McGill University

Role of the Social Worker on the Dermatology Service

An analysis of the worker's role in terms of the problems and needs of 30 skin patients.

A Thesis Submitted to

The Faculty of Arts and Science

In Partial Fulfilment of the Requirements

for

The Master's Degree in Social Work

by

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Montreal, Aug.25th,1953

Master of Social Work
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ABSTRACT

Role of the Social Worker on the Dermatology Service

An analysis of the worker's role in relation to the problems and needs of thirty skin patients.

The study was undertaken in order to clarify and evaluate the role of the medical social worker in helping patients with skin diseases. This analysis was based on an examination of the hospital and social service records of 30 skin patients who had been known to the worker on the dermatology service at the Royal Victoria Hospital between January, 1950 and March, 1953. Their environments, personalities, and reactions to the illness were studied to determine whether certain factors influenced the worker's role.

It was found that the majority of patients came from emotionally deprived and unstable homes. Many of them were unable to form adequate social, marital and sexual relationships. In addition, there was a high rate of traumatic events, financial difficulties and other stress in the environments of these patients.

In spite of their deprivation, the worker enabled 19 of the 30 patients to make a better adjustment. In several instances this was accompanied by an improvement in their skin conditions. It was noted that the patient's age, method of referral, duration of illness and other factors had a definite influence on the amount of help the worker was able to offer. The study indicated that her contribution had, nevertheless, been a significant one. The recommendations which were made were based on the need for earlier and a greater number of referrals, and for a broadening of casework services.

PREFACE

I am sincerely grateful to the many people whose help enabled me to carry out this study. In particular, my appreciation is extended to Dr. Gilbert Turner, Director of the Royal Victoria Hospital, and Miss Elizabeth Taylor, Director of the Social Service Department, for their permission in allowing me to use the hospital records. Thanks are also due Mrs. René DelaDurantaye for her interest and advice throughout the entire period.

I am indebted to Miss Helen Tuck whose valuable aid and guidance made it possible for me to complete this project. I also wish to thank Miss E. R. Younge for her helpful hints and suggestions.

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INTRODUCTION

In recent years, new trends, treatment methods and concepts in medicine have made the role of the caseworker in the medical setting a particularly challenging one. The most significant trend from the social worker's point of view has been the development of a method of treatment which stresses the relationship between the patient's mental and bodily functions. On the basis of this approach, various doctors have pointed out that such factors as economic distress and disturbed inter-personal relationships could predispose the patient to illness, and that functional disorders could lead to genuine organic changes. This approach, which has been termed psychosomatic has contributed to a greater understanding of the meaning of illness for the patient. It also has serious implications for the social worker, since an appreciation of these factors means more effective help.

On the Dermatology service, as on other services, this approach to medicine has resulted in a greater demand for casework services. Numerous research studies have been made concerning the emotional implication of skin disease. These studies have produced various theories, the majority of which will be discussed more fully in the following chapter. In this writing, little reference was made to the social worker's role in the treatment process.

Rice[1], in her study of Tropical Diseases, and Dunkel[2], who

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[1] Cynthia Nathan Rice, "Service and Tropical Diseases, Partll," Journal of Social Casework, Vol. 26, No.5 (July, 1945) pp.189-94

[2] Mary L. Dunkel, "Casework Help for Neurodermatitis Patients", Journal of Social Casework, Vol. 30, No.3 (March, 1949) pp.97-103

investigated the needs of 45 patients with neurodermatitis, were the only writers who discussed the social worker's contribution in the medical setting. It was apparent that additional studies into the problems and needs of skin patients were needed in order to clarify the worker's role still further. In view of the writer's own interests, as a student in the medical setting and at the request of the Royal Victoria Hospital, it was decided that such a study be carried out at this time.

The study will focus on the needs of 30 skin patients as shown through analysis of factors within their environments and personalities. It is assumed that such factors bear some relation to the disease process and influence the patient's recovery. The writer will attempt to show the significance that these factors have in relation to the social worker's role. How does an understanding of the needs of skin patients affect specific casework services which enable the patient to deal with their problems? What resources can the patient turn to in the community? If psychiatric treatment is recommended, how can the worker help the patient to accept this? These are some of the questions which will be dealt with through examining the worker's role in terms of the patient's needs.

It might be well to point out here that the social worker on the Dermatology service must relate to patients who have chronic illnesses for which in many cases there are no etiological findings. Treatment methods vary consideraly and are continually changing as new drugs appear on the market. This makes the problem of helping these patients still more difficult and challenging both for the doctor and the social

worker.

Altogether there are 25 skin conditions in this group of 30 patients, and most of these conditions are characterized by chronicity or acute exacerbations with recurrences. In some cases one patient had two skin conditions at the same time. More than one-half of the patients have a specific type of "dermatitis" or "eczema" such as atopic, seborrheic or vesicular. A complete list of the diagnoses is given in the Appendix.[1]

In studying the needs of skin patients, the writer has analyzed the records of 30 patients who had been known to the social worker on the dermatology service of the Royal Victoria Hospital. This is a large general hospital in Montreal, which has a bed capacity of approximately 750, and numerous outdoor clinics. Although these treatment services are known throughout the province and country, only two patients in this group came from out-lying districts. The majority lived well within the vicinity of the hospital.

At present the dermatology service holds seven weekly clinics. These comprise four "special skin" clinics (venereal disease), one lumbar puncture and two "dermatology" clinics. The patients from the "special skin" clinics are seen routinely and for the most part briefly, whereas the patients from the "dermatology" clinics are seen on a referral basis only and usually for a longer period of time. This study is concerned only with patients who were seen in the two "dermatology" clinics.

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[1] See Appendix A, Table 1

Although the term "dermatology" is an all-inclusive one and refers generally to diseases of the skin, not all patients who had been referred to these two clinics were included in this study. Only those patients were considered who had been known to the Social Service Department and for whom the skin condition was of major importance at the time of referral. Eighty patients were selected, who had been known to the worker between the period January, 1950 and March, 1953. Thirty cases were discarded as there was insufficient record material. Ten pemphigus cases were omitted from the study since it was felt that their problems were quite distinct and that this group warranted a separate study. In consultation with the social worker on the Dermatology service at the hospital, ten additional cases were discarded on the basis that their skin conditions were of secondary importance in relation to various other ailments.

Among the remaining group of 30 patients, all, with the exception of one patient, had sufferred in the past or were presently suffering from numerous other ailments.[1] It was found, however, that if they had had other chronic illnesses such as arthritis or tuberculosis, these usually diminished in severity or entirely disappeared with the onset of their skin symptoms. At the time of their referral to the social worker, therefore, their discomfort was mainly the result of their skin conditions and their treatment centred around this. However, since it was impossible to select a group where skin diseases were the only

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[1] See Appendix A, Table 11

physical factors, this places a limitation on the study.

The nature of the data from which this study was made also constituted a limitation. The writer carried one case as part of her field work experience, and, therefore, had direct contact with this patient. Information on the remaining cases was taken only from the records of the Royal Victoria Hospital. These were of three types- Outdoor Department, Indoor and Social Service. With the exception of two patients, all had outdoor records. One of these patients had been known to a private physician, and one had been discharged from the ward and placed in an institution so that she could not attend clinic. Twenty-five patients had been hospitalized and had indoor records and all had some type of social service record.

The social service records were either in the form of one or two page summary sheets which were placed in the medical charts, or more detailed folder records. Information on two-thirds of the patient group was taken from these social service summaries, which were brief, and made little mention of the worker's role. In the majority of cases the patient's history was fairly adequate but the lack of sufficient data on the worker's role was a serious limitation. Access to these records was a fairly easy task since the writer was a student in the Social Service Department of the Royal Victoria hospital while this study was being carried out.

The information was extracted from the records through the use of a schedule, a copy of which is shown in the appendix.[1]

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[1] See Appendix B.

Additional material was also obtained through library reasearch and a review of studies made in the field of dermatology. The data, which had been obtained by means of the schedule, were analyzed through both the statistical and descriptive methods and use was made of specific case illustrations. In addition, tables have been used throughout the thesis in order to show the quantitative characteristics of these patients, significant problems and the actual services that were given by the worker during this three year period.

This introductory chapter will be followed by a discussion of recent trends in the field of dermatology, theories which physicians and psychiatrists have produced with respect to etiology in skin disease and a review of some of the studies that have been made. The third and fourth chapters will describe the sample group on the basis of general characteristics, and according to factors within their environments and personalities. An attempt will be made to show their response to treatment, and the meaning that skin disease has for these patients in the fifth chapter. A discussion of the actual role of the social worker in helping this group will then be dealt with. Lastly, it is hoped to draw some conclusions as to the needs of these patients, as well as suggestions regarding the worker's role and recommendations for future research.

CHAPTER II

THEORETICAL BACKGROUND

Approach to Study

Most physicians now consider factors within the patient's personality and environment to be of importance in the study of skin diseases. Acceptance of this approach, which has been termed "psychosomatic" came about very gradually, particularly in the field of dermatology. This is the result of an understandable tendency in the medical profession to think of disease in terms of single causes and to demand tangible and visible evidence of these causes through the use of such instruments as the microscope and the test tube. Traditionally, on the other hand, there has been a tendency on the part of the psychiatrist and the psychologist to emphasize and look for psychic factors in disease. This practice has resulted in dividing the patient into parts and produced the error of disregarding the "whole" human being.

