactory record.

Four days after his discharge this patient was involved in an automobile accident and was charged with criminal negligence as a companion had been killed. Patient's elder brother, who throughout had taken responsibility for him, appealed for help, and, after advice by a legal aid agency, the services of a competent lawyer were secured. Patient, however, became dissatisfied, wanted the case settled immediately, and said he would find another lawyer with "influence". As he wanted $200 at once for this plan, he said he intended to return to machine shop work despite the doctor's recommendations. The elder brother soon telephoned for help again, however, saying there was $1000 bail to be repaid, that the original lawyer had been alienated, and that patient was terrified of jail. At this point the Montreal legal aid agency agreed to help further and matters were adjusted and the case adjourned.

Patient had seemed unwilling to return to clinic, but did not accept the suggestion of being seen privately by one of his hospital physicians. Finally, his sister-in-law telephoned to say he was feeling ill and would attend clinic. He then told his doctor of having had two different jobs since his discharge and of now working as a machinist and as a part time salesman as well. He also said he did not like his work, did not like boarding with his brother, and was often hot tempered at work and at home. Patient, after this, failed to return, but five months later, his sister-in-law reported that he was again "very ill". He asked for one of the hospital doctors, but was then attended by his family physician.

It seemed that the doctor's and social worker's attempts to win this young man's confidence, and to help him, had failed. When last seen, he was still as withdrawn, distrustful and unhappy as during his first admission. While such a patient might eventually use vocational guidance, he would first need psychiatric help.

5. Employment

While the life of every member of the family of a patient with chronic illness may be affected, the problem is all the more serious when the patient is the wage earner or the mother of young children. Those families, or individuals, who have heretofore managed on marginal incomes, are pushed into dependency, while even the relatively prosperous can be reduced to poverty. The financial restrictions and difficulties of these patients, and the effect of their illness on their source of livelihood,

have already been considered. The question now arises as to how to help those who are, or can still become, able to work.

During the period from 1947 to 1948 when these patients were under care, the main resource for work placement was National Employment Service which possessed a Special Placement Section for the guidance of handicapped persons. This section used the voluntary services of an orthopaedic doctor.[1] Since then, the service has been further decentralized into several local offices, and its cooperation with local agencies concerned in their clients employment needs, is being extended. However, placement possibilities depend on demand and there is no law requiring employers to register their needs with the National Employment Service.[2]

It was the experience of the social worker with arthritis patients that those for whom job assistance was requested in 1947 and 1948 were too handicapped to be placed. Four patients only, therefore, have been selected as possibly able to benefit from this service as organized at the present time. Placement, however, would not have been possible for any of these patients without concurrent medical advice and case work help. These patients included 3 men aged 23, 34 and 52 years with the diagnoses of Pes Planus, Rheumatoid Arthritis and Subacromial Bursitis respectively, and one woman of 40 with a diagnosis of Migraine. This woman had formerly been a governess and it was not know whether she really wanted to work, yet it was apparent that her dependency in the home of a brother could not

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1. Montreal Rehabilitation Survey Committee, "Re-Establishment of Disabled Persons", Montreal, 1949, p. 82.

2. Confirmed by telephone by Mr. F. Fanning, Special Placement Section, National Employment Service, Montreal, May 31, 1951.

be satisfying to her. Of the 3 men, 2 at least, had histories of erratic employment, and for the two younger patients, prior vocational service appeared to be indicated.

> Case (16), a 52 year old Hebrew man, born in Canada, with a diagnosis of Subacromial Bursitis, worked as a night clerk at an hotel for $10 a week and his board. When seen, he was anxious, not only about his health, but because the hotel was to close in two months and he did not know where he should find work. Patient said he had first done clerical work and proof reading, and then had played the drums in a night club orchestra for 15 years. When this orchestra's leader died, he had sold his instruments and re-purchase would now be prohibitive. He did not like his present job, saying he could not sleep during the day "because of his nerves". He also felt it was very difficult for a man of 52 to find any employment.
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> Patient said little of his family. His mother was in Jewish Old People's Home, a crippled sister was not well, and he did not get along with his brothers. In all that he said, he gave the impression of loneliness and drifting and seemed somewhat slow mentally, as if he would be unable to fill any position which demanded too much of him.
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> Jewish Family Welfare reported that patient was considered somewhat of a "black sheep" by his family, and had long been erratically employed. It was not considered that vocational service would help him and all that could be recommended was that he find other employment. This patient did not continue with physiotherapy as recommended or return to see the doctor. Perhaps more active help and interest would, however, have led to a measure of rehabilitation for him.

6. Sheltered Shop and Employment Training

When a handicapped person is untrained, or unable to compete, or ignorant of how to carry on and adjust to his disability, a sheltered workshop may be a temporary resource in a rehabilitation plan. In some cases, where a patient will never be able to meet the demands of industry, it may provide a permanent occupation. Such a shop appeared to be the greatest need of those patients with employment problems in this study. Even in those cases in the previous section where employment counselling appeared to be indicated, the patients might possibly have benefitted by some such

workshop experience. It seemed to be an absolute necessity if constructive ways were to be found to reestablish 11 of these patients. Such a shop would also be of most value to patients with arthritis if it were organized in somewhat the same manner as the Altro Workshop in New York.[1] This model shop, established in 1915, provides work in the needle trades for tuberculous patients who need this transitional experience after discharge from sanatorium. With the patient's doctor determining hours and work, and a flexible arrangement with rest periods, patients can attend from 9 A.M. to 5 P.M., earning prevailing wages for an 8 hour day. The average stay has been computed at 21 months after which the patient can be frequently rehabilitated into industry. A study of the first 25 years of this service to tuberculous patients, revealed that, 5 years after discharge from Altro, 75 per cent of the patients were working or able to work. A similar service was begun for cardiac patients, when they were included in the program in 1949.[1] This Jewish community agency does not only provide a medically directed work program and adequate pay, but includes other services such as convalescence, vacations and housekeeping help. The whole program is based on the interdependence of emotional and physical processes, with medicine, psychiatry and social casework cooperating on the patient's behalf.[2]

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1. Edward Hochhauser, "Objectives of Sheltered Workshops" Jewish Social Service Quarterly, Vol. XXV No. 4 (June 1949) pp. 533-545.

2. Florence Haselkorn and Leopold Bellak, "A Multiple Service Approach to Cardiac Patients", Social Casework, Vol. 31, No. 7. (July, 1950) pp. 292-298.

There is no such resource in Montreal which might be as constructively used in the treatment of arthritis patients. L'Association Catholique de l'Aide aux Infirmes offers paid sheltered employment and a special driving service to its invisable mending workshop. However, this service can only assist about 16 French Roman Catholic women at the present time.[1] There is also the Occupational and Rehabilitation Therapy Centre. This has been planned to serve the whole community but it cannot offer any form of financial support or remuneration to its clients. It is also only able to accept those patients who are ready for an active, and reasonably short term, program.[2] Finally there is a sheltered shop administered by Federation of Jewish Philanthropies. To date, however, this has been restricted to Jewish Family Welfare clients.

Among the 11 cases here classified as needing sheltered workshop facilities, there were 2 patients who might be considered unacceptable. These were women in their early sixties with osteoarthritis who were physically able to do light work but psychologically lacked courage to try. The medical condition of the other 9 required a well rounded service such as an Altro Shop would be able to give. Two of these patients, case (83) and Case (71), with Rheumatoid Spondylitis and Gonorrheal Arthritis, have already been described.[3] Case (83), in particular, would probably have been

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1. Visits to shop and hostel and interview with Mme. Bruno, Supervisor, L'Association Catholique de l'Aide aux Infirmes, June 5, 1951.

2. New policy interpreted at a meeting by Mrs. V. P. Summey, Supervisor, Occupational & Rehabilitation Therapy Centre, May 17, 1951.

3. Supra pp. 79-81.

helped immediately if he could have been offered a restricted program and adequate payment which would have preserved his self respect. Of the remaining 7 patients, one, with Osteoarthritis and Mitral Stenosis, was only able to earn $75 a month for his wife and himself. The other 6, affected in varying degrees by Rheumatoid Arthritis, would also have benefitted by work under medical supervision. During the period in which they were known, 4 of the patients with Rheumatoid Arthritis had to remain completely dependent.

As the aim of a sheltered shop is the rehabilitation into industry of as many clients as possible, the question of training while attending is important. In the Altro shop, training is considered of secondary importance, though patients are prepared for the needle trades and use the most modern machinery. In Montreal, there are broad facilities offered at the Montreal Technical School and the various trade schools, which are all under the direction of the Quebec Government Department of Social Welfare and Youth.[1] In connection with these, there is "Youth Aid Services" which offers free testing prior to entry into the trade or technical schools by 5 psychologists. Guidance is also given in the placement of students.[2] Fees for these courses of training are low, but there are no arrangements for maintenance allowances while at school. Such courses as these would, however, be of no use to this patient group unless, after a sheltered shop

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1. Quebec, Department of Social Welfare and Youth, Montreal Technical School, Prospectuses, Day and Night Courses 1950, and Ecoles d'Arts et Metiers, Prospectus Général, 1951.

2. Interview with Mr. Lewis G. Hearle, Officer, Industrial Efficiency Training, Youth Aid Services, Department of Social Welfare and Youth, Quebec, June 6, 1951.

experience, government funds could be made available during the period of training.

The two cases given here illustrate the need for a sheltered workshop of the Altro type in the case of a younger man and of a more elderly woman.

> Case (63), the 27 year old man with Rheumatoid Arthritis, has already been described as needing financial assistance to enable him to be more independent of his family.[1] This patient's Rheumatoid Arthritis dated from the age of 21 and had been treated elsewhere before he attended Royal Victoria Hospital in 1945. He was followed in clinic and then admitted to the ward in 1948. At that time his hands, elbows, ankles and wrists were affected, and his chest deformed, while he walked in an ungainly and shuffling way. Patient told of having finished Grade VII at school and then taking a six month's night course. He had had no vocational training and apparently had been employed at unskilled labour such as messenger, garage man, and delivery boy. Prior to his 1948 hospitalization he had been employed for over 4 years, with time off for sickness, at labelling cans. He had also been packing and lifting 50 pound weights which might have involved excessive effort. Patient came to social service for help when discharged from hospital as his employer was unable, or unwilling to re-employ him. The doctor recommended that a sedentary occupation be found and pointed out that work was necessary to maintain patient's morale. He felt patient would be conscientious and reliable, and might fit in to some small concern. All avenues of work for this patient were then explored. He was referred to Jewish Vocational Service which reported, after psychological tests, that placement was practically impossible. Eighty-five per cent of the male population surpassed this patient mentally, while, physically, his condition forbade lifting, pushing or pulling and fine hand movements. Special Placement Section, National Selective Service was also unable to make suggestions. Patient, however, explored more than fifteen possible jobs on his own, only to find that they all required an amount of physical effort which was too great for him. Finally he tried elevator work which he was forced to stop as it was further damaging his arms.
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> Occupational Therapy Centre had not been suggested for this patient. At that time, it served a group of older handicapped persons for whom rehabilitation was practically impossible. The doctor therefore considered that it would not offer a constructive experience. But, as patient was becoming increasingly demoralized by his pain and disappointment, he finally agreed to attend, and

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1. Supra p. 74.

found more satisfaction than he had anticipated. No remuneration was, however, possible, so that no means could be found which would add to his sense of independence or self respect. Instead, he continued living at home in an unsatisfactory environment. Now, with the reorganization of this Centre into an active treatment unit, patient will be deprived of even this source of occupation and interest.

Case (12), a 52 year old Protestant woman with Rheumatoid Arthritis, has also been mentioned in the section on marital unhappiness.[1] Patient was first known to Social Service in 1944 when her 62 year old husband was admitted for a hip operation due to traumatic degenerative arthritis. When patient was herself examined, a diagnosis of Rheumatoid Arthritis was made. Up to this time, both this man and his wife had been independent, with the former employed first as a gardener, than as a cleaner and janitor, while patient herself worked as clerk in a department store. An adopted son was married and in the army. This couples' health, however, now made further work impossible, and the doctor in charge of the clinic recommended permanent placement in an institution. As the only institution available for indigent Protestants was a demoralizing and restrictive one, the aid of a family agency was requested. In 1945, however, patient and her husband left Montreal as he had secured a watchman's job in Ottawa where the adopted son had his home.

This patient was not seen in Arthritis Clinic again until 1948. She had returned to Montreal with her husband who was now, at 66, too incapacitated to work even as a watchman. Patient herself had been employed as a cashier until she felt too ill to continue. Patient was in pain, could not sleep, and had no appetite for food. But she was afraid to take gold injections and said physiotherapy made her feel worse. Later, as she talked of the strained relations with her husband, she said he complained she was always lying down, yet she was so tired, and in such pain, that she had to do this. On the other hand, patient refused to accept taxis for clinic visits, but forced herself to walk to clinic "to loosen her joints". She also climbed unnecessarily up and down her lodging house stairs for the same reason. At the same time, believing that nothing could be done for her, she refused to return to clinic and was visited several times by the social worker. The monthly budget was $75 from the family agency and patient lived with her husband in one large, but dingy room, in a run-down lodging house. These conditions added to patient's bitterness and resentment.

This patient was only 52 and should have had the opportunity of making something of the years remaining to her. Her life history had been unhappy, but she had an intense drive to feel adequate and independent. Had a sheltered workshop been available with suitable

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1. Supra p. 50.

remuneration, medical control might have been continued. Besides this, patient's driving anxieties might have been relieved, and the tension she felt in confinement to one room and her husband's continual society, modified. Supportive case work might have also been carried on, and some adjustment to patients' disease and social situation have been achieved by her.

7. Family Service

As has been already explained, there is no public welfare program to meet all relief needs for basic subsistence in Quebec. Instead, in the City of Montreal, various family and voluntary agencies perform this service by administering the allowances provided by the Quebec Public Charities Act. Certain agencies can supplement these allowances, but others are unable to do this. While there are old age pensions and mother's allowances for widows with young children, these were, and still are so low that the recipients can barely subsist.[1] Here also, in certain cases of ill health, a family society gives some help. Much, therefore, of a family agency's service in Montreal, is the provision of financial assistance. This may preserve a family from destitution but, for the majority, cannot even supply adequate food. An agency's service, however, is not limited to financial help, but includes family and individual case work. This has the aim of understanding social and personal problems and of finding ways to solve or modify these. Such problems may exist in families or individuals who do not require financial help. In all these cases, the agency may help in a time of crisis, may assist over a longer period, or may provide a continu-

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1. Grant allowed mother and one child in Quebec is $35 a month with $1.00 per month increase for each of the four subsequent children. Canada, Department of National Health & Welfare, Special Supplement #17 on Mother's Allowances. January 1950.

ing support which will prevent further breakdown.

Among these 100 patients, 27 appeared to require some social agency service, and for 24 it was available. This has been classified as adequate from the case work point of view, as, though financial restrictions may frustrate constructive planning, it is not possible here to analyze the extent of this frustration. Of the 24 patients eligible for service, 15 needed total financial support, 6 needed temporary or partial financial assistance, and 3 did not require this kind of help. Among these 24, there were 4 cases of family conflict, which included 3 desertions, 12 cases where the problems of illness were aggravated by problems of aging, and 8 where loneliness and lack of relatives was a factor. Among these patients were also one man who needed encouragement in his search for work, 2 women in their early sixties, who felt unable to seek employment any further, and a widow, with growing children, worried about the rising costs of food despite the earnings of her older son of 17 years. Of the 3 patients for whom family service was not available, one lived out of town, and the agencies concerned felt they could do nothing in 2 cases.

Of the total group of 27, 12 had a diagnosis of Rheumatoid Arthritis, 10 had Osteoarthritis, while the remaining 5 diagnoses were varied. The two cases which follow illustrate the individualized nature of family services and their important function in present society.

> Case (33), a 44 year old Protestant man, born in Canada, with a diagnosis of Rheumatoid Arthritis, had been summoned before Juvenile Court on a charge of beating his children and drinking. There, the judge placed him on probation and ordered him to attend Arthritis Clinic and accept psychiatric treatment. The family agency reported that patient came from an unstable background and had never been able to support his children adequately. Hoping to induce him to

make more effort, the agency had discontinued financial help. Patient, however, remained irresponsible and the burden of supporting the family was left with a son of 16 and patient's wife. This boy was only able to contribute $5 a week, while patient's wife, with 4 other children between 11 and 15 years and a baby of 18 months, earned $18 a week as a night cleaner. The home consisted of four ramshackle rooms, more like a shed than a dwelling, built over a chicken market. Though the rent for this inadequate housing was only $16.50 a month, the total income of $134.70 was about $80 to $90 short of what it should have been by satisfactory agency standards.

While this patient felt hounded and afraid, he had never attended clinic regularly before and did not possess enough confidence to change his pattern now. As there was a danger of his being sentenced to prison for two years, a psychiatrist was consulted about him. It was considered that this patient had "a severe personality disturbance related to his arthritic condition and that his behaviour was determined by this." The medical social worker was advised to visit patient and to endeavor to make him feel that the clinic doctors wished to help him and that he could attend any time of his own free will.

When he received the hospital report, the judge decided to put patient on extended probation. The family agency also felt that financial assistance should be given for the sake of the wife and children, even though no medical certificate that patient was actually unable to work could be supplied. In administering this allowance, the family agency case worker would henceforward be keeping in close touch with this mother and her children, and further attempts would be made to establish a better relationship with patient. While this left the problem of patient's behaviour unsolved, a prison sentence could have obtained no constructive result and necessary assistance was given to a mother and her children.

Case (54), a 71 year old Roman Catholic man, born in Roumania, and with a diagnosis of Osteoarthritis, had apparently only worked irregularly for 10 years. At that time he had suffered a fractured skull and subsequent clinic visits recorded malnutrition and pediculosis. While he could no longer work, and complained of having little to eat, he could not obtain a $30 old age pension due to having lost his immigration papers 35 years previously. Patient had no relatives here, so was referred for help to a family agency. As language difficulties made it impossible to understand what he was trying to say, the help of the elderly Roumanian woman with whom he lodged was also enlisted. A fellow immigrant was then found who could give details of his arrival in Canada in 1913 so that the assistance of the Immigration Department could be obtained. This Department requested that he attend for medical examination. But instead of reporting his age, the Department made out an order for his deportation. This was done on the grounds that he was illiterate, was not a citizen, had "hernia, heart condition, loss

of power of inferior extremities, chronic skin disease and senility", as well as "psychopathic inferiority (mentally unstable because of old age)." Since this patient would probably have died if deported, a lawyer was consulted and the social agency took up the matter with the Immigration Department. Legal assistance was unnecessary, however, as the deportation order was not enforced. As old age pension was now impossible, the doctor signed a certificate that patient was unable to work. The family agency then obtained a regular assistance allowance of $45 a month for him. As his wants were few, and his Roumanian landlady helpful, this would be sufficient for his needs as long as he remained with her.

8. Special Home Care

In a discussion on home care for the aged, Dr. Ernst Boas points out that, while the very ill may require care in general or chronic hospitals, there are many for whom vigourous medical treatment is not indicated. These patients, however, may need custodial care but, this care should be of a better type than is generally available. The necessary homes or institutions should have porches, doors, elevators and grounds adjusted and planned for the handicapped, wheel chair, or bed patient. In this way, no one will be isolated in one room or on one floor. There should be sufficient attendants and visiting physicians. A social director and a recreational program should be provided, and workshops must also be included. These are only some of his suggestions for a modern type of institution for patients who are chronically ill and need more than the kind of supervision which an adequate boarding home might give.[1] At the same time, he also stresses the necessity of using the patient's home, or an adequate boarding home, for as long as possible before turning to an institution. Such a home care program requires a complete visiting service by doctors, nurses and social workers and cooperative planning

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1. Boas, op. cit. pp. 54-56.

by this personnel on the patients' behalf.[1]

The lack of facilities for chronic care in Montreal was studied in 1940 and recommendations were made for an English hospital for chronics of 500 beds and a French hospital of 1000.[2] Since that time, nothing effective has been done to meet the needs of the chronically ill and aging. Homes for the elderly are also lacking. An article on "Our Shameful Old People's Homes" described some of the conditions in 1948, though without naming the English institutions concerned.[3] There are a considerable number of "hospices" for French Catholics on the other hand, but it has been the experience of Royal Victoria Hospital Social Service that these have long waiting lists.[4] The needs of the Jewish community are met in the well planned Montreal Hebrew Old People's Home which provides a recreational program for those who live there.[5] For Protestants in particular facilities are totally inadequate. There are several fairly small church homes, two of which, at least, do not keep the aged who become ill and bed ridden; there is a well run home for the ambulant and the ill kept by Anglican sisters, which has a waiting list for several years

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1. Ibid pp. 76-80

2. Metropolitan Life Insurance Company, The Care of the Chronically Ill in Montreal, Ottawa, 1941. P.25.

3. Gallant, Mavis, "Our Shameful Old People's Homes". The Standard, Magazine Section, April 24, 1948.p. 3.

4. Conseil des Oeuvres, Montréal, Reportoire des Oeuvres Sociales de Montréal, 1946 pp. 43-45.

5. Interview with Mr. Ben Stein, Group Leader, Young Men and Young Women's Hebrew Association, May 17, 1951.

ahead;[1] and there is a large and depressing institution where the aged and helpless are classified as "inmates" and where there is no planning for their emotional and social well being.[2] One English agency, giving temporary shelter in a planned manner, has also place for 4 permanent residents, and one other, with place for about 10 couples and 4 old men, is a model experiment but can only accept the physically independent.[1]

Besides these limited, or unsuitable, facilities, there are a number of commercial nursing homes. In 1948 the Protestant family agency was giving increased allowances to support the chronically ill in these homes, but present policy no longer allows such supplementation.[3] The French Catholic family agency also cannot place the ill in such homes, except for cases where Canadian Cancer Society will meet the cost above the public assistance allowance.[4] An article on the needs of the aged suggests, "Many types of housing are needed to meet the individual needs of older people... low-cost, small, independent housing units that minimize physical exertion needed in their upkeep, for older couples... independent, one-room apartments with central dining rooms or even room service for the more physically handicapped..." [5]

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1. Confirmed by telephone by Miss M. Boyd, Elderly Persons Department, Family Welfare Association, Montreal, May 25, 1951.