The term "psychosomatic" indicates a method of approach to treatment based on the concept of the "total personality" with emphasis placed on the correlation and understanding of all factors contributing to illness whether they be emotional or physical. On the basis of such an approach, disease is regarded as merely a symptom of some breakdown in the equilibrium of the total personality. This implies that removal of the organic symptom does not necessarily constitute a complete cure. If the original disturbance, which was responsible for the breakdown, is not treated, then the symptom may reappear either in the same form or it may be channelized in some other direction. Seguin explains that

"a cure can only be declared when all stimuli altering the psychosomatic equilibrium of the organism have been taken into account and the total situation has been favorably modified, thus restoring the equilibrium".[1]

The viewpoints of both the dermatologist and psychiatrist will be discussed here since they illustrate how the psychosomatic approach is applied in the study of skin diseases. The dermatologist, Dr. John Stokes, states that:

> the psychoneurogenous factor, like the focal infective, the bacterial, the toxic and the traumatic factor, rarely seems to act alone. It is part of an interplay-an affair of predispositions and excitants, of broadening and narrowing influence, as one or another element approaches, recedes from, collides with or combines with other factors in the causal complex.[2]

In a discussion of Stoke's article, Dr. Harry C. Solomon, a psychiatrist, points out that with regard to personality factors in skin disease "the important thing to bear in mind is that it is not a single approach that is wanted. It is a matter of correlation of the personality factors on the psychologic level with the physiologic levels, an understanding of the central nervous system and the central controls, an understanding of the skin-the synthesis of a coherent whole, with the psychiatrists on one hand in the picture and the dermatologist and the physiologist on the other".[3]

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[1]Alberto C. Segeuin, "A Note on Concept of Cure", Psychosomatic Medicine, Vol.XI, No.5 (Sept.-Oct.1949), p.306.

[2]John H. Stokes, "The Personality Factor in Psychoneurogenous Reactions of the Skin", Archives of Dermatology and Syphilology, Vol.42, No. 5 (Nov.1940), p. 780.

[3]Ibid, p.797

It is interesting that neither of these viewpoints conflict, and neither doctor shows a fear of loss of status or resentment of infringement into his field. Rather each shows a new awareness of his contribution and how he can make use of the other's available knowledge and services.

The psychosomatic approach is of importance in this study as it introduces a new approach to the treatment of skin diseases. Consequently it influences the role of the social worker on the dermatology service. since it calls for a more discerning consideration of factors within the personality and the environment. This, therefore, implies that the traditional methods the caseworker uses to aid patients with skin diseases must be related to this deeper understanding of the emotional and social factors involved.

Greater co-ordination of hospital services and teamwork effort are also a basis for this approach to treatment. Dr. Solomon aptly explains this when he states that:

> the great problem, when one is confronted with the patient, is treatment and this may be dependent on what is learned from the various factors. It may be based on a question of physical fitness, such as some dietary restriction, or it may also be based on a question of the personality, such as reducing the amount of tension or clearing up some of the underlying difficulties that the patient is unable to handle in a normal, well-integrated manner. All these considerations come into the problem of treatment of any dermatitis .[1]

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[1]Stokes, op.cit. p.796.

Review of Theories

The thinking of physicians, psychiatrists and others interested in the field of dermatology has shown that they differ widely in their concern about the relative importance of various predisposing factors in skin disease. However, this difference is the result of each focusing on a certain area and they are all in agreement that none of these is the sole contributing factor. In general these theories are based on recognition that the skin is an important organ of expression in normal behavior. This is especially noticeable when one experiences such emotions as pain and pleasure, embarrassment and fear. Blushes, pallor, goose flesh and sudden sweating are all evidence of similar reactions. It is felt that consideration of these natural phenomena is basic to an understanding of the various theories.

The psychiatrist, for example, has placed stress on psychic influences. Intense itching or scratching is regarded as a means by which the patient deals with feelings of hostility, aggression, guilt or shame. Scratching may be interpreted as a masochistic tendency if it is found that the patient is relieving aggressive feelings toward someone else by attacking himself through the skin. Scratching may also be interpreted as a means of obtaining sexual gratification, or as dealing with exhibitionistic feelings and feelings of intense longing. Franz Alexander explains how a somatic source is added to the psychological stimulus for scratching. "Continued scratching leads to changes in the delicate structure of the skin, which makes the sensory endings more sensitive to external stimuli. This perpetuates scratching, which in turn increases the structural changes which cause the

itching."[1]

The physiology of emotion, that is, the way in which it can influence the skin through certain physiological mechanisms such as nutritional, vasomotor and reflex, is stressed by some physiologists and dermatologists. Disturbances of the gastro-intestinal tract and of the sweat glands as in dyshidrotic eczema are examples of this. The interplay of these mechanisms with emotions results in a complexity of factors which may predispose the person toward skin disease. Allergic manifestations also fit into this group.

Both Stokes[2] and Lynch[3] emphasize personality and constitution as underlying factors in skin disease. Stokes calls his theory the 'psychoneurogenous component of the cutaneous reaction mechanism'. He describes the adult eczema personality as having a family history of tension and instability coupled with allergy. The patient, although usually outwardly calm, is tense as a result of overconscientiousness and "I-sensitiveness" which engenders a sense of the obligatory in conflict with the more or less characteristic sense of inadequacy or inferiority of this type. In more detail the characteristics of these patients include a deep-seated feeling of insecurity, aggressiveness, a disposition to dominate, a marked lability of physical and mental

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[1]Franz Alexander, Psychosomatic Medicine, (New York, 1950),pp. 168-9

[2]Stokes, op.cit. pp.780-801

[3]Francis Lynch. "Psychobiologic Studies of Patients with Atopic Eczema (disseminated neurodermatitis)". Archives of Dermatology and Syphilology, Vol.51, No. (Sept.1945), pp. 251-260

reaction, intrinsic kinetic drive, a higher than average intelligence, restlessness, deep-seated over dependence and a special "reactiveness" to competition. Lynch stresses suppressed resentment as the most outstanding factor, whereas Stokes feels that it is basically a conflict which is responsible for the patient's trouble with his skin.

One of the main criticisms of this theory is based on the "cart-horse" argument-that is, what is cause and what is effect? It is generally recognized that chronic illness, and particularly conditions of the skin, influence the emotions and that such illnesses could unquestionably cause changes in the personality. The question, therefore, arises as to whether the skin disease makes the person what he is or whether the person makes the skin disease.

Becker's theory[1] is an offshoot of further studies into the personality "make-up" of skin patients. He finds that an inability to obtain sufficient rest is common to all these patients, and maintains that it is a protoplasmic instability or unrest associated with an underlying constitutional defect which makes for constant fatigue. He believes that it is these products of exhaustion, which have no outlet, that cause skin disease.

The limited amount of research which has been done in this field does not as yet allow for any definite conclusions, although this does not invalidate or weaken the experience and knowledge that has already been gained.

Studies Made in Field

Numerous more or less disconnected studies have been made in

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[1]Stokes, op.cit. p.798.

this field although systematic research is still lacking. The four examples which are cited in this section represent studies whose findings were most pertinent to this thesis. The first two studies were made by psychiatrists, the third by a dermatologist and the fourth by a psychologist.

With an ultimate diagnostic and therapeutic goal in mind, Greenhill and Finesinger[1] carried out a study of the role of emotional states and situational factors in the precipitation or exacerbation of atopic dermatitis. A questionnaire was used in order to obtain information on the problems, personality characteristics, childhood and clinical psychiatric histories of 32 patients with atopic dermatitis. Three controls groups, which included a group of psychoneurotics, of normal persons and of patients with lupus erythematosus, were also questioned and the findings for all groups compared. It was found that patients with dermatitis had a significantly higher number of symptoms of phobia and compulsive neurosis during their childhood than the patients in the other three groups. Feelings of hostility, depression and inadequacy were also much greater for dermatitis patients than for the others. Situations, where problems might be found, were rated according to their frequency and their relation to the exacerbation of the skin condition. It was found that one third of these situations dealt with problems arising out of work, 25 per cent were family problems and 15 per cent arose out of psychosexual situations or changes in the

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[1] H. Greenhill and J. E. Finesinger, "Neurotic Symptons and Emotional Stress in Atopic Dermatitis", Archives of Dermatology and Syphilology, Vol. 46, No.I (Aug, 1942), pp. 187-200

environment. Situations associated with feelings of hostility and insecurity were much more frequently associated with exacerbation in atopic patients than in other groups.

Wittkower and Edgell[1] made a study of 90 patients with eczema, atopic dermatitis, neurodermatitis and lichen simplex. The purpose was to find out what type of patient had eczema, whether emotional factors, if any, precipitate the disorder or cause relapses and whether psychotherapy can help these patients. The patients, 37 of whom were in the army, were interviewed for at least two hours. Behavior under examination and in social, occupational, sexual and marital spheres was considered in detail. In 46 cases, that is, in more than one-half of the same group, events of a disturbing nature preceded the onset of the malady. These situations consisted of threats to their security, either through loss of a key figure in the patient's environment, blows to this self-esteem, conflicts over sex and aggressiveness. Eczema patients as a whole tended to have been more strongly attached to one parent than to the other. Psychotherapy was attempted on 34 patients, 29 of whom benefitted both physically and mentally. In a few cases the treatment was complicated by an exacerbation of the eczema, which was attributable to the bringing of unconscious conflicts into consciousness. In other cases psychoneurotic symptoms became manifest while the eczema subsided.

Lynch studied 13 patients with atopic eczema between the ages of

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[1] E.D.Wittkower and P.G.Edgell, "Eczema, a Psychosomatic Study", Archives of Dermatology and Syphilogy, Vol.63, No.2 (Feb.1951) p.207-19

[2] Francis Lynch, "Psychobiologic Studies of Patients with Atopic Eczema (disseminated neurodermatitis)", Archives of Dermatology and Syphilogy, Vol. 51 (1945) pp. 251-260

18 and 26 years and four additional older patients. All the patients were being seen by the psychiatrist, and information was obtained through these records as well as by interviews. Constitutional and somatic factors, together with personality structures, as well as psychodynamics and situationsl conditions were considered. It was felt that with the exception of one patient, all could be described as vigorous persons who had a high degree of alertness and tension. Where the eczema began in adolescence, intrapsychic factors of the personality showed up predominatly or at least equally as much as environmental stress. However, where the disease began in later years, the reverse situation appeared to hold. Lynch describes these patients as appearing to have considerable self-adequacy and efficiency, although in actuality they show varying degrees of inability to get along with or effect an adjustment with others.