2. The Old Peoples' Home under the direction of The Protestant House of Industry and Refuge. Visited September 23, 1950.

3. Confirmed by telephone by Miss E. Barnstead, Casework Supervisor, Family Welfare Association, Montreal, May 30, 1951.

4. Confirmed by telephone by Mlle. F. Marchand, Director, Bureau d'Assistance Sociale aux Familles, May 30, 1951.

5. Margaret Boyd, "Economic Needs of the Aged", The Social Worker, Vol. 19, No. 4 (April 1951) p. 12.

It must be pointed out that, despite all the present inadequacies for chronic care in Montreal, there are two agencies which give most effective service. The Victorian Order of Nurses and Societé d'Infirmières Visiteuses make regular visits in order to carry out the medical recommendations of private or clinic and hospital physicians. Beginning in March, 1948, the Victorian Order of Nurses also established a visiting physiotherapy service. It was only possible to engage one physiotherapist for this demonstration, but an evaluation of her work showed that she was able to further the rehabilitation of the patients she treated. It was necessary, however, to limit her cases to those for whom most could be accomplished.[1] Because of this, none of the arthritis patients known in this study could be referred for her services as the time they required was too great or attendance at the Hospital Physiotherapy department was still possible for them.

Thirteen patients in this study group needed special home care. For 2 of these, such care appeared to be adequate. In one terminal case of multiple myeloma the patient's family paid for the practical nurse at $3.50 a day which was then the current rate. For the other, with Rheumatoid Arthritis, the agency involved made exceptional arrangements. There were 4 patients for whom the available home care has been classified as inadequate. While 3 of these were visited by Victorian Order of Nurses, such visiting nurse service was not sufficient for their needs. The fourth patient, who did not receive adequate care, lived in

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1. Physiotherapy Service with the Greater Montreal Branch of the Victorian Order of Nurses, unpublished report, March 31, 1950.

a hostel which was not intended for the reception of the chronically ill. This patient, with Rheumatoid Arthritis, was sensitive to the lack of warmth and discouraged by the restricted diet. Finally, 7 patients needed a type of care that was not available to them. Five of these patients were cases of Rheumatoid Arthritis and 2 had Osteoarthritis. Two were wheel chair cases and had to manage in rooms as best they could, 2 felt very ill and needed a planned environment in which effort would be minimized for them, and 3 were in need of a home for the elderly where medical and nursing care would be available if necessary.

It did not seem to the writer that a visiting housekeeper service would have met the need in these cases. Closer medical supervision, a more comfortable environment and, in the case of the patients with Rheumatoid Arthritis, visiting physiotherapy services appeared to be the requirements. While certain family agencies will assist with housekeepers, experience has shown that there are many problems involved when the wife or mother sees her homemaking functions usurped by another woman. It may, therefore, be a happier arrangement for the family, if there is one, to help with the house. For the aged, and for those who live alone, specially serviced homes should be provided as has been already discussed.

Case (47), and Case (46), reveal two different types of need which, at the time when these patients were known, were not being adequately met in the community.

> Case (47), a 71 year old Protestant woman, born in Canada, with a diagnosis of Osteoarthritis, came to Arthritis Clinic worried about her "bronchial trouble" and arthritis of the fingers. Patient said she had spent 22 years away from Canada, 7 as a secretary in the United States and 15 with the League of Nations Institute of Intellectual Cooperation. She had now a small pension of $60 a month but $26 of this was required for rent. There were two sisters

in Vancouver and a brother living outside Montreal. Patient said she had little social life now but the "memories of her travels". She gave an impression of loneliness and reserved independence, as well as of fear lest anything be found radically wrong with her. She was greatly reassured when she was told she need not be anxious about herself. This patient, however, obviously needed some more protected way of living than in a room alone with only $34 for her clothes and food. While it is possible that her brother might be sending her some money, she did not speak of this, though she said he would help her "if necessary".

Case (46), a 56 year old, Protestant woman, born in England, (Diagnosis: Rheumatoid Arthritis), lived with her 80 year old mother who was on old age pension of $30 a month. A family service society supplemented this amount with $35.70 monthly. Patient had formerly been in a nursing home, but had been very unhappy and had wanted to return to her mother. Finally, arrangements were made for patient and her mother to take a room together, but this also involved strain as there was unavoidable tension due to age, illness, restricted income, and personality factors. When patient became known, she told of her past history, her desertion by her husband, her ties to her mother, and her disappointments. She cried as she recalled the death of a pet pekinese and spoke of "not looking forward to anything". All that could be done was to arrange for visits by an occupational therapist (a service now no longer available), plan an expedition to a department store, and borrow a wheel chair for patient's use at home from Canadian Red Cross. Due to the impossibility of finding a volunteer to push this chair, this last project was not successful. This patient and her mother obviously were in need of a suitable home where being together would have been varied by seeing others, where necessary services would have been obtainable, and where recreation would have given pleasure and enabled patient to forget her past unhappiness and present pain to some extent.

9. Other Needed Resources

There were 4 patients who needed services which have not been classified in Table XIII. For 3 of these patients, the necessary services were available but, in one case, adequate assistance was not secured. One patient required legal advice and the counsel of a free community legal aid agency. This was available through Society for Protection of Women and Children which was not, however, able to take the case as it was to be heard outside the city limits. However, the Society could suggest a competent lawyer and assist with certain adjustments. In a

second case, a direct interpretation of the patient's medical social situation was sent to the Juvenile Court Judge concerned, as well as to the family agency. Though no actual recommendations could be made, the Judge's disposition of the case was based on the medical social report as well as on the other sources of information available to him. The two remaining patients needed the assistance of understanding employers. In one case, this was obtained when a medical letter interpreting the condition of the patient's husband who was still able to do light work, was sent to the employing company. As a result, a more sheltered position was assured this man and the strain on the patient herself was greatly relieved. In the other case, the doctor requested additional time off for the patient so that she might follow recommendations for physiotherapy treatment twice a week. In this situation, the employer would only consent to clinic visits and not to absences for physiotherapy treatments. Further attempts at interpretation of the need to follow medical advice was necessary in this case. If understanding cooperation was not obtainable, a change of work should have been indicated for this patient. Sheltered workshop employment, while following recommendations, might possibly have been one of the community resources needed as a solution to this problem.

Table XIV, on the following page, is included here as of interest from the point of view of diagnosis and need. The foregoing chapter has already illustrated this to some extent as it is apparent that the more incapacitating forms of arthritis required more assistance than does Osteoarthritis which develops in the aging who are becoming dependent in any case.

TABLE XIV

FREQUENCY OF COMMUNITY RESOURCES NEEDED BY 100 PATIENTS ATTENDING ARTHRITIS CLINIC, ROYAL VICTORIA HOSPITAL, ACCORDING TO DIAGNOSIS.

Resources	Frequency Related to Diagnosis											
	Total	Infectious Arthritis	Rheumatoid Arthritis	Rheumatoid Spondylitis	Rheumatic Fever	Osteo-Arthritis	Mixed Arthritis	Gout	Traumatic Arthritis	Miscellaneous	No Demonstrable Arthritis	Other
Total	112	5	54	5		30		3		5	7	3
Outside Medical Planning	10	1	3			1					5	
Financial Assistance	30	1	14	2		11		1		1		
Recreation	9		7			2						
Vocational Service	4	1	1	1								1
Employment	4		1							1	1	1
Sheltered Shop and Employment Training	11	1	6	1		3						
Family Service	27		12	1		10		1		2	1	
Special Home Care	13		8			2		1		1		1
Other	4	1	2			1						

This table shows that, of the 25 patients with Rheumatoid Arthritis alone, 14 needed financial help, 6 required a sheltered workshop, 12 needed family services and 8 needed special home care. On the other hand, among 39 patients with Osteoarthritis, 11 needed financial help, chiefly because of problems of aging, 3 might have used a sheltered workshop, 10 required family agency service, and only 2, aged 71 and 69, could be said to require special home care.

From the available records, it would seem that 10 per cent of these patients needed planning on their behalf with other psychiatric and medical agencies. This was possible in Montreal with the exception of one case. Financial assistance needed, by 30 patients, was not available in 11 cases. This was chiefly due to the limitations in agency resources which restrict assistance budgets to an inadequate minimum except in the case of one agency. For this reason also, 15 cases assisted received inadequate help, and adequate help was only available to 4 patients.

Special recreational resources were needed by 9 patients, but were only available to one young man. The 8 women considered here required the type of community group which is now being established in several small experimental units for the elderly. These have not yet developed transportation and home services.

Four patients required vocational services and 4 needed employment direction. This was available, but the rehabilitation of the 6 patients concerned required case work understanding and treatment as a directional service alone would not have been sufficient. The needs of 11 patients, however, could have been met only by a sheltered workshop on the lines of the Altro Shop in New York. There, medical and social treatment are part of a rehabilitation plan and the patients' self respect and motivation

to improve are maintained by a regular wage scale regardless of the number of work hours recommended.

Twenty-seven of these patients required family agency service to assist them to cope with their varied difficulties. Such service was available to all but 3 patients. Special home care was needed in 13 cases and this could only be secured for 2 patients in a satisfactory manner. Three patients remained at home and were given care by a visiting nurse, one stayed in a hostel, 6 lived in rooms without adequate supervision, and one young man remained at home under conditions of strain. Other specific services were needed in 4 cases.

In addition to the community resources considered here, transportation to and from clinic was needed for 10 patients. It was the policy of the hospital to provide transportation for patients on the request of the attending physician, but, if the patient was the client of a family agency, and this agency could assist, the hospital paid half the transportation only. The present policy is that the hospital should provide this service to patients who cannot afford special transportation. This is because the hospital is primarily responsible for medical care and community agency budgets are designed to cover subsistence needs only. The provision of recommended supplies, such as elastic stockings, glasses, trusses and crutches, which 9 of these patients required, is also now considered to be the responsibility of the medical care agency. These items have, therefore, not been included among needed community resources.

Finally, the tangible services reviewed in this chapter were required more often by those patients with the more serious forms of arthritis. Omitting the 2 patients with Mixed Arthritis, 20 of the 25 patients with Rheumatoid Arthritis alone needed specific assistance in

54 instances. Thirteen only of the 39 patients with Osteoarthritis, on the other hand, required various community resources in 30 instances. In the case of the patients with Osteoarthritis, need was often due to the factors of aging, while with Rheumatoid Arthritis it could be caused by premature incapacity.

A conclusion that may be drawn from the cases discussed is that these patients needed casework understanding and help if they were to make full use of the community services available. Each patient had his individual problem to be understood in its relationship to himself. The 112 community services were, however, only required by 49 of the total group. Can it then be said that the 51 remaining patients did not need case work help? In view of the problems discovered among these patients, this would obviously be a mistaken inference. The nature of the help needed, the kind of social treatment required by these patients, whether community resources are involved or not, will next be examined.

CHAPTER VI

TREATMENT OF PERSONAL PROBLEMS

It is now apparent that the patients in this study presented problems which required the most skilled medical and social management. It might be suggested that, as they were for the most part from a low income group, many of their difficulties would be due to the financial hardships caused or exacerbated by illness. While 30 per cent of these patients needed financial assistance, and a further 20 per cent apparently experienced financial difficulty, this study has shown that lack of money was only one of the possible reasons for stress in their lives. Again, only 49 of the total group apparently required community services, but more than this number were experiencing strain and unhappiness which would affect their possible reaction to their disease. Such considerations as these lead to the conclusion that these patients, or any similar group, irrespective of their income, needed an individualized type of treatment. Such treatment would involve an evaluation of each patient from the social as well as from the medical point of view by the physician in charge of the case. He would then decide which members of the available treatment team he might use in his care of the patient. Thus, for example, he might ask for the cooperation of a nurse, a physiotherapist, an occupational therapist, a psychiatrist or a medical social worker. While the treating physician would be the leader of this team, a cooperative plan would ensure the use of all the possible resources which the medical and social sciences now have to offer.

It might be questioned whether social adjustment would not be impossible in many of the cases discussed in this study. However, just as physical ailments may be cured, arrested or alleviated, so social and psychological conditions may be amenable to treatment or may deteriorate through neglect. The aim of the Arthritis Clinic, Royal Victoria Hospital, is to assure the best possible treatment and this implies social as well as medical care. The possible use of the medical social worker can therefore be considered as her function is casework in the medical setting and interpretation to community agencies. In the following discussion, it will be taken for granted that the necessary casework services are available. It is also taken for granted that there are no restrictions on the time which may be needed for carrying out a treatment plan for each individual.

To serve as a basis for a casework consideration of these patients, Table III of Chapter II will be used as this illustrates the ages of the patients involved in relation to their diagnoses.[1] References will also be made to former case illustrations so that unnecessary repetition may be avoided. It must be remembered, however, that conclusions on these individual cases are only presented here in a tentative manner. Plans for treatment would necessarily be worked out under the leadership of the patient's physician. They would also be subject to modification or change, as indicated, during the period of the patient's care.

1. Gonorrheal Arthritis

Only one of the 2 patients with Gonorrheal Arthritis would be available for casework help, as the psychiatrist believed nothing could

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1. Supra, p. 20.

be accomplished for the 26 year old male with a diagnosis of Psychopathic Personality, Anxiety State and Paranoid Trends.[1] This man appeared potentially dangerous, as he spoke of attacking others who aroused his hostility, and said that "he enjoyed seeing social workers cringe". For the second patient, psychiatric help was necessary. This young male of 21 years, was defensive and withdrawn, as well as being terrified about what his diagnosis might involve for him.[2] In his case, medical and social treatment were palliative only, as he broke down again after hospital discharge. While he might have refused to cooperate and have insisted on complete independence, a psychiatric diagnosis and continued acceptance, together with follow up by the caseworker, might have begun a process of rehabilitation for him. Psychiatric treatment was probably indicated, but the caseworker could have been used when questions of adjustment to the community arose.

2. Rheumatoid Arthritis

It seemed that 23 of the 25 patients with Rheumatoid Arthritis needed the help of casework treatment. These 23 patients could be divided into two groups of those under 39 years and those over this age. There were 8 patients under 39, two single males aged 27 and 34, a single young woman of 24 and 3 housewives and 2 deserted women between 35 and 38. The male of 27 was so incapacitated that he needed sheltered shop facilities, but he also needed help in leaving his home and a supportive contact with a caseworker.[3] It was significant that, when

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1. Supra, Case (45), p. 46.
2. Supra, Case (71), p. 80.
3. Supra, Case (63), pp. 74 and 87.

his case was closed with the Social Service Department, he would still come to the office when any matter particularly distressed him or shook his precarious adjustment. This illustrates a need which should be met if potentially damaging strains are to be avoided. The second male of 34 had lost his parents and a sister in a bombing raid and his brother in an airoplane crash. Formerly employed by an English film company, he needed vocational help and a steadying relationship with his physician or psychiatrist. The caseworker might have assisted here in cooperating with the community agencies necessary for this patient's work adjustment.

The single young woman of 24, who cried when she remembered her father at night, also needed the support of a relationship with her physician and with a caseworker as she did not carry out recommendations.[1] As in the case of many of these Rheumatoid Arthritis patients, she appeared young and dependent, yet defensive and rebellious at the same time. A permissive and supportive relationship might have met some of her insecurity and lessened her fear of being "pushed around". Similar time in establishing a relationship should also have been given to the 3 wives and 2 deserted women, particularly as there were younger children in these families. Family agency help was already available in 2 cases, but interpretation of the medical situation was needed by the agency. One of these deserted women later became reconciled with her husband. In the other case, family disintigration had reached the stage of child placement, but the patient herself might have been helped by being afforded some relief from her feelings of guilt. Further work with the stepmother of the

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1. Supra, Case (44), p. 46.

defective children might have led to better planning for them,[1] while the other two women needed to be better understood. One required a follow up service and possibly a visiting physiotherapist. Some dietary supplementation might also have helped her, as she was not eating and was progressively loosing weight. The other showed her ability to respond when she said that the interest of her physician had helped her, not only physically, but "to worry less". She had formerly been "easily hurt by criticisms of others", now she felt better and her husband was pleased that she was less nervous.

It is obvious that a great deal of time to establish rapport and carry on a sustaining relationship would be necessary in the above 8 cases. Frequent consultation with physician and psychiatrist would be mandatory also. If, however, the complete treatment needs of these younger adults is to be met, such time and individual attention will be provided for. The best methods of treatment will, also, only be found after further practise and research.

In the older age group of Rheumatoid Arthritis patients, were 5 males and 10 females aged from 40 to over 70 years. For these, with individual modifications a different type of treatment by the caseworker is suggested. This would require a similar acceptance of the patient himself and a similar type of supportive contact, but there would be less likelihood of change in behaviour patterns. Social treatment of environmental problems might alleviate strains, but the relationship with the patient would be aimed at increasing his self confidence and supporting him in his adjustment. With a lessening of anxiety, some improvement might be expected and further breakdown avoided. Frequent interviews,

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1. Supra, Case (41), p. 52.

or much follow up, might not be necessary, but the patient would know of the caseworker's availability. In cases known to community agencies, part of the responsibility would also be carried by the family caseworker, who would want the necessary interpretative guidance for constructive co-operation.

Among the males in this older group, 3 were in their forties and 2 in their fifties. One of these might, perhaps, have been led to better behaviour towards his children if he could have been assured that his doctor and caseworker were personally concerned about him.[1] Three others required a sheltered shop, from which 2 might possibly have returned to life in the community, but which would be a permanent resource for the third.[2] One man was still able to support his family, but, with a wife who had been treated for Involutional Melancholia and a daughter with a diagnosis of Chronic Psychoneurosis, could not behave in a reasonable manner to his young son of 16. Contact with this patient seemed to show that casework treatment would have relieved some of his tension and helped him to be less rigid with his children.

Five of the 10 women were under agency supervision due to disablement or old age. In such cases, supportive treatment would be carried out in cooperation with the agency concerned. One wheelchair case needed special home care and means whereby the tensions between her and her mother could be modified.[3] Another patient needed recreational planning and a continuation of the telephone interviews which helped her as she said,

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1. Supra, Case (33), p. 90.
2. Supra, Case (17), p. 47 & 60.
3. Supra, Case (46), p. 50.

"Nothing can happen when I'm talking to you".[1] The psychiatrist, who read this patient's social record, recommended this procedure, but said that the patient's personality would remain the same as, due to her age and chronic condition, psychiatric treatment was contraindicated. Three other patients, of whom 2 were helpless and one was aged 73,[2] needed primarily the assurance that they would be secure and cared for. There was also the danger that the condition of one of these women would deteriorate as she found visits to clinic or for physiotherapy too burdensome and stayed in a room alone with inadequate care. One woman, who seemed somewhat unbalanced, perhaps could not have made use of casework. In her case, however, another hospital, which was supervising her cretin child, asked for cooperation. Of the remaining 4 patients, a widow with three children needed to know she would be helped if necessary, and a patient with her daughter in sanatorium should have had the assurance of the caseworker's concern since the problems of tuberculosis might again become acute in her home.[3] One patients' confidence was not won, but this should have been possible over a period of time. Finally, a frightened and resentful woman was helped by a sustained type of interest in her.[4] This should have been continued indefinitely despite her recurrent hostility and chronic attitudes of resistance.

There were only 2 cases of Rheumatoid Arthritis for whom case work treatment did not appear to be indicated. One patient was upset by being referred to the social worker as she seemed to feel such a service was for "the poor". Her physician's help, however, in clarifying her problems

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1. Supra, Case (15), p. 77.
2. Supra, Case (27), p. 76.
3. Supra, Case (25), p. 54.
4. Supra, Case (12), p. 50.

with her might have led in the future to a referral. A second patient was aged 71 and casework was impossible due to language difficulties. In this case, the patient's family seemed able to manage and, as she was Jewish, adequate community resources were available if necessary.

3. Rheumatoid Spondylitis

It seemed that the three younger males with Rheumatoid Spondylitis, in particular the patients aged 21 and 23, needed the same individualized attention as the young patients with Rheumatoid Arthritis. The problems of the patient whose father had separated from his mother were never completely understood. But he might have been helped by a psychiatrist who could use the caseworker as indicated.[1] An older male of 37 years could also have been followed up, though adjustment for him, due to the traumatic experiences of his childhood in Europe, might have been difficult.[2] On the other hand, a fourth patient, aged 68, needed interpretation to a community agency and financial help. This man was afraid his common law wife would leave him and that he would be helpless with his small veteran's pension of $37.60 a month.

4. Rheumatic Fever

The case of Rheumatic Fever, a young man of 22, was seen on one occasion only but his confidence was not won. This young man was extremely tense and strained and there was a disquieting history of rheumatism and heart disease in the family. There was also a note in the medical record that this patient believed that smoking, dancing and

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1. Supra, Case (83), p. 79.

2. Supra, Case (42), p. 55.

drinking had brought on his illness. Further help was needed by this patient as he was apparently afraid that his condition would become worse if he tried to enjoy himself.

5. Osteoarthritis

Osteoarthritis has already been considered as a disease of aging, but its affect on this group of patients was, in many cases, out of all proportion to the bony changes taking place in their bodies. This appeared to be due to the environmental and psychological strains which also affected them and relief of these stresses often appeared to be more possible than in the case of patients with Rheumatoid Arthritis.

Casework services were needed for 5 of the 8 males with Osteoarthritis, and, in 3 cases, this would be mainly environmental. A 71 year old man needed assistance when he was unable to procure an old age pension,[1] another, aged 62, had never had regular employment and was now mentally and physically incapable of work, and, in the third case, a 65 year old man's family helped him to follow recommendations when the social worker won their cooperation.[2] With the 60 year old patient who was frightened about his health and the future and asked, "What if anything should happen to me?" a more intensive service was required.[3] This was probably also the case with the 54 year old patient whose condition was complicated by Mitral Stenosis, and for whom no sheltered workshop was available. Of the 3 patients not included as requiring casework, 2 seemed

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1. Supra, Case (54), p. 91.
2. Supra, Case (50), p. 68.
3. Supra, Case (39), p. 57.

adjusted and with no complaints, while one was so disturbed as to require direct psychiatric care. This man believed he had been poisoned by a blood transfusion and that his entire blood supply should be replaced.