Ruth Levy[1], a psychologist, used the Rorschach test on 50 veterans with neurodermatitis as well as on a control group of patients with industrial skin ailments. Her purpose was to study the personality structures of these patients in an attempt to establish whether there was an consistency amongst them, and whether they differred significantly from others. Her findings, which were interpreted from the Rorschach scores, showed that neurodermatitis may be a conversion symptom wherein the hypothesized personality characteristics are somatized, and that these characteristics drain psychic energy from the areas of tension,

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[1]Ruth J. Levy, "The Rorschach Pattern in Neurodermatitis", Psychosomatic Medicine, Vol. XIV, No. 1 (Jan.-Feb. 1952) pp. 41-8.

lowering the Rorschach scores which purport to measure these areas.

Although the viewpoints of the above mentioned investigators differ somewhat, it is apparent that there are many similarities in their studies. All have placed stress on the importance of personality factors and emotional conflicts in patients with skin disease.

Recommendations for Treatment

Many writers point out that patients with skin conditions frequently admit that they are nervous, worried and depressed, and that this seems to affect their skins. Yet few actually receive help in these areas. Wittkower[1] recommends that this be remedied through the efforts of the physician, himself. He explains that only a limited number of patients require psychiatric help and that the doctor should deal with both the allergy and the emotional problem, through allowing the patient to unburden himself and helping him to make his own decisions. All agree that it is important for the doctor to obtain as much information about the patient's personality and background as possible.

Carol H. Cooley comments on how the nurse can help the patient with skin disease: "By her kind manner, acceptance of the patient, and skillful interviewing, she can show him that she considers him neither dangerous nor repulsive. This acceptance means a great deal to the patient, who is sure the nurse knows what she is doing, and, therefore, he gains confidence in himself as someone not different from or dangerous to others"[2]. Miss Cooley adds that many of these patients

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[1] E.D.Wittkower, "Psyche and Allergy," Journal of Allergy, Vol.23 No. 1 (Jan. 1952) p.85.

[2] Carol H. Cooley, Social Aspects of Illness, (Phil. 1951) pp. 216,18

feel inferior and react by either withdrawal or aggressiveness. She feels that they need help in overcoming this and that one method is to guide them to new interests and contacts where they can feel they are making a contribution.

According to Stillians, mental possibilities should be investigated in every condition where there is persistent itching. He feels that not every case requires psychoanalysis but that the patient needs encouragement and confidence in the doctor.

> A painstaking investigation of possible worries or fears, and patient explanation of the evil effect of such emotions, may often be the most important part of the treatment. They should never be overlooked.[1]

Stokes[2] is of the opinion that many patients can be helped to recover through a successful office catharsis, and identification of a simple conflict together with rest, reassurance and readjustment. He also draws up a list of at least nine recommendations which the skin patient should follow. Some of these include training in the technique of relaxation and discharge of tension, learning self-acceptance and depersonalization of outlook, change of scene, and help in management of the parent problem.

Most writers believe psychotherapy to be of value in treating skin patients, since it attacks the underlying emotional factors, affords insights and sometimes results in new solutions. It is recommended that the therapist be permissive and giving, and encourage the patient to vent his hostility. In all cases it is felt that an evaluation of emotional

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[1] A.W.Stillians, "The Therapy of Pruritus", J.A.M.A. Vol. 114, No. 17, (April, 1940), pp.1632.

[2] Stokes, op.cit. pp.794-5.

factors should be made as early as possible after onset of the disease since the longer the symptoms are present, the more difficult it is to use this treatment effectively.

Although the literature has made little mention of the social worker, neverthless, it is obvious that much of the treatment, which has been advocated in this section, is applicable to her role. The physician would not have the time to carry out some of the recommendations that Wittkower makes. His role is directed toward giving medical recommendations rather than in helping the patient unburden himself of all possible worries and fears. The worker, on the other hand, is concerned with understanding the patient's behavior and how her relationship can help in the treatment process.

A review of the literature shows that the medical profession, as a whole, have placed stress on etiological factors, although this has been incidental to obtaining insight into the patient's behavior and the meaning that the illness has for him. The following chapter will consider the general characteristics of a sample group of 30 skin patients as another step toward understanding their needs.

Chapter III

Characteristics of Sample Group of Patients

In studying the problems of thirty skin patients who had been known to the social worker, it was felt that such general characteristics as age, sex, marital and employment status might have significance both in evaluating the needs of this group and in clarifying the role of the medical social worker.

The majority of skin conditions are of a chronic nature and for this reason may affect the patient in every area of his life--his capacity to work or to marry and raise a family. Age and sex may be important factors in determining the extent of his impairment since "earning a living" might not be as imperative for the housewife as it would be for the married man with four dependents. The problems of a fifteen year old girl would also be quite different from those of an elderly man. The capacity to meet the costs of treatment and adjust to the illness might be considerably easier for the patient whose financial resources are not seriously depleted by illness or whose occupational status is not influenced by a chronic eczema of the hands. Unfortunately the patient whose condition results in serious financial deprivation may not always be the first to receive treatment.

In view of the effect that such circumstances may have on the illness and the reciprocal relationship of this illness to these circumstances, it is important that knowledge of the patients' general characteristics be known to the medical social worker.

Age and Sex

The age and sex groupings of the patients in this study were carefully examined. It should be pointed out that skin patients below the age of fifteen were seen in the Pediatrics clinic and were, therefore, not included in this study. Table I illustrates clearly the group's pattern both with reference to their age and sex.

TABLE I

Age and Sex Distribution of Sample Group of 30 Skin Patients known to the Medical Social Worker.(a)

age in years \ sex	both	male	female
total	30	12	18
15 to 24.....	2	-	2
25 to 34.....	5	-	5
35 to 44.....	5	2	3
45 to 54.....	8	4	4
55 to 64.....	10	6	4

(a) In all tables unless otherwise indicated, age is at the time of first referral to the social worker.

It is rather significant that in such a small group 60 percent of the patients were women and that an equal percentage of the entire group were over forty-five years of age. Another striking finding was the apparent lack of men in the younger age groups.

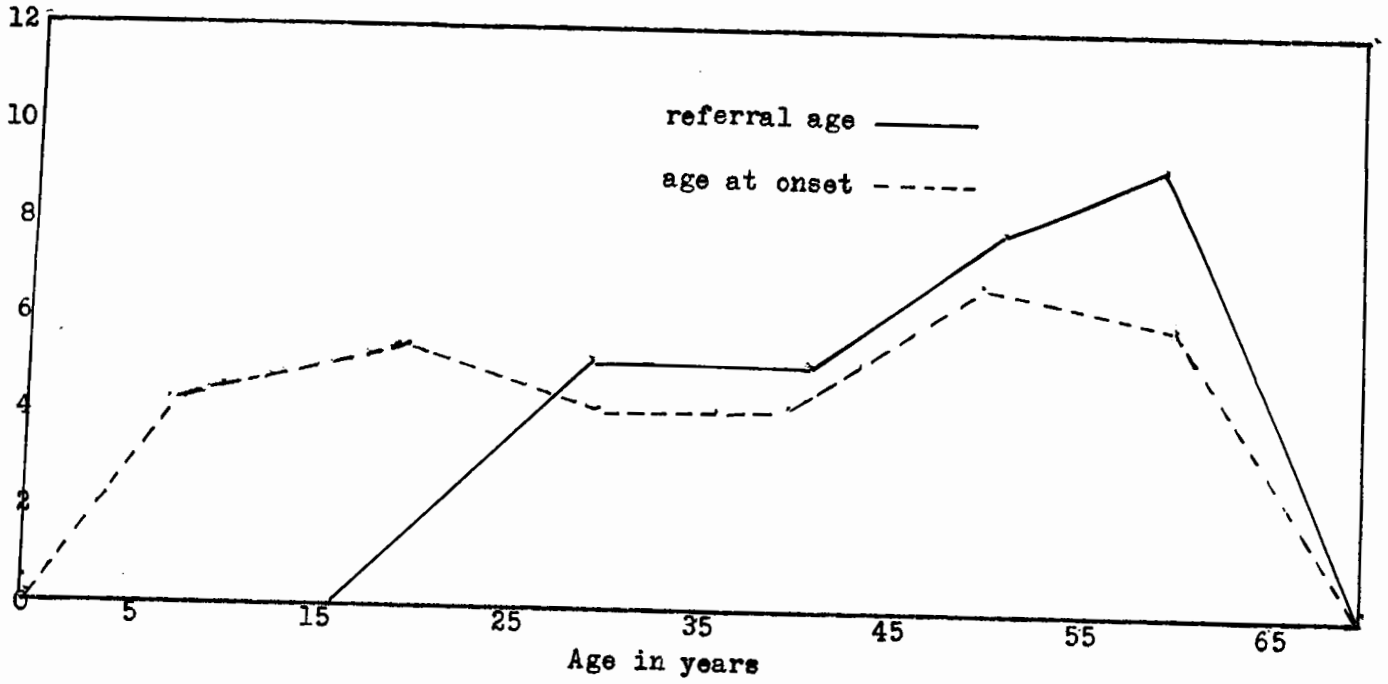
Several questions can be raised as a result of the information which this analysis reveals. Is there a sizeable proportion of younger skin patients who are facing difficulties and who could be helped by the

social worker? Why are these patients not being referred? Is the caseworker limited as to how much help she can give the older patient whose symptoms have been present for several years? Why are fewer male patients known to the social worker on the Dermatology service? Some of these questions will be answered in the later chapters when the problems and the role of the worker are studied more fully.

The distribution of the patients at the age of onset of the disease was a step in attempting to find out whether they might have been referred to the worker at an earlier date. Chart I was used to show the comparison between the age at which they became ill and the age at which they sought help from the caseworker.

CHART I

Relationship between Age at Onset of the Disease and Age at Referral to Medical Social Worker of 30 Skin Patients



The distributions in this graph show that a large number of skin patients do not receive help until they have been sick for several years. The mean age at onset of the disease is 35 years whereas at referral to the social worker it is 46 years. In view of the fact that several authorities stress the need for early social and psychotherapeutic help for patients with skin conditions, this information would be of vital concern to the caseworker. In addtion, the problems of those patients whose illness began in early life appeared to be quite different from those in which onset came in later years. Lynch[1] points out that in her study of patients with atopic eczema, where the illness began in adolescence the patient showed predominantly or at least equally the effect of intrapsychic factors of personality as against environmental. The reverse, however, was the tendency when the illness appeared in older age groups.