Twenty-two of the 31 Osteoarthritis female patients appeared to need a caseworker. Six, all over 60 years with one exception, needed financial help and cooperative agency planning. Three of these patients, a woman of 56,[1] one of 62,[2] and one of 69,[3] illustrate how closely the medical and community agency would need to work together for constructive results. Another patient not known to an agency, lacked a satisfactory place to live, and the assurance of care if she were ill.[4] Fifteen, however, were patients who could have been helped by an understanding of their individual problems alone. The patient whose pains were increased because she had no security as a common law wife,[5] the patient suffering from a grief reaction,[6] the patient who was identifying herself with her harassed father,[7] and the patient who was unhappy with her adopted daughter,[8] illustrate some of the problems involved. These might be relatively long term cases and not comparable to that of the woman who knew she would be able to manage once her husband could be reemployed.[9]

The remaining 10 women of this older group of 15 patients with Osteoarthritis, presented varying medical and social problems needing con-

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1. Supra, Case (31), p. 51.
2. Supra, Case (92), p. 48.
3. Supra, Case (34), p. 73.
4. Supra, Case (47), p. 96.
5. Supra, Case (5), p. 58.
6. Supra, Case (84), p. 53.
7. Supra, Case (18), p. 53.
8. Supra, Case (51), p. 57.
9. Supra, Case (37), p. 55.

sideration. It seems to be important with such patients never to minimize the pain they may have. Nor can they be helped by being told bluntly that their anxieties add to their sufferings. Only if they have complete confidence that their physician is interested in them individually, and that he will continue to see them as necessary, can they also have confidence in their caseworker. With these patients also, a form of casework therapy, which has been described as "experiential", may be employed. In this type of treatment, the patient experiences a kind of relationship with the caseworker which differs from that with his own family. He now feels accepted and understood, instead of rejected or criticized. As a result, his anxieties are reduced and he may make a new adaptation to reality. While insight is not a necessary goal, the patient, secure in his relationship with his caseworker, can then bear to look at his life with more objectivity without feeling any need to defend himself from blame.[1] This kind of of therapy would not be possible perhaps, among patients who were too elderly and unable to change. For these, the protective relationship in supportive therapy would be most helpful.

There were 9 female Osteoarthritis patients for whom such services as these did not appear to be indicated. Six described no present strains which were beyond them, one seemed to be adjusted to her marital quarrels, at least for the present, one lived out of town and could not be followed, while one woman seemed to be so fixated on her physical symptoms that it would not have been possible to help her redirect her thoughts.

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1. Austin, Lucille N., "Trends in Differential Treatment in Social Casework", Journal of Social Casework, Vol. XXIX No. 6. (June, 1948) pp. 207-210.

6. Mixed Arthritis

The two patients in this category would need the same consideration as did those with Rheumatoid Arthritis. The 70 year old man could have been assisted environmentally as he was on a small pension and burdened with a presumably unemployable son. The 57 year old woman illustrates the necessity for conservative treatment and the unwisdom of encouraging the patient to go too far in self revelation. This case will be described at the end of this chapter.[1]

7. Gout

The single patient with Gout was a wheel chair case and was under family agency care. There was a history of separation from her husband with delinquency of her children, but the social situation had now been stabilized as far as possible. This patient, however, felt that attending clinic was worthless and exhausting. As treatment might have improved her condition, patience and persuasive methods were required. This might mean that the medical social worker would visit and then use a volunteer to travel to and fro with the patient when the doctor wished to see her.

8. Traumatic Arthritis

No problems were expressed by the patient with Traumatic Arthritis who was cheerful and independent in manner despite his 73 years.

9. Miscellaneous Types

Among the patients with miscellaneous types of disease, the two males with Bursitis needed a supportive contact during work adjustment

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1. Infra, Case (29), p. 118.

as their anxiety and loneliness were adding to their difficulties.[1] The home situation of the elderly woman with Osteomalacia was unmodifiable, due to her psychopathic lodger, but she required help with transportation and cooperation was indicated with the visiting nurse. Particular attention was needed by the 31 year old wife with Sacro-iliac Arthritis of undetermined origin. This unhappy woman said that her husband had had a "nervous depression" since marriage and that she herself had been "demoralized" at the birth of her youngest child. The psychiatrists' diagnosis was Anxiety in a Maladjusted Marriage. While psychiatric treatment was arranged for the husband, the patient herself needed a concurrent supportive relationship.

10. No Demonstrable Arthritis

The patients with no demonstrable arthritis were a varied group. Fourteen, however, 3 males and 11 females, needed planned help as much as did those patients with Osteoarthritis. Some of these patients had muscle and joint pains which seemed to have a psychogenic basis. In such cases it might be maintained that the doctor should transfer these patients elsewhere as rapidly as possible, or else tell them plainly that there is no organic cause for their complaints. Such an experience of rejection, however, only drives the patient from clinic to clinic, or leads him to seek help from charlatans and quacks. The fear that the patient will become fixated in his misconceptions will not be realized if individual plans to help him are made. Such plans need as much care as in the case of patients with organic disease.

One of the 3 males in this group, with an undetermined diagnosis,

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1. Supra, Case (16), p. 83.

was distressed by his relationship with his wife and his daughter. While an attempt at some adjustment had formerly failed, the situation could have been explored anew, and the patient's guilt for not supporting his family, relieved.[1] Two other males of 42 and 45 were not successful in their work adjustment. One of these crumpled a piece of paper up in his hand as he tried to describe the state of his "nerves". While transfer to Psychiatry Clinic was indicated in this latter case, the patient's confidence had first to be won as he said he was not a "malade imaginaire".

The 11 women needing help ranged in age from 24 to 58 years. The most elderly patient had a diagnosis of Diabetes as well as Psychoneurotic Depression. This woman could have been transferred to Diabetic Clinic but only after reassurance by a doctor she could trust that she would not become "paralyzed".[2] A woman of 38 illustrated the uselessness of a psychiatric consultation when the patient is afraid of being called "neurotic".[3] This patient attended another clinic and was referred to a psychiatrist before her confidence had been gained. This resulted in her leaving the hospital, still convinced of her illness, to seek help elsewhere. Another patient with chronic anxiety and Psychogenic Myalgia, whose unhappiness had affected her son,[4] and one with probably Psychogenic Rheumatism, who screamed at her daughters "though she knew it was a crime,"[5] were responsive to the caseworker and should have been followed. Instead, they were referred to Psychiatry Clinic. One failed to attend, and the other did not establish

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1. Supra, Case (21), p. 49.
2. Supra, Case (93), p. 54.
3. Supra, Case (22), p. 48.
4. Supra, Case (52), p. 46.
5. Supra, Case (80), p. 56.

any rapport with her psychiatrist. In such a case, the social worker could still have kept in touch with her till a means of helping had been found. Such women can only love their husbands and their children, at least in, some measure, when they can experience a relationship in which they find complete acceptance.

Of the remaining 7 patients in this group, one other needed transfer back to, and casework help in, Diabetic Clinic, one young mother needed encouragement to establish her own home, cooperation with other hospitals was required in 2 cases, and ways of helping 3 other patients could have been explored further.

There were 4 patients with no demonstrable arthritis for whom casework might not be recommended. One was content to return to the clinic supervising her for Post-Traumatic Mental Deficiency, one had been mainly afraid of being diagnosed as tuberculous, one expressed no anxieties, and one was afraid that her confidence would be forced. Such a patient would first need to trust her physician before she could be referred for casework help.

11. Other Conditions

The patients with Other Conditions were a 22 year old man with Pes Planus and a 59 year old woman with Multiple Myeloma. The former's withdrawn and depressed state of mind would impede his rehabilitation,[1] the latter was a case of terminal illness whose family needed reassurance and help in planning for the patient's care at home.

The following cases will illustrate how three patients were helped

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1. Supra, (Case 89), p. 60.

through the medium of interview only. They also seem to show the greater severity of the problems found among patients with the rheumatoid types of arthritis, and the value of giving them support and acceptance. However, as the adjustment of these older patients is in some measure precarious, interviews should not be of such a nature that the patient will feel threatened or become upset. This is particularly important in the rheumatoid cases, where insight may be damaging since the patient's life pattern cannot be changed and the past cannot be altered. The patient must then feel that his difficulties in the past have been understood by the caseworker, that she understands and accepts him as he is now, and that she is ready to help him work for whatever satisfactions in living are still within his reach.

The first case given here reveals the needs for a continuing supportive type of relationship for a patient whose Rheumatoid Arthritis might develop to a serious condition.

> Case (29), a 57 year old married woman, born in Russia and of Hebrew faith, had a diagnosis of Rheumatoid and Osteoarthritis. She complained of pain in the joints, and also of insomnia, restlessness and lack of appetite, She said she had had a "nervous stomach" and headaches since childhood, and now had a feeling of "twisting inside". She was referred to the social worker because she spoke of extreme reactions to injections by a private physician. She also said she was excessively nervous.
>
> The patient was a small woman with a precise manner unattractively dressed in gray. Unlike the usual Rheumatoid Arthritis patient, she quickly established rapport and, in the course of several interviews, gave the following history. Patient said she had been the youngest of six children. Her father was "strict, proud and proper" and struck the children to enforce instant obedience. Her mother was " gentle and an angel" who stressed how wrong it was to misbehave. Patient said she had always "tried to be good". At the same time she was "spoiled", as her mother had to coax her to eat, and "none of the others was so delicate and sickly as she". The family called her "the little doll", and she weighed no more than 98 pounds until she was 20.

Patient learned to regard all the natural functions of the body as "disgusting". This made marital adjustment impossible and she would scream when her husband approached her. She excused herself for not having had children on the grounds that her physical structure did not allow it. As smoking, drinking and card playing had been forbidden by her parents she now considered them with revulsion, and refused social gatherings where they were indulged in.

Patient seemed to find relief in talking about her life, and decided to accept gold injections, though she stopped the recommended physiotherapy which she said, made her feel worse. She then began to express her resentment about the way she had been brought up. She told how her father had struck the childrens' arms off the table at meals and asked, "Wouldn't you think he would say something instead of just hitting?" Patient spoke as if it had been a painful puzzle trying to meet her father's demands from fear, and her mother's because of the reproach that she was "doing wrong". But she maintained that she was not sorry she had been brought up that way. "Some people", she said, "would have been angry, but I am grateful". She then said other people did what was wrong and nothing happened to them. But she had tried to be good and didn't "deserve" her pains. She spoke of not understanding why her husband had lost everything in the Depression so that now they were just able to manage on his wage of $27 a week. She also said she could never answer back when she met annoyance or criticism, but could only cry.

After the interview in which she implied criticism of her parents, patient had an attack of "indigestion" which she described as so severe that a doctor had to give her morphine. While she reported similar attacks two or three times a year, the social worker believed that it would be wiser not to encourage her to talk further of the past. Patient herself said that she and her husband were now like "sister and brother". It was therefore apparent that both had reached some kind of mutual adjustment. In such a case, insight might only increase anxiety, whereas, supportive therapy could possibly relieve it. Thereafter, patient was only seen briefly from time to time. On one occasion, when the social worker had asked further about her recreation or synagogue affiliations, she explained that the rabbi did not visit and that in her faith there was no "confession". She said she was sure that confession was helpful and it was the worker's impression that she considered her early interviews in this light. Two months and a half after first attending clinic, she lapsed. When telephoned, she said she could not bear any more injections. She was encouraged to return and assured that no treatment she did not want would be given but she did not do so. She was met on the street, however, not long afterwards. At this time she looked quite cheerful, her hair had been waved, she was more attractively dressed and was wearing quite bright and contrasting colours.

After discussing this case with the social worker, a psychiatrist later suggested that it would have been of value to the patient if the

worker had visited her home as she had been invited to do. While it would be likely that the patient would make many demands, these could have been met as far as seemed indicated and the patient might have been helped to reach a happier adjustment to her present lot.

The two further cases describe women with Osteoarthritis. The first found courage to remain independent from her interviews, the second could have been helped to surmount her unhappiness if the doctor and case-worker had continued to treat her.

Case (14), a 47 year old French Canadian woman of Roman Catholic faith, with a diagnosis of Osteoarthritis, was referred by her physician because she was so upset. Patient's arthritis had affected her fingers but objectively there were only minor changes. She began crying as soon as she entered the office, saying she could no longer work because of her "pains" and would lose her job at a printing press where she earned $17 a week. Patient's life experiences seemed to explain her timidity and loneliness. She said her father had died when she was 2 years old and that she had been brought up by an aunt who "hated children" and had finally sent her away to a convent school. But "sunstroke" at the age of 7 caused her to "lose her memory so that she had no education, never finished school and had no talents". When she was 16, patient went to live with her mother and helped to support her until she died at the age of 77. Patient said unhappily that her mother had never loved her. Rather, patient had felt hated because of her resemblance to her Scotch father. A brother was in the home part of the time and patient feared both mother and brother who, "whenever she lost a job because she was ill, threw her out". But, despite this, when patient's mother became old and helpless patient felt that it was her duty to care for her until her death.

Patient said that she could not mix with people and that, as a girl, she had never been to parties and dances and had never had "a boy friend or any friend". She felt her poverty now made friendship impossible, while the pain in her hands kept her from regular work. Besides this, she worked so slowly, because of her hands, that her forelady became impatient and she was in danger of loosing her job altogether. Patient also said she had no appetite and vomited when she became upset.

This patient came several times for interviews and also telephoned. At first she continued to cry and said that she had been warned by a priest that "if she did not stop thinking about her troubles, she would go crazy and scream on the street". Patient

dreaded the irritation or impatience of others, as this reactivated all her fears of rejection. In her contact with this patient, the social worker assumed the role of a "good mother" who accepted and understood the patients' unhappiness and approved her for what she had done about her own mother's care.

At length patient asked, and was allowed, two weeks leave from her job. After she had returned to work, she telephoned to report that she was getting on satisfactorily. Finally, she came to see the social worker on one of her free Saturdays about 3 months after referral. She said she felt better and happier and, though her hands were still painful, she was no longer afraid of loosing her job. While she did not return for interviews after this, she came in on several occasions to say how she was getting along. She also sent cards to the worker at special holiday seasons and kept in touch in this way with the hospital.

Case (56), a 40 year old married woman, born in Canada and of Roman Catholic faith, had a diagnosis of Hypertrophic Spondylitis (Osteoarthritis of the Spine). She had formerly been to another hospital and a private doctor, and the reports were that there was a probable dislocated cervical disk. Patient said she could not sleep or find a comfortable position in bed because of the pains in her shoulders and arms. She reported having had a nervous breakdown about four months previously, and her doctor found her excitable and voluble.

Patient was seen by the social worker as a routine admission case and, during two interviews, spoke of her family history. She said her only brother had died as a child so she "became a tomboy to please her father" whose favourite she was. He was proud of her and encouraged her to dive and climb trees. She thought she resembled him and, when she once asked why her mother hated her, he had answered, "Perhaps I like you too much." Patient described her mother as "méchante". Her mother had called her activities "disgraceful and turbulent" and had said she needed "severe surveillance". As a child, patient had been frequently punished, "as everything she did was bad". Once, when she was ill, she said she had heard her mother say, "I wish God would take her". Even when she was a young girl, patient said her mother would not allow her to go out with men friends but insisted that she be chaperoned by a younger sister. Another unhappy memory, in connection with a sister, was of an incident when she was 9 years old. When she knocked against the bed of this 17 year old girl who was dying, her sister complained, "Get that devil out of here".

There had been bitter experiences at school also. On one occasion, she had been told she was "evil" and had sat in a chair "like an animal and not like a human". For this she was forced to kneel and beg forgiveness of her fellow pupils. Yet patient seemed proud of her education and had finally graduated. Patient

said she had married at 30 and that her husband "never caused her the slightest grief or worry", though he refused to talk with her mother. Since her marriage, except for 6 months, they had remained in her mother's home.

As patient's mother constantly criticized her and there was a separated daughter at home, the social worker wondered whether patient had ever thought of establishing a home of her own. Patient said, however, that her mother had been ill and, if ever she suggested this, would cry and complain that "leaving her would be desertion".

Patient then failed to return to clinic and, when the social worker telephoned, she said she had been in the country. She had also played golf which she had not done for 6 years. Patient said her pain was bearable and that she felt better. She was to return to the country and take a job later. In the Autumn, she would return to see the doctor. Patient said that her husband was very pleased with her improvement and she added, "One shouldn't keep a grudge".

The social worker felt that, besides her medical treatment, this patient needed a sustained relationship over a period of time. She might then have been helped to find a more satisfying way of living. She also needed to talk further of the reasons for her bitterness and grief in the past. Unfortunately this did not prove to be possible as this patient only returned to clinic on one other occasion.

These three patients might all have made more use of the case-worker if they had been encouraged to do so. The patient with Rheumatoid Arthritis needed a continuing support until she could further relax some of her demands on herself and learn to enjoy periods of relaxation with others. The second patient also might have been encouraged to establish ties with friends and the third needed to experience a relationship in which she felt a warm acceptance and understanding. Problems with her mother, and the question of whether she would continue at home or not, could then have been worked through.

This chapter further illustrates the kind of casework help which these patients needed whether other specific community services could be offered or not. In all, 78 per cent of this patient group required individualized case work treatment. Of the remaining 22 per cent, 12

patients expressed no current anxieties. Ten, however, had personal problems but it appeared that casework service was not indicated at the time for various reasons.

Depending on the diagnosis, the problems involved, and his own capacities, the individual patient, may be helped by different types of casework treatment. He may need a brief type of understanding service, a more protracted period of help, or perhaps a permanent contact of a supportive nature that will enable him to continue to function to the maximum of his capacity. Treatment may also be designed to give the patient an experience of a different kind of human relationship in which he is accepted and feels secure. This may result in his growing insight into some of his own behaviour and so lead to readjustment and change. It was the writer's impression that it was more difficult to work with those patients with the more severe types of arthritis. It was also more difficult to discover ways in which they might be helped as they often seemed to be defensive and reserved. For the younger patients, it would seem that every effort to help should be made, and that further research into constructive casework methods with them should be embarked on. For the older patients with the severe types of arthritis, the case-worker's role can be one of psychological support as she explores methods of alleviation. On the other hand, it would seem that with those patients with Osteoarthritis, and with many of those who have no demonstrable arthritis, much more change and adjustment can be looked for than might at first be expected. If these patients have not become physically helpless or exhausted due to advancing age, they are often capable of finding much more satisfactory adjustments with casework help. With all

these patients, however, there are possibilities of creative development. It is the task of the medical social worker to find where she can help these inherent possibilities for growth.

SUMMARY AND CONCLUSIONS

The problems presented by Arthritis and the rheumatic diseases are receiving increasing attention at the present time. It has been estimated that 600,000 Canadians suffer from these diseases, 100,000 of whom are totally or partially disabled. Complicating factors are the variety of forms which these diseases take and the lack of specific known cures. For example, Rheumatoid Arthritis and Rheumatoid Spondylitis affect individuals between the ages of 20 and 50 years for the most part, and may progress to a stage of crippling, whereas Osteoarthritis is associated with the aging process itself. A third group of patients attending an Arthritis Clinic may complain of pain, though no cause for such pain can be demonstrated. All these patients may be subjected to environmental and personal strains which affect their lives and adjustment.

An understanding of the importance of these social factors prompted the interest of the physicians of the Arthritis Clinic, Royal Victoria Hospital, when a study of 100 patients was undertaken in 1947 and 1948. The present study attempts to assess the intensity of the problems then found, and to determine the needs of these patients for community resources and for casework treatment of individual problems.

In trying to assess the social and emotional problems presented by these patients, the possible effect of these problems on the individual's reaction to the disease process was considered. Walter Cannon, writing in 1929, emphasized the physiological mechanisms of emotional

disturbance and spoke of the human organism as a mind-body unity.[1] Cobb, Bauer and Whiting concluded, 10 years later, that environmental stress seemed to bear more than a chance relationship to the onset and exacerbation of Rheumatoid Arthritis.[2] Selye, in describing what he called the General Adaptation Syndrome, postulated that the constant exposure of the organism to stress produced reactions which resulted in "Diseases of Adaptation". Among such possible diseases, he included Rheumatoid Arthritis.[2] While there is no general agreement among physicians about the importance of these factors, the social implications of arthritis are apparent in their effects on the lives of patients. Osteoarthritis, for example, may increase the difficulties inherent in aging. Rheumatoid Arthritis and Rheumatoid Spondylitis may disable the younger adult. It would also seem, that these two forms of arthritis are, in many cases, accompanied by severe emotional problems in the present, together with a history of strain which perhaps dates from childhood. It is of importance to discover whether these stress situations, or the individual's reaction to them, can be modified. The rehabilitation of these patients may therefore include both environmental measures and help in personal adjustments. There are also those patients who complain of pain yet have no demonstrable disease. For these, a similar understanding of their personal lives is necessary.

The 100 patients on whom this study was based were consecutive admissions to the Arthritis Clinic of Royal Victoria Hospital between November 20, 1947 and December 30th, 1948, with the exception of 17

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1. Supra, p. 5.

2. Supra, p. 6.

patients who were specially referred during that period by their physicians or by social agencies.

The seriousness of the medical problems involved was revealed by a consideration of the different diagnoses of these patients. Two per cent were young males with Infectious Arthritis of the Gonorrheal type. Prognosis in these cases depends on the nature of the original disease and its treatment. In these 2 cases, the patients' eventual prognoses were questionable. Rheumatoid Arthritis among these patients presented serious problems because of the possibility of crippling, the exacerbations and remissions of the disease process and the lack of any known method of cure. In these cases a treatment regime is planned to prevent deformity by a balanced program of rest and activity with special corrective measures. These might include transfusions, physiotherapy, bed rest, splints or casts. Gold injections are sometimes given and experimental work on ACTH and cortisone is being done. Including patients with a mixed form of arthritis, 27 per cent were cases of Rheumatoid Arthritis. Eight of these were male and 19 were female. These patients are usually a younger group and just under 50 per cent were under 50 years of age. However, this can be explained by the fact that these patients were not all diagnosed for the first time but had medical histories already. Five of the male patients with Rheumatoid Arthritis were unable to work, 3 females were wheel chair cases and one used crutches.