No research has been done in the field as to the significance of age and sex factors in patients with skin disease. However, the studies of Mitchell, Curran and Myers[2] bear out similar findings since there was a definite preponderance of women among the skin patients, especially in the middle age levels between twenty to forty-nine years.

Marital Status and Living Arrangements.

Since problems vary considerably in accordance with a person's marital status, the group was studied in order to find out whether they showed any particular trend or pattern in this area of their lives. The

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[1]Francis Lynch, "Psychosomatic Studies in Dermatology", Archives of Dermatology and Syphilology, (Sept,1945), Vol. 51, No. 3,p.251-260

[2]Mitchell, Curran & Myers, "Some Psychosomatic Aspects of Skin Allergic Diseases", Psychosomatic Medicine, (May-June, 1947) Vol.IX, No. 3, pp. 184-91

findings in Table II revealed that a large group, which comprised a third of the patients, were single and that most of these were women.

TABLE II

Marital Status of Sample Group of Thirty Skin Patients, according to Sex.

sex / marital status	Both	Male	Female
total	30	12	18
Married	13	7	6
Single	10	2	8
Separated	3	1	2
Widowed	4	2	2

This high percentage of single patients cannot be explained on the basis of age since only one patient fell below the age of twenty-four. It may, however, be evidence of an inability to form relationships or to adjust to a new way of life. Wittkower[1], in his study of ninety eczema patients, comments about this indirectly when he describes these patients as having a reluctance to embark on any new way of life, such as marriage or a new job.

Although two-thirds of the patients had at one time been married,

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[1] E. Wittkower; P.G.Edgell, "Eczema, a Psychosomatic Study" Archives of Dermatology and Syphilology, (Feb.1951) Vol.63, Vol.2,p.214

less than half were presently living with their spouses. There were more than twice as many unattached women as there were men. Since the majority of patients were in the older age groups, this meant that the social worker would be in contact with a large number or middle-aged andelderly women who were dependent upon themselves and who might possibly lack close family ties. This raised the question as to whether these patients had problems around finding suitable living accommodation. The group was studied in order to clarify this further and to determine whether such problems might exist.

TABLE III

Living Arrangements for Sample Group of 30 Skin Patients, according to Sex.

Living Arrangements	Both	Male	Female
Total	30	12	18
Living with family in own home	12	7	5
Living alone in own home	3	1	2
Living with relatives.....	3	1	2
Living with strangers.....	5	2	3
Domestics (living in).....	3	-	3
Institutional care.....	3	-	3
No data.....	1	1	-

Table III seems to bear out the evidence that these were real problems for a large number of patients. In the entire group only half were living with their families or relatives. The remaining number of patients were living under a variety of conditions—either alone, with strangers, in institutions, or wherever they could find accommodation.

Eleven of these fifteen patients were women.

The following case of a middle-aged patient is typical of this type of problem:

> Miss D.I.* aged 46, prior to her hospitalization, lived with her brother, who is a widower, and his six children. She was sensitive that she was a burden on them and felt that they rejected her. Her brother had expressed a reluctance to take her back, and she claimed that she would like to be independent of her family. An exploration was made of further living resources, but nothing suitable has yet been found.

Religion and Ethnic Origin

It would be expected that the Royal Victoria Hospital, being in the centre of a predominantly French Canadian city, would serve a large proportion of Catholic patients. The figures for the thirty skin patients in this study are in accord with the religious conposition of the population in Montreal. It was found that twenty-one, that is seventy percent of the group, were of the Roman Catholic faith, and that two-thirds of the Catholics were French Canadian. The remaining patients included eight Protestants and one Greek Orthodox. There were no Hebrew patients and this was rather surprising since the hospital is the closest to a rather large Jewish district, and serves a large number of Jewish patients.

Further analysis of the origin of these patients showed that there were sixteen Canadian-born against fourteen immigrants in the group. This appeared to be a rather high percentage of immigrants. However, it was not possible to compare these findings with the overall percentage of immigrants in the country, and, therefore, no deduction could be made as to the significance of this factor. It must be

*The initials used to designate the patients described in this study have been disguised in order to conceal their real identity.

pointed out, however, that at least half the immigrants were recent arrivals and the majority were in the older age levels. Whether the insecurity of being in a new country where they had difficulty in speaking the language and finding employment, might have been a factor in the illness of this latter group cannot be confirmed. Neverthless, it was found that where the patients received help in adjusting to the country, their skin conditions improved and in many cases cleared completely.

Economic and Employment Status

The patients in this study are a select group with respect to their economic status since with the exception of two patients, they had to meet clinic eligibility requirements at the Royal Victoria Hospital and were, therefore, in a low income class. At least half the patients were receiving financial assistance at one time or another either from the Bureaux D'Assistance aux Familles or the Family Welfare Association. This meant that the majority of patients had not been fully self-supporting or were living on a marginal income level.

A study of the employment histories of the thirty skin patients disclosed further evidence of their precarious financial circumstances. It was found that at the time of their referral to the social worker, only nine patients were actually working. Six additional patients obtained employment with completion of treatment. The unemployed were mainly housewives or patients whose skin conditions required considerable care. Four of these patients had not worked at any period during their lifetime.

The types of jobs which they held were extremely varied and numerous for a group of only twenty-six patients. In Table IV, where these jobs are listed, the number of occupations amount to almost twice the number of patients. Further analysis of

TABLE IV

Job Classification for Sample Group of 30 Skin Patients, showing Number of Patients Employed in Each Class.(a)

Classifications	Occupations	Number of Patients in each class
Total		50
Unskilled	cement worker lumber jack night watchman	3
Semi-skilled	aircraft worker factory workers	5
Skilled	painter toolmaker ironworker stationary engineer tiler	5
Service-Non Professional	chauffeur elevator operator baby sitter taxi driver baby nurse milk man packager cook porter waiter cleaner domestic	20
White-collar	bookkeeper stenographer office clerk bank clerk civil servant timekeeper cashier salesman stockkeeper hotel clerk	14
Owners of Business	inn keeper sewing machines	3

(a) These classifications were arbitrarily selected by the writer.

this information showed that frequently where the patient changed his job, he went into an entirely different type of occupation. It is significant that the largest group worked in small, non-professional types of jobs, which require for the most part a very minimum amount of training. There was also a sizeable number of patients in the white-collar jobs but there were no professional workers.

The findings regarding the economic and employment status of this group reveal that the majority of patients had problems in the area of self-maintenance. In many cases these problems could be related to difficulties which arose out of their work situations. Twelve patients spoke quite freely about these problems to the medical social worker. Usually these difficulties centred around misunderstandings owing to their skin conditions, poor relations with the employer and dissatisfaction or instability on the part of the patient, himself. Greenhill and Finesger's[1] study of 32 patients with atopic dermatitis showed that in comparison with other control groups, problems arising out of work situations rated highest for dermatitis patients.

The work situations of the patients in this study will be discussed more fully in the following chapter. At this point, one case may suffice to illustrate the type of problem that arises.

> Miss A.J., a 27 year old patient with generalized dermatitis and psoriasis, had difficulty in finding work and remaining on the job

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[1] M.H.Greenhill and J.E.Finsinger, "Neurotic Symptoms and Emotional Stress in Atopic Dermatitis", Archives of Dermatology and Syphilology, (Aug. 1942), Vol. 46, No.1, pp.187-200

> owing to her skin condition. She had been a baby nurse at a time when she was free of symptoms. However, she was fired when her skin lesions reappeared. Her skin became much worse while she was unemployed. Finally she was given a job as an elevator operator at a large general hospital, but was dissatisfied and had a relapse of her skin condition which resulted in her admission to the ward. While in hospital, she was given occupational therapy and spent all night making leather bags instead of sleeping. Her hospitalization was extended considerably by her inability to obtain rest. She was referred to a rehabilitation centre, but they were unable to find work for her owing to the appearance of her skin condition. In March 1953, Miss J. obtained a job in a hat factory through an occupational therapy centre, and after approximately one week she was promoted to forelady. When she heard the news she fainted from surprise and joy, explaining that she could not believe this was happening to her.

The general characteristics of this sample group have been shown to have some significance both in relation to the role of the worker and to the problems of these patients. It was found that there was a preponderance of patients between the ages of forty-five to sixty-four, and that the majority were women. There was also a high percentage of single, female patients. These factors appeared to have a definite effect on the kinds of problems the social worker was likely to handle. A high proportion of French Canadian and immigrant patients were noted although this did not have too much significance. Information on the poor financial status and erratic work histories of these patients bore out the most striking findings in relation to understanding their problems and needs.

CHAPTER IV

Problems and Needs of the Sample Group.

A review of the literature and a survey of studies, as was presented in Chapter II, has given an indication of some of the problems skin patients are likely to face. It was found that personality characteristics such as compulsiveness and extreme sensitivity, emotional conflicts, especially with regard to dependency needs and situational stress, were more often part of the pattern of the skin patients than other groups. There were also definite similarities in the childhood histories of skin patients. These usually included loss through death or separation of a parental figure or attachment to one parent more than to another. The majority of writers focused on the etiological implication of these factors and little reference was made to treatment.

In this chapter stress will be placed on the significance that those factors have in relation to the role of the social worker. The actual role will be discussed more fully in a later chapter. The patients in the sample group will be studied for the purpose of determining their problems and needs, and consequently of assessing how the worker can meet these more adequately. This will be done by examining the patient's background and environment, both past and present, and then by looking at certain features of his personality. Before attempting this analysis, it might be appropriate to explain briefly what is meant by the terms "personality" and "environment". A definition of these terms is given by Murray:-

> The personality of an individual is the product of inherited dispositions and environmental experiences. These experiences occur within the field of his physical, biological and social environment, all of which are modified by the culture of his group. The crucial period of personality development is in his early childhood and infancy. The most profound influences being the parental figures and family constellation. [1]

H. M. Margolis also defines personality in the following excerpt:-

> The personality of an individual is determined largely by his inherent constitutional endowment and its reaction to environmental pressures. The individual may choose one of several ways of solving emotional conflicts and this will depend on the force of various factors. Everything in the patient's environment influences his personality and colors his emotional reaction:-the patient's contemporary life situation and his reactions to his family, siblings, vocation and social milieu. [2]

According to these definitions, everything which the patient experiences and comes into contact with shape his personality-his family, friends and his vocation. These influences which are regarded as his environment will be discussed in the following section.

The Patient's Environment

Family Influences

The patient first comes into contact with his environment through the family, particularly his mother on whom he is dependent for satisfaction of his infantile needs. If he is born into a harmonious and emotionally healthy family, these needs can be met adequately. If on the other hand, there is evidence of parental

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[1] Kluckhohn, Murray & Schneider, Personality in Nature, Society and Culture, Knopf (New York '53) p.67

[2] H.M.Margolis. "The Psychosomatic Approach to Medical Diagnosis and Treatment", Journal of Social Casework, (Dec.1946) Vol.27, No.8 p.294,5

discord, frustrations, economic strife and other difficulties, the patient may suffer as a consequence and grow up to be a conflicted or emotionally deprived adult.

The family histories of the patients in this group were studied in order to determine whether there was evidence of excessive stress or deprivation in their backgrounds. Information was obtained only on the parental situation and not on the situation in their own marriage. The latter will be discussed more fully in another section. Much of this information was incomplete since the majority of patients were in the older age groups and rarely spoke of childhood occurences.

Where it was possible to obtain information, it was felt that the patient's position in the family group, the tone of the parental marriage and the frequency of family tragedies such as deaths and separations would show what type of childhood he had had. This in turn would also have significance for the worker since it would permit greater understanding of adult conflicts and needs which all too often are based on unstable and deprived family backgrounds.

The position of the patient in the family may influence his feeling of security. The oldest child may bear the strain of responsibility or competition with younger children. The only child may lack the stimulus of competition and have the undivided attention of his parents, and the youngest child may be either running to keep up or too discouraged to keep up. These are what Wittkower[1] calls

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[1]E.D.Wittkower and P.G.Edgell, "Eczema, a Psychosomatic Study", Archives of Dermatology and Syphilology, Vol.63, No.2 (Feb.'51) p.211,12

the "difficult" and most stressful positions in the family. He observed that in his study of 90 eczema patients, a larger proportion than average fell into these positions.

The positions in the family group of patients in this study are shown in Table V.

TABLE V

Positions in Family Group of 30 Skin Patients according to age at onset of Disease

Age at onset	Total	Eldest	Youngest	Only Child	1 of Large No.	Other Positions	No Data
Total	30	4	8	4	4	2	8
Under 15	4		3				1
15 to 24	5	2	1		1		1
25 to 34	4	2		1		1	
35 to 44	4		2	1			1
45 to 54	7		1	1	3	1	1
55 to 64	6		1	1			4

As illustrated in this table, more than one-half of the patient group fall into what Wittkower calls the stressfull positions. These findings may have some significance in themselves with regard to the patient's adjustment in later life.

The tone of the patient's home, that is whether it is set in a happy and harmonious atmosphere or whether there is tension or uneasiness, will depend to a great extent on the kind of people his parents are and the type of marriage they have made. This will influence his own attitudes toward marriage, and will deeply affect his emotional life. Constant bickerings, turmoil and upheavals in the home can result in bitterness and deep-seated conflicts on the part of the children. In addition, the parent of an unhappy marriage may be unable to give a child a warm, secure kind of love.

In spite of the importance which this information has in such a study, 18 of the 30 patients in this group did not speak about the emotional tone of their childhood family life. This may be explained in part on the basis that such information might not have appeared relevant to a pressing problem in the patient's present situation. In most cases, these patients were in the older age groups. A study was made of the family backgrounds of the remaining 12 patients. Separations, desertions and parental discord of another nature were regarded as evidence of emotionally unstable and deprived family life. Death of a parent was also shown, although it must be borne in mind that this does not necessarily result ina lack of sufficient warmth and stability in the family group. In this analysis it was noted only when it occurred during the patient's early childhood and either resulted in extreme difficulties for the patient or had an effect on the family cohesiveness.

TABLE VI

Childhood Family Backgrounds for 12 Skin Patients, according to age at onset of disease.

Patient's age at onset	Total patients	Separation	Desertions	Other Pa. Discord
Total	12	7	3	2
under 15	3	3		
15 to 24	3	1	1	1
25 to 34	3	2	1	
35 to 44	1		1	
45 to 54	2	1		1
55 to 64	-	-	-	-

Unfortunately, the information in Table VI, although of value, is based on a very small sample group of patients. It is interesting however, that evidence of a deprived family background was found more often among patients whose skin condition had begun early in life.

Two examples are cited as evidence of deprivation early in life:-

> Mrs. D.V., aged 24, is a young, attractive housewife who is unable to adjust to her own marriage. She is extremely dependent, depressed and nervous. She told the worker that she felt she had suffered a great deal as the result of her parents' discord. Her mother deserted the family when the patient was ten years old and she had to assume all the responsibility. She is the eldest child among siblings. She stated that her father has been very kind to her but she has missed her mother.

> Mr. P.S., aged 56, has had dermatitis for the past 25 years. He states that he was deserted by a spendthrift, irresponsible father and promiscuous mother at seven years of age.

> The patient and his brother were inseparable and mutually supportive during childhood but the father separated them by placing them intentionally in separate homes. The patient and his brother have suffered from extreme degrees of socio-economic deprivation since this time. At present Mr. P.S. is undergoing psychiatric treatment and has been found to have deep-seated conflicts and dependency needs which have never been met.

Traumatic events

Unfortunately, deaths, accidents or other traumatic events happen at times in everyone's life. It is difficult, therefore to assess the significance of these events in this sample group of patients. Nevertheless, a study was made of this information in order to discover whether the frequency for such events was extremely high in this group, and whether these events had some relationship to the onset of the skin disease.

It was found that of 25 patients, 12 had had siblings who had died during the patients' childhoods. Of the entire group, 18 presently had no living parents. In at least nine cases, death of the parent co-incided with the onset or exacerbation of the patient's skin condition. Further analysis disclosed the fact that at least 24 patients mentioned having faced other events of a traumatic nature, such as deaths of a brother or husband, accidents, explosions, robberies and burns. Frequency of traumas was fairly high in the lives of these patients, and in several cases bore a direct relationship to the onset of the illness. These findings are in accord with those of Wittkower[1]

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[1] Ibid, p. 209

who noticed that in his study of 90 eczema patients, 40 percent of the skin episodes followed actual or threatened loss of a much needed key figure in the patient's environment.

In the following case the patient's skin condition bears some relationship to traumatic events in her life:-

> Miss W.M. was born in England and had lived there up until a year ago when she immigrated to Canada. Miss M. had two married sisters living in England and in the period of six years, four deaths occurred in this family. One of her sisters had been nursed by Miss M. when she died. Another sister died shortly after the patient left the country. Within a month she was completely covered with a generalized dermatitis. She admitted to the worker that this last death had especially shocked her since she felt guilty at having left England. The patient's only brother was living in Canada. She was given considerable support by the worker and gradually her condition subsided.

In another case a traumatic blow set off a chronic skin condition:-

> Miss P.H., aged 26, had had recurrent ulceration of the skin of both feet over the past eight years. This began immediately after she had sustained a blow on her left toe. She had a general eczematous reaction to this condition as well. At the time she was working 12 hours a day in a war factory in Germany where she stood continually. No etiological factors could be found in spite of numerous tests. Her skin condition improved on hospitalization but returned when she went back to work.

It is apparent in these cases that other factors were involved and that the blow or shock seemed to act as a trigger-mechanism in setting off the skin reaction. Where these patients received

psychiatric treatment it was found that they had had no grief reaction or outlet for their feelings. After they had been given considerable support by the social worker and encouraged to express their feelings, their conditions frequently improved.

Financial Deprivation

Lack of an adequate income to maintain oneself according to a decent living standard can be an obstacle both to obtaining treatment or to eventual recovery. Sudden loss of income may have precipitated the patient into a difficult situation. He may be unable to face this realistically and as a result may be experiencing considerable anxiety. In addition, if the patient has never attended a clinic, he may find it difficult to accept this at first and may put off coming for treatment. Tension may mount owing to his inability to handle these circumstances and he may utilize scratching as a means of releasing these feelings, thus aggravating his condition.

Financial insecurity is a detriment to recovery from any illness, but in skin patients it may also bear some relationship to the onset of the condition. Wittkower[1] found that in his study of eczema patients, at least 60 percent of those cases where events of a disturbing nature preceded onset of the disease were situations which involved loss of job, impoverishment, and failure on the part of the patient to maintain a certain level of achievement.

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[1] Wittkower, op.cit., p.208,10

The patients in this study showed an extremely high incidence of financial insecurity. Only seven cases made no mention of having difficulties in this area. The histories of the remaining 23 patients were studied in order to find out whether the skin condition was a factor in the patient's financial deprivation or whether other circumstances had precipitated or contributed to his present situation. In many cases it was found that other circumstances aside from his skin condition had resulted in his lack of income, although in the majority of cases the skin condition was the main factor, either precipitating the patient into a loss of income or immediately following such a loss. Table VII shows how these findings were obtained.

TABLE VII

Instances of Financial Insecurity in 23 Skin Patients, both according to Age and according to Accompanying Situations or Circumstances.(a)

Age at Onset	Total Instances	During Childhood	On Marrying	On arrival in country	Owing to Age	Owing to mental problem	At onset of skin disease
Total Instances	37	5	3	3	3	5	18
15 to 24	0	-	-	-	-	-	-
25 to 34	3	-	-	1	-	-	2
35 to 44	6	2	1	-	-	1	2
45 to 54	15	2	1	2	-	3	7
55 to 64	13	1	1	-	3	1	7

(a) The number of total instances is greater than the number of patients since financial insecurity arose more than once during their lives.

Age seems to have some definite bearing on the frequency of financial difficulty since inadequate income was far more apparent in

the older age groups than among the younger patients. It is important for the social worker to be aware of how such circumstances can lead the patient into difficult financial problems, and also how such problems can affect his skin condition. With this understanding she will be better equipped to help him face and cope with his situation more realistically.