Rheumatoid Spondylitis, in many ways similar to Rheumatoid Arthritis, affects the spine and is treatable by x-ray therapy. It was the diagnosis of 4 per cent of these patients who were all males. The beginning deformity of a young man of 21 years could be observed. Rheumatic

Fever, which is noted for its possibly damaging effect on the heart, was found in one case of a young man only.

The largest group of 39 per cent of these patients had a diagnosis of Osteoarthritis which is associated with aging and involved bony changes. The treatment here is planned to alleviate strain on affected joints. All these 39 patients were over 40 years of age with about 80 per cent being over 49 years. Patients with anxieties seemed to be more conscious of their disability. There were 8 males and 31 females in this group.

Gout, which may be as crippling as Rheumatoid Arthritis, and for which Colchicine is a specific treatment, was found in one case of a 55 year old woman. Traumatic Arthritis, resulting from trauma, was also found only in one case of an elderly male. Miscellaneous types, which included Bursitis, a type of non-articular rheumatism, Sacro-iliac Arthritis of undetermined origin, and Senile Osteo Malacia, which is a softening of the bones, were diagnosed among 4 patients. No demonstrable arthritis was found in 19 cases. Of these, 11 had an uncompleted or undetermined diagnosis, 4 had psychoneurotic conditions, 2 had questionable synovitis and myositis, which is muscle tissue or membrane inflammation, one had menopausal arthralgia, or joint pains, and one potential rheumatic fever. Four of these patients were male and 15 female. Other conditions of Pes Planus, or flat feet, and Multiple Myeloma, a bone marrow disease of a terminal nature, were diagnosed in 2 cases.

The possible complications introduced by associated and other conditions, could only be assessed by a physician. Twenty-five other types of illness were found among 40 per cent of the patient group 65 times in all. Cardiovascular Disease, chiefly affecting the patients over 60 years,

was found in 15 cases, and Psychoneurosis or Anxiety State in 14. While Diabetes affected 6 patients, other conditions were found in about one or 2 cases each.

The age and sex of these patients illustrated their presumable position in the community. Illness that affects the younger adult may disrupt plans for marriage, damage family self sufficiency, and result in premature dependency. The effects may vary according to the sex of the individuals involved. Thirty-one per cent of these patients were male and 69 per cent were female. While 8 per cent of the total number was over 70 years of age, 70 per cent were between 40 and 69 years and 22 per cent were under 40. The proportion of males and females would not be effected by the removal of the 17 specially referred patients from the consecutive clinic admission group. The age groupings would likewise remain the same.

The marital status and number of living children did not appear to be of significance in themselves, as the patient's individual adjustment was the essential factor. Twenty-five per cent of these patients were single and 55 per cent were married. Two per cent lived in a common law relationship, 12 per cent were widowed and the remaining 6 per cent were separated or divorced. There were 175 living children, but only 33 of these, in 19 families, were under 16 years of age. Two considerations here are that older children can often no longer assume responsibility for their parents, and families with younger children need special help in consideration of the effect of parental illness upon these children.

The significance of the birthplace and religion of these patients could not be determined from this study. Fifty per cent had been born in Canada, 23 per cent in the British Isles and 25 per cent in Europe,

with 2 per cent coming from the British West Indies. While 41 per cent were Protestant, 37 per cent Roman Catholic, and 2 per cent Greek Orthodox, as many as 20 per cent were Hebrew. This was due to the location of Royal Victoria Hospital near an old established Hebrew community.

The type of occupation of these patients showed that adjusting their work, or changing to new employment, might be difficult for the wage earning group as it was largely unskilled. Nine per cent were employed in clerical and sales positions and 13 per cent in cleaning and domestic services. Twenty per cent were semi-skilled or unskilled, and 4 per cent comprised a student, a patient whose former occupation was unknown, and 2 unemployed individuals. Only 5 per cent could perhaps be classified as skilled. The remaining 49 per cent were housewives whose activities would be capable of adjustment.

A complete study of income was not possible. It was found, however, that 34 per cent of these patients were probably living as individuals or families, on less than $100 a month. Thirty-six per cent lived on between $100 and $150 a month, and only 17 per cent had amounts over this figure, while there was no data for 13 per cent. A comparison of these monthly incomes with the most adequate budget of a Montreal family agency revealed that at least 21 per cent of these patients had an insufficient income for adequate nutrition.

The majority of these patients paid extremely low rents. As many as 52 per cent paid rents of from $10 - $29 a month. Fifteen per cent paid $30-$39 a month, and only 6 per cent paid over this figure. Details are not known for 12 per cent and 15 per cent paid no rent. Property was only owned in 4 cases, in 2 of which it was mortgaged. At

least 18 patients, earning or living on less than $100 a month, paid over one quarter of their income on rent.

An analysis of the source of livelihood of these patients during their disability, revealed that 22 per cent continued as wage earners. Eight of these however, might later find their medical condition would lead to unemployment, and 8 considered themselves more or less incapacitated. Of 42 housewives dependent on their families for support, 4 of the 9 patients with Rheumatoid Arthritis were very incapacitated. Fourteen with Osteoarthritis and other conditions or complaints, were apparently more affected by their anxieties than by their medical condition. Two patients were really ill, and only 17 appeared to be able to function in a normal manner. There were 14 patients dependent on emergency family support and 17 dependent on public or private agencies. There appeared to be a possibility of 4 males becoming self sufficient, the rehabilitation of 6 individuals seemed doubtful, and 21 patients seemed likely to remain dependent. Nine of these were incapacitated by the severer forms of arthritis, while 12 were over 60 years of age.

→ The significance of the anxieties revealed in interviews with these patients, lay in the intensity of their expression. Loss of parents by death or separation was found among 19 per cent of these patients and had apparently affected them adversely, while unsatisfactory relationships with parents were described by 13 per cent. Later inability to adjust happily in marriage seemed to be a possible result in either case. Marital unhappiness was found among 24 and anxiety or conflict over children among 22 per cent. An important consideration in trying to help such patients would be the well-being of children at home. At the time of this

study there were 12 families with children under 16 whose homes were unstable in various ways.

Death in the family had affected 11 female patients, while family illness caused anxiety to 29 per cent of the group. In all these cases there were other reasons for distress. Fifty one per cent were anxious about their own health and 7 expressed fear of the future and of old age. Closely allied to these fears were financial anxieties mentioned by 39 per cent. While 31 patients of this group, had other causes for anxiety, financial restrictions exacerbated their problems.

Work history was only considered for 13 of these patients where it was found to have been erratic due to lack of training and a general sense of restlessness and disatisfaction.

The strains revealed were damaging factors in the life experience of these patients, since as many as 47 per cent, 14 males and 33 females, exhibited states of generalized anxiety. Three males and 24 females, or 27 per cent, were in tears as they spoke of their difficulties.

It is not possible to reach any exact conclusion about the significance of these social problems in relation to the specific diagnosis. It was the writer's opinion, however, that, not only did the severer rheumatoid and infectious types of arthritis present the more serious physical problems, but that these patients had been subjected to greater strains in their personal adjustments. There was a higher incidence proportionally among these patients of strains which affected family inter-relationships, than among those patients with Osteoarthritis alone. Eighteen of the 27 patients with Rheumatoid Arthritis also displayed attitudes of timidity and submission which often concealed a resentment they had been

unable to express. The effect of a long continued experience of pain, and the fears associated with progressive deformity and an uncertain prognosis, must not be forgotten as these might also account for such attitudes.

Forty-nine of these 100 patients needed the help of community resources in 112 instances. However, these were not available in 41 instances and were inadequate in 20. In 9 cases, medical planning with other hospitals or psychiatric institutions caring for relatives of these patients was indicated. In one case, the type of psychiatric institution needed for the patient himself was not available.

Financial assistance was only available in 19 of 30 instances of patients who needed such help. That only 4 could be helped adequately, was due to the restricted resources of Montreal agencies. The absence in Quebec of a public welfare programme, and the low rates of government grants to these agencies for the assistance of persons unable to work, result in food budgets which are below minimum requirements for health. Besides these 30 patients, there were 20 others who experienced financial difficulties.

Recreation of a specialized kind could only be found for one patient. Eight others might have been benefited had such groups as the Darby and Joan or Golden Age Clubs been available to them. These groups for older persons are only now being established in Montreal and should each serve a small neighbourhood. Transportation and home services will necessarily be a later part of their development.

Four patients required vocational services and 4 employment direction. While this was available, the 6 patients concerned needed casework help, as a directional service alone would have been sterile in

its results. The needs of 11 patients could only have been met by a sheltered shop such as the Altro Workshop in New York. These patients needed a medically supervised regime of work and rest, together with a salary based on an eight hour day and sufficient to support them. Employment training might possibly be carried in such a shop as is done in the Altro Shop which is geared to the needle trades. Government subsistence allowances for patients who might be able to attend technical or trade schools, however, is not available. There is also, as yet, no sheltered shop project which might serve the whole community in Montreal.

Family agency service, which included the administration of financial assistance and help with various environmental and family problems, was needed by 27 patients and was available for 24. Special home care, however, was only adequate in 2 cases and was inadequate in 4 and not available in 7. This is due to the lack of suitable, non-profit, government or agency assisted homes in Montreal where nursing services would be available to those who needed them, and facilities would be designed for the comfort and convenience of the handicapped and aged. Of these 11 patients needing more adequate home care, 3 remained at home and were visited by a nurse of the Victorian Order, 6 lived in rooms without adequate supervision, one stayed at home in a similar case, and one lived in a hostel which was not designed for invalids of his type.

Other services were needed in 4 cases and were available in 3 of these. It was apparent that the more incapacitating forms of Arthritis required more frequent services, while the dependency of the patients with Osteoarthritis was more often due to the needs of the elderly.

The assistance which might be procured in the community for the

49 patients who required definite services would only be of maximum benefit if individual needs were assured of casework consideration. Besides these 49 patients, there were also 29 who required casework help which might have been offered in interviews alone. There was thus a total of 78 per cent of these patients who might have been helped by case work treatment. This included 24 of the 27 patients with Rheumatoid and Mixed Arthritis as compared with 27 of the 39 patients with Osteoarthritis alone. The 4 patients with Rheumatoid Spondylitis, one with Rheumatic Fever, and one with Gout, all needed casework help, as did also 14 of the 19 patients with no demonstrable arthritis. Four patients with miscellaneous types of disease, and 2 patients with other conditions, could also have used such a service.

It is the aim of the Arthritis Clinic of the Royal Victoria Hospital to try to meet the medical and social needs of its patients. Adequate medical social planning would require the evaluation of each patient by the treating physician. He would then, as leader of the treatment team, make use of the psychiatrist, medical social worker and any other staff member who might be able to help in the patient's rehabilitation. This study particularly emphasizes the social needs of these patients. Special problems were found among the younger patients with the more severe types of arthritis. Such patients might need psychiatric supervision. They also present problems of understanding and management which demand further study by the medical social worker and special casework skill. The older patients with the Rheumatoid and severer forms of arthritis might be unable to bear the strain of insight or of much readjustment in their thinking. In such cases a supportive therapy and the alleviation of environmental situations would seem to be the method of casework treatment. These

same considerations apply to those patients with Rheumatoid Spondylitits, Rheumatic Fever and Gout.