Work Situations

Problems arising out of the patient's employment situation may seriously affect his financial security. These problems may be the result of factors within his own personality or they may be due to circumstances over which he has little control. In such cases the social worker may be able to intervene and act on his behalf.

Typical circumstances which arise in the work situations of skin patients are pointed out by Cooley.[1] Fear of contagion and the patient's appearance may result in rejection or withdrawal on the part of his co-workers. An employer may hesitate to keep an employee whose appearance is distasteful to others and this may result in his being fired. In cases of allergic substances at the place of employment, the skin is more likely to react to this irritant if other conditions of work are not satisfactory.

In this group of 30 patients, it was found that one-third had problems in their work situations over which they had little control. Among the circumstances which created these problems, the following were most obvious:-

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[1] Carol H. Cooley, Social Aspects of Illness, Saunders, Phil. 1951, p. 214

1) Allergic substances at place of employment:- Four men were laid off from work owing to their sensitivity to such substances as oil cement or chemicals they had contacted. Not all the men reacted positively to sensitivity tests. Nevertheless, only one man was accepted back and only after the worker had spoken to his employer.

2) Immigrant in a new country:- Two men left their jobs owing to inability to speak the language and maintain their previous level of achievement. They were both given jobs in the hospital and adapted quite well, possibly owing to the greater security and acceptance they received in this setting.

3) Age: This may have been a complicating factor in several cases since there is a reluctance to accept older persons in industry. In the case of a salesman, who had no other trade, it seriously affected his ability to continue working.

4) Business failures: In two cases this resulted in a loss of income. With the help of the worker, one man was able to find employment while the other was referred to a family agency for financial assistance.

5) Appearance: This was a problem only in one case and created considerable difficulties for the patient in obtaining work.

With the exception of the last case, all the patients who had been facing these difficulties were men. An example of how such problems arose and were dealt with is shown in the following case illustration:-

> Mr. J.L., aged 59, was laid off on the recommendation of the nurse at the factory where he worked as she thought that the chemicals he had to use were causing his dermatitis. Mr. L. had been working there for twenty years and his skin condition had only started the previous year. He did not react positively to allergy tests. The social worker interpreted the findings to the nurse, but it was not until six months later, when the patient's condition had improved, that he was accepted back.

Social and Marital Situations

Events of a disturbing nature in the patient's contemporary life situation were studied in order to determine their frequency and whether they had any significance in relation to the needs of these patients. Mention has already been made of some of these events under the section on traumas. Here, only those situations will be discussed which arose out of some relationship which the patient had formed, either to a husband, fiancee, or another individual.

Only eight patients made no mention of any unpleasant social or marital situation in their present lives. The incidence of these events in the lives of the remaining 22 patients is shown in Table VIII.

TABLE VIII

Instances of Disturbing Events in the Social and Marital Situations of 22 Skin Patients.(a)

Types of Disturbances	Total Instances
Total Instances	24
Marital Problems due to loss of income, pregnancy, alcoholism, etc.....	10
Separations in Marriage.....	4
Death of a Spouse.....	5
Broken Engagements.....	3
Death of Fiancee.....	1
Illegitimate Pregnancy.....	1

(a) The number of disturbing events is greater than the number of patients since these occur more than once in the lives of some.

The occurrences of such events in the lives of these patients is fairly frequent. However, it is difficult to evaluate their significance since many people experience similar situations. It was only when studying their behavior that it was found that these patients were too insecure or dependent to cope with the reality of such situations. Two examples illustrate the way in which these patients reacted to disturbing situations:-

> Miss S.A., aged 30, was referred to the social worker as she had been upset about her skin condition. She was fearful that her body would remain marked and that she would be repulsive to others. She finally explained that she was to have been married a few months before, that this had been

her first love and that her fiance had left her without giving any reason. She had had a history of eczema at the ages of 2, 14 and 19; on the last occasion following loss of her job. Miss A. had been well up until the time that her fiance had left her. She was unable to confide in the worker, claiming that she was now more concerned about her health than about her love affair. Finally she left without completing her treatment.

Mrs. M.C., aged 45, had become extremely upset by her husband's death and reacted with a facial dermatitis and a severe depression. She became hysterical and it was finally recommended that she be admitted to the Allan Memorial Institute. At this point treatment of her dermatitis was interrupted and the patient became very upset about her condition as well. A few days after admission, she left the hospital without permission.

Both these cases showed violent, almost hysterical reactions to their experiences. They appeared to withdraw into their illness and to be unable to relate or use the worker's help in any way. Further adjustments of these patients to their environments will be discussed more fully in the following section.

A study of environment has shown that at least 12 patients came from emotionally unstable and deprived family backgrounds. Patients whose illness began early in life showed greater incidence of this deprivation than patients in whom onset of the skin condition came in later years. Many of these patients could not face disturbing experiences in later life. In a significant number of cases onset of their skin conditions immediately followed these disturbances and the

patient withdrew into a chronic type of illness situation. In the older age groups all the patients showed evidence of financial insecurity and all the older male patients faced problems in their work situations over which they had little control. Many of these factors were shown to have a definite influence on the patient's personality.

The Patient's Personality

The patient's personality has been defined as being the "product of inherited dispositions and environmental experiences."[1] Some insight has been gained into the patient's behavior through a study of these environmental experiences. It has been found that many patients were unable to cope with their situations and that the illness appeared almost as a retreat from these unpleasant circumstances. Their adjustments and behavior patterns will now be discussed more fully.

Owing to the nature of the record material and the fact that the writer did not interview the patients personally, it will not be possible to give a full intensive description of their personalities. Therefore, on the basis of the available information, the patients will be described according to their appearances, manner and the nature of their relationships.

Appearances and Manner

The worker's first impression of the patient is important

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[1] Supra, p.1

since they are part of the initial step in evaluating personality. First impressions, although sometimes misleading, can still give clues to underlying problems. Mannerisms, dress or speech may betray the person's true nature or may be a wall behind which he hides his real self. If this last pattern is applicable to any of the patients in this group, it is important that the worker be aware that this poised patient may not be a happy one. If she is not observant, she may by-pass someone who might have used her help.

The data on appearances were taken from records and in most cases the descriptions of the patient were limited to a few sentences. They are illustrated in the following two examples which have been transcribed verbatim from the social records:-

> The patient is very attractive and looks younger than her stated age. She has a fair complexion, dresses neatly but has a worried look on her face. She is very nervous, cries easily and is very tense and talkative.

> The patient, a well-mannerred, middle-aged man, appeared pleased to be able to talk to someone about his problems. He spoke in French as the doctor felt it would be easier for him to express his anxiety.

In analyzing this data, it was found that the majority of patients were described as well-mannered, pleasant, attractive and intelligent-looking. This was surprising in view of the fact that these same patients were also found to be anxious, nervous, tense, irritable and depressed. In spite of these obvious signs of underlying difficulties, their outward personalities were described as

pleasant. In this group it appeared that the patients were either fairly easy-going with little outward signs of emotion or they were very upset and nervous, crying frequently. A small group of patients did not fit into this category as they were completely withdrawn and unable to establish any rapport with the worker. Table IX shows that almost all the patients fitted into these three main groups.

TABLE IX

Description of the Appearances and Manner of Thirty Skin Patients, according to sex.

Appearances and Manner	Total	Male	Female
Total	30	12	18
Easy-going Pleasantly-mannered, attractive, intelligent. (little sign of outward emotions)	10	2	8
Emotionally upset Fairly pleasant personality but irritatle, crying, depressed and overly upset.	11	4	7
No rapport Withdrawn, introverted, anxious-looking, unable to express feelings.	5	4	1
Did not fit into above categories.	4	2	2

This had significance for the social worker since it was found that the patients in the second group were usually able to use her help and spoke about their problems at length. Those, however, in the first and third groups could not always relate closely or express

their real feelings. The patients who could not establish rapport and who were withdrawn and aloof, did not maintain their contact after the first few interviews. Unfortunately, they were the ones whose problems were most deep-seated and who required the most help. The majority of these patients were men in the older age groups. More women than men were able to form relationships and use the help of the social worker.

These findings were compared with Wittkower's[1] since in his study of 90 eczema patients, he had also divided them into three groups on the basis of appearances. The first type he described as the "undisguised" patient who had a rather childlike and immature appearance, usually looked younger than his years, and favored juvenile dress and simplicity of manner and make-up. They were characteristically well-dressed, good-looking and likeable people.

The second type was what Wittkower called the "resentful" patient.

> He may superficially appear calm, poised and friendly. The underlying tension and repressed anger may be betrayed only in the rigidity of their muscular armor. The calm face is really a frozen mask; the poise is not that of relaxation and comfort but of tenseness to resist attack. The hands are not folded but clenched.

The third type he termed as the "limelight seekers" or "self-drivers". These were the patients who overcompensate and cover their

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[1]Wittkower, op.cit., p. 212,13.

basic insecurity with a facade of defense reactions. They appeared as successful men of the world, apparently poised and at ease. These disguises, however, covered an essential unsureness of which they were only vaguely aware. Often they extended themselves beyond the point of comfort and betrayed their vulnerability by a blush, a tremor or an involuntary itch.

Although the findings in this study bear similarities with Wittkower's, none of the patients in this group appear to be "limelight seekers" or "self-drivers". Since clinic patients are not usually those who have been most successful financially, such men would likely be found in a more representative group of skin patients.

Nature of Relationships

(1) Inter-familial

The parent-child relationship is an extremely important one since it is the foundation on which the patient builds his emotional life and the basis for the type of relationships which he will form in later years. Through this relationship most of the patient's basic needs for love and understanding are met. However, too little or too much satisfaction of these needs may lead to stress, and, in consequence, to a sense of insecurity and feelings of anxiety. Where there is indulgence, rejection or over-attachment to one parent, there is also insecurity and possible immaturity.

It was decided to study the nature of the relationships of the patients in this group in order to find out whether there were any signs of emotional insecurity. Since one-third of the patients were over 55

and rarely spoke of their backgrounds, information on their inter-familial relationships was not available. This was unfortunate as the findings for the remaining number of patients were very significant. The analysis was based on the patient's relationship to his parents, his own children and to his siblings. Disturbances in these relationships were considered most evident either through over-attachment or rejection. Over-protection was considered under the same heading as over-attachment and desertion of the patient by a member of the family was regarded as apparent rejection.

TABLE X

Analysis of Inter-Familial Relationships in 19 Skin Patients, according to Age.(a)

Patient's age in years	Total Relationships	Over-attachment of Pt. to Parents	Over-attachment of Pt. to Children	Rejection of Pt. by Parent	Rejection of Pt. by Children	Rejection of Pt. by Siblings	Over-attachment to Siblings
Total Relationships	24	12	4	4	1	1	2
15 to 24	4	2	-	1	-	-	1
25 to 34	3	3	-	-	-	-	-
35 to 44	5	2	2	1	-	-	-
45 to 54	8	5	-	2	-	1	-
55 to 64	4	-	2	-	1	-	1

(a) Some patients can be included under more than one type of relationship, and, therefore, the total number of relationships is greater than the number of patients.

Table X shows that emotionally unhealthy inter-familial relationships were evident in approximately two-thirds of the patient group. The most significant problem for most of these patients appeared to be

over-attachment or over-protection of the patient by one or both parents. In addition to insecurity, lack of self-confidence, resentment toward the parents and conflicts over dependency needs are some of the by-products of this type of relationship.

The following case illustrates a problem which arose as a result of over-protection:-

> Mrs. C.R., aged 25, had eczema since the age of ten. Her parents have spent a fortune on her illness and have indulged and over-protected her. The eczema disappeared after her marriage. However, her parents continued to meddle in her affairs, had to know everything and even dressed and looked after the children. A year ago she persuaded her husband to move from her home in Quebec to Montreal. Since then her eczema has re-appeared. Mrs. R. claimed that she resented the interference of her parents, and that she was glad she had no relatives or friends in Montreal as she was tired of being told what to do. However, when her parents visited Montreal, Mrs. R. left quite suddenly without completing treatment and returned to Quebec city.

This patient seemed to be conflicted about her dependence since she both resented and still accepted her parents' protection. Obviously this must also have created difficulties for her in her marriage.

Marital and Sexual Relationships

The patient's sexual and marital relationships are a further indication of his ability to make a mature and emotionally healthy adjustment in life. The person who is immature and dependent, and who has not had the security of a warm parental relationship, may be unable to achieve an adequate sexual and marital adjustment. Marriage requires that the person invest himself emotionally in a relationship and that he

also assume a certain amount of responsibility in the management of home and family. If he is unable to do so, both partners may be conflicted, anxious and tense in their relationships. Wittkower[1] found that in his study, 55 percent of the eczema patients had made inadequate sexual adjustments, with such characteristics as inhibited sexual interest, impotence, premature ejaculation and frigidity. Marriage in many of these cases was rarely found on a sound or stable basis.

Two-thirds of the patients in this study showed indications of being unable to form healthy sexual and marital relationships. Since there were several single patients in this group about whom such information would not always be available, this analysis is actually not too accurate. Nevertheless, the findings are significant of an extremely high rate of sexual and marital maladjustment in this group.

TABLE XI

Analysis of Sexual and Marital Relationships in 20 Skin Patients, according to Sex. (a)

Types of Relationships	Total Incidence	Male	Female
Total incidence of relationships	23	12	11
Fripidity and Impotence.....	3	1	2
Homosexual Trends.....	2	2	-
Disinterest in opposite sex.....	3	1	2
Other sexual maladjustments.....	5	1	4
Separations and Desertions.....	4	2	2
Dominance and Aggression toward Partner	2	2	-
Passive and Dependent on Partner.....	4	2	2

(a) Some patients show patterns which fall under more than one heading, and, therefore, the total incidence of relationships is greater than the number of patients.

[1] Wittkower, op.cit. p.213

This information is pertinent to the role of the social worker since many of these patients will require marital counselling. Her awareness of some of the underlying sexual conflicts will also prompt her to make more referrals to the psychiatrist.

In the following case the worker helped a passive and dependent man to regain some authority in the household:-

> Mr. L.A., aged 63, was a well-mannered but extremely anxious and depressed man. He related well to the worker and admitted that he was upset as he had no authority in the house. His wife always has her own way even if he disagrees. He relies entirely on his wife's judgement, particularly with regard to the children. To avoid any arguments, he keeps his disappointments and hostile feelings to himself. Mr. A. was given a great deal of support and encouragement to express his own opinions in the home. At the same time the patient's wife and daughter were interviewed and obtained some insight into this situation, which consequently changed their way of relating to the patient.

Social Relationships

Feelings of insecurity may result in two extremes of behavior- the tendency to withdraw and avoid social contacts or the tendency to domineer and become aggressive. Usually the patient is in a conflict about his behavior since he is never sure of himself in either situation.

It was found that two-thirds of the patients in this group were either withdrawn and asocial or extremely demanding on their family and friends. An example of asocial behavior is shown in the following case:-

> Mr. W.W., aged 48, has not made any friends in Canada as he is the "old-fashioned" type who does not drink or play cards. He is not a good mixer and does not confide in anybody. Mr. W. felt that if he could regain sexual potency, he might live with a woman and overcome his loneliness.

Another case is that of an extremely demanding patient:-

> Miss D.I., aged 46, keeps stressing the negative side of things and worries considerably over her inactivity. She realizes that she is a burden on her family and that they reject her, but is, nevertheless, very demanding toward them. She states that she would like to be independent, but that her skin condition does not permit this.

Work Adjustments

In certain instances it was found that problems arose in the work situations as a result of difficulties inherent in the patient's own personality. Some of these included instability on the job, the patient's dissatisfaction with his level of achievement and his suppressed resentment or hostility toward the employer.

Three examples are cited in order to illustrate work problems which arose as a result of the patient's personality:-

> Mrs. G.L., aged 28, worked for four years in an unskilled clerical capacity. She stopped work owing to a nervous breakdown and has not returned since this time. She believes that her nervousness started at work as she was the youngest and could not "tell them off".
>
> Mr. G.M., aged 36, worked as a taxi driver but was never satisfied. He had been looking forward to taking over his father's undertaking business but an uncle forced him to sell it at a low price. Fifteen months ago he went to Quebec city to take a new job as a clerk and his skin broke

down immediately. Since then he has not been working.

Mr. W.W., aged 48, was in the civil service in England and gave up many advantages to come here. He has been working in construction jobs as stock bookkeeper and does not think highly of the work. Mr. W. considers himself the "black sheep" of the family since he never did as well as his brothers. He has been inculcated with high standards which he has never been able to fulfill to his satisfaction. He has not been working for several months owing to his skin condition.

A study of the personality patterns of the patients in this group has shown that approximately two-thirds did not experience a secure and healthy type of relationship with their parents. As a result their basic emotional needs had not been met, and they could not form stable or meaningful relationships in the sexual, social or marital spheres of their lives. In spite of the obvious unhappiness and anxiety which these patients felt, their appearance to the world was poised and in the majority of cases quite pleasant. This was felt to have significance for the worker who would need to be aware of some of these underlying problems.

Chapter V

The Effects of Skin Disease on the Patient

Some consideration has already been given to the problems of skin patients apart from the effect of the illness in itself. It has been pointed out that the patient is influenced by factors in his environment and that to a considerable degree these influences determine his pattern of response. The manner in which the individual adjusts to his illness, the meaning that it has for him and his reaction to treatment will to a large part depend on these same influences. The family, for example, plays an important role in influencing the patient's reaction to illness. If he has been over-protected, pampered or rejected, he may show this through the illness by becoming very dependent and by attempting to gain the attention he may feel he has missed. The patient's inability to adjust to illness, therefore, may be a sign of some underlying problem.

Although each individual reacts differently to illness depending on his own inner capacities, his past experiences and his method of dealing with situations, the social and emotional consequences of a disease which affects the skin are keenly felt by every patient. Irritability owing to itching and discomfort, self-consciousness, the fear of being different and anxiety over a condition that may become chronic-all these are feelings which almost every skin patient has experienced. An understanding and awareness of these feelings will enable the worker to plan with the patient and help him carry out his treatment with due consideration of the problems that the disease may have created.

The thirty patients in this group were studied in order to determine their reactions to illness and treatment. It was felt that this would provide a further clue to their problems and needs, which in turn would clarify the role of the medical social worker in facilitating their treatment.

Meaning of Illness

In examining the data, it was found that in many cases there was little or no mention of the patient's emotional reaction to the skin condition. This omission could mean that either the patient showed no obvious response or that this information was not included in the recording. Owing to the brevity of the records, the latter was more likely to be true.

The findings, which are illustrated in Table XII, show that more than two-thirds of the patients expressed some feeling about the disease.

TABLE XII

Reactions to Illness of 25 Skin Patients, according to Sex.(a)

Types of Reactions	Both	Male	Female
Total incidence of reactions	26	7	19
Passive acceptance of illness owing to secondary gains.....	10	2	8
Markedly depressed by condition	8	4	4
Worried about disease progressing, cancer, scars.....	3	-	3
Sensitive, self-conscious, avoiding people.....	4	1	3
Psychotic.....	1	-	1

(a) There is overlapping between incidence of reactions and number of patients since one patient fitted under two types.

It seemed rather striking that as many as a third of the patients in this group were using illness as a way of solving their problems and to satisfy needs which had never been met. As a result they would either withdraw into themselves and become completely dependent upon their family and friends, or they would become aggressive, demanding and resentful. In both situations this behavior created hardship and undue stress for those persons who were immediately concerned with their care.

It was significant also that more than twice as many women were able to bring out their feelings about the illness. This might be explained by the high premium which is placed on the physical appearance of women in our culture. In addition there was a tendency for the male patient to become markedly depressed or so tense that he could no longer relate or confide in the worker. Anxiety concerning their illness, however, was expressed indirectly by the majority of men when it had an affect on their employment status. The reaction of the men was in contrast to that of the women who were much more concerned about their appearance.