For the older patients with Osteoarthritis, other conditions, and no arthritis, treatment would also be on an individualized basis. It might, however, not only be environmental and supportive, but might offer the experience of a new relationship. Such a relationship can often help an individual find a better adjustment to life.

APPENDIX

SCHEDULE

1. Case 2. Name 3. O.P.D. 4. Ward

5. Address 6. M.F. 7. Age 8. S.M.W.D.Sep.

9. Birthplace 10. Religion 11 Occupation

12. Family Composition

	a) Family	b) Age	c) Birthplace	d) Occupation	e) Wages
i					
ii					
iii					
iv					
v					
vi					
vii					
viii					

13. Financial Status and Effect of Disability

A. Income and Source	a) Before Illness	b) After Illness	B. Rent
i Wages			
ii Family Allowance			
iii Established Family Support			
iv Emergency Family Support			
v Savings			
vi Public or Private Agency			

14. Medical Status A. Diagnosis B. Associated & Other Conditions

15. Social & Emotional Problems

i	Loss of Parents	vi	Illness in Family
ii	Unsatisfactory Relationship with Parents	vii	Anxiety about Health
iii	Marital Unhappiness	viii	Fear of Old Age & of the Future
iv	Anxiety or Conflict over Children	ix	Financial Anxieties
v	Death in Family	x	Erratic Work History

16. Community Resources Needed

	A. Available a) Adequate	B. Not Available b) Inadequate
i Outside Medical Care		
ii Financial Assistance		
iii Recreational Facilities		
iv Vocational Guidance		
v Employment Service		
vi Sheltered Workshops & Employment Training		
vii Family Agency Service (specify)		
viii Special Home Care (specify)		
ix Other (specify)		

17. Medical Social Treatment

BIBLIOGRAPHY

BOOKS

Bartlett, Harriet M., Some Aspects of Social Casework in a Medical Setting, Chicago, George Banta, 1940.

Boas, Ernst P., The Unseen Plague - Chronic Disease, New York, J.J. Augustin, 1940.

Cabot, Richard C. and Dicks, Russell L., The Art of Ministering to the Sick, New York, Macmillan, 1938.

Cannon, Walter B., Bodily Changes in Pain, Hunger, Fear and Rage, New York, Appleton & Co., 1929.

Cassidy, H.M., Public Health and Welfare Reorganization, Toronto, Ryerson Press, 1945.

Comroe, Bernard I., Arthritis and Allied Conditions, Philadelphia, Lea & Febiger, 1944.

Dunbar, H. Flanders, Psychosomatic Diagnosis, New York, Paul B. Hoeber, 1943.

_____ Emotions and Bodily Changes, New York, Columbia University Press, 1946.

Holbrook, W.P. and Hill, D.F., Manual of the Rheumatic Diseases, Chicago, Year Book Publishers, 1950.

Selye, Hans, The Physiology and Pathology of Exposure to Stress, Montreal, Acta Inc., 1950. pp. 2-109, 393-403, 773-792.

Weiss, E. and English, O.S., Psychosomatic Medicine, Philadelphia, W.B. Saunders, 1949.

PERIODICALS

Austin, Lucille N., "Trends in Differential Treatment in Social Casework", Journal of Social Casework, Vol. XXIX No. 6 (June, 1948) p. 203.

Boland, E.W. and Corr, W.P., "Psychogenic Rheumatism", Journal of the American Medical Association, Vol. 123, No. 13 (November, 1943) p.805.

Booth, G.C., "Personality and Chronic Arthritis", Journal of Nervous and Mental Diseases, Vol. 85, No. 6 (June, 1937) p. 637.

Boyd, Margaret, "Economic Needs of the Aged", The Social Worker, Vol. 19, No. 4 (April, 1951) p. 11.

Cannon, W.B., "The Role of Emotion in Disease", Annals of Internal Medicine, Vol. 9, No. 11 (May, 1936) p. 1453.

Cobb, S., Bauer, W., and Whiting, S., "Environmental Factors in Rheumatoid Arthritis", Journal of the American Medical Association, Vol. 113, No. 8 (August, 1939) p. 668.

de la Fontaine, Elise, "Some Implications of Psychosomatic Medicine for Casework", The Family, Vol. XXVII, No. 4 (June, 1946) p. 127.

Deutsch, F., "The Associative Anamnesis", Psychoanalytic Quarterly, Vol. 8, (1939) p. 354.

Edmonds, E.P., "Psychosomatic Non-Articular Rheumatism", Annals of the Rheumatic Diseases, Vol. 6, No. 1 (1947) p. 36.

Emerson, C.P. "The Importance of the Emotions in the Etiology and Prognosis of Disease", Bulletin of the New York Academy of Medicine, Vol. 5, No. 11 (November, 1929) p. 985.

Gordon, R.G., "The Psychological Factor in Chronic Rheumatism", British Medical Journal, Vol. 1 (June 10, 1939) p. 1165.

Halliday, J.L., "The Concept of Psychosomatic Rheumatism", Annals of Internal Medicine, Vol. 15, No. 4 (October, 1941) p. 666.

_____ "Psychological Aspects of Rheumatoid Arthritis", Proceedings of the Royal Society of Medicine, Vol. 35 (February 20, 1942) p. 455.

_____ "Psychosomatic Medicine and the Rheumatism Problem", The Practitioner, Vol. 152, No. 907 (January, 1944) p. 6.

Haselkorn, F. and Bellak, L., "A Multiple Service Approach to Cardiac Patients", Journal of Social Casework, Vol. 31, No. 7 (July, 1950) p. 292.

Heald, C.B., "Rehabilitation in Rheumatism", The Practitioner, Vol. 152, No. 907 (January, 1944) p. 16.

Hench, P.S. and Boland, E.W., "The Management of Chronic Arthritis and other Rheumatic Diseases among Soldiers of the U.S. Army", Annals of Internal Medicine, Vol. 24, No. 5 (May, 1946) p. 808.

Hochhauser, Edward, "Objectives of Sheltered Workshops", Jewish Social Service Quarterly, Vol. 25, No. 4 (June, 1949) p. 533.

Johnson, A., Shapiro, L.B., and Alexander, F., "Preliminary Report on a Psychosomatic Study of Rheumatoid Arthritis", Psychosomatic Medicine, Vol. 9, No. 5 (September 1947) p. 1295.

Margolis, H.M., "The Care of the Patient with Rheumatoid Arthritis", The Family, Vol. XXV, No. 9 (January, 1945) p. 323.

_____ "The Psychosomatic Approach to Medical Diagnosis and Treatment", Journal of Social Casework, Vol. XXVII, No. 8 (December, 1946) p. 291.

_____ "The Biodynamic Point of View in Medicine", Journal of Social Casework, Vol. XXX, No. 1 (January, 1949) p. 3.

McGregor, H.G., "The Psychological Factor in Rheumatic Disease", The Practitioner, Vol. 143, No. 858 (December, 1939) p. 627.

Nissen, H.A. and Spencer, K.A., "The Psychogenic Problem (Edocrinal and Metabolic) in Chronic Arthritis", New England Journal of Medicine, Vol. 214, No. 12 (March, 1936) p. 576.

Pottenger, R.T., Constitutional Factors in Arthritis with Special Reference to the Incidence and Role of Allergic Diseases", Annals of Internal Medicine, Vol. 12, No. 3 (September, 1938) p. 323.

Rosenblum, A. and Ruth L., "A Study of Seventy Rheumatic Families", American Heart Journal, Vol. 23, No. 1 (January, 1942) p. 71.

Schless, Bessie, "Social Casework Services to the Arthritic Patient", The Family, Vol. XXV, No. 9 (January, 1945) p. 331.

Swaim, L.T., "The Problem of Chronic Rheumatism", Annals of the Rheumatic Diseases, Vol. 5, No. 6 (1945-1946) p. 192.

Swift, H.F., "Factors Favoring the Onset and Continuation of Rheumatic Fever", American Heart Journal, Vol. 6, No. 5 (June, 1931) p. 625.

Thomas, G.W., "Psychic Factors in Rheumatoid Arthritis", American Journal of Psychiatry, Vol. 93, (November, 1936) p. 693.

White, Grace, "The Role of the Medical Social Worker in the Management of Rheumatic Fever and Heart Disease", American Journal of Medicine, Vol. II No. 6 (June, 1947) p. 618.

Wright, H.P., "The Challenge of Arthritis", Canadian Medical Association Journal, Vol. 51, No. 3 (September, 1944) p. 264.

Wright, H.P., "Psychogenic Arthralgia", Annals of the Rheumatic Diseases, Vol. 6, No. 4 (1947) p. 204.

Wright, H.P., "Rheumatoid Arthritis", Canadian Medical Association Journal, Vol. 51, No. 4 (October, 1944) p. 362.

PAMPHLETS

American Medical Association, Primer on the Rheumatic Diseases, Prepared by a Committee of the American Rheumatism Association, Chicago, 1949.

Candian Arthritis and Rheumatism Society, Arthritis Plan for Attack, Ottawa, 1949.

Conseil des Oeuvres, Reportoire des Oeuvres Sociales de Montréal, 1946, Montréal, Commission Diocésaine des Oeuvres de Charité et de Service Social, 1946.

French, Thomas M. and Ormsby, Ralph, Psychoanalytic Orientation in Case Work, New York, Family Welfare Association of American, 1945.

Metropolitan Life Insurance Company, The Care of the Chronically Ill in Montreal, Ottawa, 1941.

Montreal Council of Social Agencies, Social Service Directory 1950, Montreal, 1950.

Montreal Rehabilitation Survey Committee, Reestablishment of Disabled Persons, Montreal, Sun Life Assurance Co., 1949.

Quebec, Department of Social Welfare and of Youth, Youth Aid Services - Bursaries.

_____ Montreal Technical School, Prospectuses, Day and Night Courses, 1950.

_____ Ecoles d'Arts et Metiers, Prospectus Général, 1951.

Sterba, Richard, Lyndon, B.H. and Katz, Anna, Transference in Casework, New York, Family Service Association of American, 1948.

MISCELLANEOUS

Canada, Department of National Health & Welfare, Special Supplement #17 on Mothers' Allowances to Canada's Health and Welfare (January, 1950).

Family Welfare Department, Baron de Hirsch Institute. Relief Allowance Budget, July, 1949. (Unpublished).

Gallant, Mavis, "Our Shameful Old Peoples' Homes", The Standard, Magazine Section, Montreal, April 24, 1948. p. 3.

Jewish Child and Family Welfare Bureaux, Monthly Budget Samples. Obtained July, 1949.

Jewish Family and Child Welfare Bureaux, Montreal, 1948 Clothing Budget, Compiled by Mrs. Esther Spector. (Unpublished).

McCallum, Lester, "Survey of the Facilities for the Treatment of Arthritis in Canadian Hospitals", Unpublished Report made for the Arthritis Survey Committee of the Canadian Medical Association Between December 1, 1949 and February 28, 1950.

Montreal Council of Social Agencies, "A Proposal for the Development of Recreation Programmes for the Aged in Montreal" (Unpublished) April 24, 1951.

_____ "Old Age Can Be Fun", A Handbook on the Organization of Clubs for Older People (Unpublished) Montreal, 1951.

Victorian Order of Nurses, "Physiotherapy Service with the Greater Montreal Branch of the Victorian Order of Nurses". Unpublished report, March 31, 1950.