Typical reactions of the patients to illness are shown in the following cases:-

> Miss A.J., aged 27, was described by the doctor as "a chronic invalid who is resigned to being sick and different from other people". On September, 1950 it was noted that her "skin was improving but she is attempting to find other devices for remaining in the hospital". The social worker recorded that "the illness meant to her a lot of attention from doctors, hospital, family and friends.

> Miss J. needs some kind of stimulation to overcome the feeling of rejection she has had all her life."

Mr. S.A. was seen to have quite a different problem.

> "The patient was very upset and crying when introduced to the worker. He explained that he was no longer the master of the household and he had to rely on others. All his life he had been a self-supporting person and suffered a severe depression when he realized that he had a long-term illness. He states that he is very anxious to work but feels that his wife does not believe him. His frustration has made him vent his resentment against his family."

It is apparent that the attitudes of family and friends may either aggravate or help alleviate the feelings of skin patients. The social worker needs to be aware of the underlying reasons for the patient's behavior, the need for interpretation of the disease process to the family and how their help can be enlisted in order to facilitate the patient's recovery.

Reaction to Treatment

The patient's reaction to treatment is to a large extent determined by his adjustment to the illness. However, such characteristics as duration or severity of the disease, itself, may affect his acceptance of the medical recommendations. Where a condition is chronic, the patient tends to become easily discouraged and to lose faith in any kind of treatment. Since at least 25 of the 30 patients in this group had chronic or recurrent skin conditions, it was felt that this might have some significance in their response to treatment.

The patients were studied both on the basis of their reaction

to hospitalization and to specific medical recommendations both on the ward and at the clinic. In several cases this information was missing, and in only twelve was it actually available. Nevertheless, Table XIII bears out the findings of the previous table since the same patients who used their illness to satisfy their dependency needs, also found it difficult to leave the security and warmth of the hospital setting.

TABLE XIII

Reactions to Hospitalization in 30 Skin Patients, according to Sex.

Types of Reactions	Total	Male	Female
Total number of patients	30	12	18
Desire for hospitalization and difficulty around discharge	10	2	8
Anxious to leave hospital.....	1	-	1
Left hospital without permission.....	1	-	1
No information available on reactions.....	18	10	8

This analysis confirms the information that a significantly higher percentage of women showed evidence through these reactions of the underlying insecurity and deprivation in their lives. It is not too clear as to why this was so apparent in the female patients. Closer study of these cases would perhaps be needed in order to establish the reasons. However, it must be pointed out that there were six more women than men in the entire sample. In addition, many more women were single and, having no families to return to, they would welcome the attentions of the doctors and nurses. The men, on

the other hand, could still be dependent in the home setting where they received the care and concern of their wives and children.

The meaning that hospitalization can have for the dependent individual is aptly described by Wittkower in the following comment:-

> The common observation that endogenous eczema dramatically subsides with hospital treatment, only to recur on return to the outside world, is readily understood in view of the basic characteristics of the sufferers. In hospital they are relieved, at least to a certain extent, from their cumbersome responsibilities. They are looked after by parent substitutes in the shapes of physicians and nurses. Compresses and ointments are applied to them in a situation analogous to their dimly remembered infancy when they were caressed, nurtured, bathed, oiled and powdered. [1]

Some insight was gained into the behavior of the men in this group through a study of the patients' reactions to treatment.

TABLE XIV
Reactions to Treatment of 30 Skin Patients, according to Sex.

Types of Reactions	Total	Male	Female
Total number of patients	30	12	18
Unco-operative; not following treatment.....	10	2	8
Impatient with treatment...	4	1	3
Overly co-operative.....	7	6	1
Worried over treatment costs	2	1	1
No information available on reactions.....	7	2	5

[1] E. Wittkower and P.G. Edgell, "Eczema, a Psychosomatic Study", Archives of Dermatology and Syphilology, (Feb.1951) Vol.63, No.2, p.217.

Whereas this table shows quite clearly that the men were more co-operative than the women, examination of their histories revealed intense anxiety over financial insecurity as well as an inability to accept help. The majority were men in their fifties who had worked steadily for years, were maintaining households and who could not relinquish the prestige and position they felt they had gained in the family group. This cooperation was actually part of their anxiety. The worker's awareness of the emotional impact which the illness had for these patients was an important factor in helping them to vent some of their feeling and accept their illness on a more realistic basis.

The findings in this chapter disclose that in the majority of cases, the skin disease had definite social and emotional implications. It was rather striking that the women showed the most marked reactions to illness and treatment through their fears, sensitiveness and unwillingness to follow recommendations. The men appeared to be more cooperative. On the whole, however, the analysis in Tables XIII and XIV shows that one-third of the patients in this group were having difficulties regarding hospitalization and were not following treatment. It was found that in the majority of these cases, dependency needs, feelings of rejection, anxiety around financial matters and threats to the person's position in the family had a direct effect on the meaning of the illness for the patient and his consequent reaction to treatment.

CHAPTER VI

The Medical Social Worker's Contribution in the Treatment Process

The preceding chapters have given some indication of the problems and needs which this group of skin patients have faced and the particular meaning which illness holds for them. How the social worker was able to deal with these problems will now be described in the following analysis. An introduction to her specific setting, however, is necessary in order to understand more clearly the significance of her contribution.

The social worker in the medical setting must not only administer her casework skills, but must do so according to the regulations and pressures of a complex institution which is designed primarily to give medical care. Her services, therefore, are only part of a program the aim of which is the treatment and care of the sick. She functions as a member of the medical team, together with the doctor, psychiatrist, nurse and other professional personnel, all of whom are concerned with the patient's recovery. Her contribution is particularly subject to the decisions of the doctor as he is the leader of this team.

The social worker's role in helping the patient to recover differs from that of the other members of the treatment team since her main skill lies in the area of the social and emotional aspects of illness. Her services are directed toward enabling the patient to meet personal or environmental difficulties that result from illness or that interfere from his obtaining maximum benefits from medical or psychiatric care. This help is based on her understanding of the patient and of what this illness experience means to him. It depends

as well on her ability to relate to the patient in a constructive way so that he will be influenced to make most use of the resources both within himself and his environment. The social worker must be able to interpret her role to the patient so that he will be more accepting of her help and will be able to enter more readily into a relationship with her. She must also be able to share her knowledge and understanding of the patient with the doctor and other members of the team. According to Bartlett:-

> It is a challenge to the medical social worker's skill to function as one of a succession of specialists who serve the patient and to be able to make him understand the peculiar quality of the contribution which she has to offer in such that he can take hold of it and use it effectively.[1]

The psychosomatic approach to illness has underlined the significance of the social worker's role and has deepened her responsibility. This has been brought about by the doctor's own keen awareness of the social and emotional factors which predispose the patient to illness and his demand for increased casework services. The social worker has also gained in her understanding of the psychic implications of illness and has been able to help in a more effective way. In view of this development in medicine and the change that this has brought to the worker's role in the medical setting, there is a need to redefine and clarify her contribution.

This is most evident on the dermatology service where most doctors now recognize that emotional and social problems may interfere

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[1]Harriet M. Bartlett. Some Aspects of Social Casework in a Medical Setting. Chicago, 1940. p. 29.

with the patient's recovery and in some cases may even bear a relationship to the onset of the disease. The literature, however, has made little reference to the caseworker's role in helping patients with skin diseases. Of the two studies which have been carried out by social workers, only Dunkel is directly concerned with the problems of skin patients, whereas Nathan briefly discusses the worker's role in helping skin patients as part of another study.

In this latter study, Cynthia Rice Nathan comments on the meaning of skin conditions to men in the armed forces who had succumbed to tropical diseases. She states that in these cases:-

> the services of the social worker are particularly important since the mental state of the patient with a skin disease has a direct relationship to the rapidity with which he will recover. Anything that will improve morale, solve personal problems, relieve anxiety, give reassurance and provide diversion is a direct aid to treatment.[1]

An analysis of the caseworker's role on the dermatology service was made by Mary L. Dunkel[2] in a study of 45 patients with neurodermatitis. Referrals to the caseworker were based on the doctor's recognition of a problem or on his request for a social study since the patient's progress was poor. It was found that many of the patients had intrapsychic conflicts which required psychiatric help. This was not always practical, however, since modification of personality

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[1] Cynthia Rice Nathan. "Service and Tropical Diseases", Journal of Social Casework, Vol. 26, No.5 (July, 1945), pp.189-194.

[2] Mary L. Dunkel. "Casework Help for Neurodermatitis Patients", Journal of Social Casework, Vol.30, No.3 (March, 1949), p.97.

structure in these cases is a long and hazardous undertaking. It was felt instead that the techniques of the caseworker in helping the individual deal with his emotional problem in relation to the pressures of his situation, would be more effective for these patients. This recommendation was made on the basis that the worker meet regularly for consultation with the psychiatrist and the doctor. Dunkel states that the goal in helping skin patients is a limited one, and that if the patient regains his highest previous level of adjustment and acquires a modicum of self-tolerance and superficial insight into why he reacts as he does, the case may be regarded as successful.

The present study of the caseworker's role on the dermatology service is not a comprehensive one since it is based on the problems and needs of only 30 patients. In addition, it is limited by the nature of the record material from which the data has been drawn. This is described fully in Chapter I[1]. The helping process is mentioned very briefly, usually with a statement regarding the plan and a follow-up summary of what took place. At times it has been necessary to infer the worker's role from a description of the patient's reaction. This, however, has not proven to be too satisfactory a method. Nevertheless, in spite of those limitations it has been possible to give a fairly comprehensive analysis of the worker's role through showing the referral procedures and examining the extent and motive of her services.

The following section deals with the source and reasons for referral of skin patients to the medical social worker as a partial

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[1] Supra, p. 5

indication of her responsibility.

Source and Reasons for Referral

In the medical setting the patient, himself, rarely seeks out the help of a medical social worker. His purpose in coming to the hospital is to obtain medical care and if he has had no previous contact with the Social Service Department, the worker's visit may be an unwelcome one. In the event that the doctor has not prepared the patient for her visit, the entire responsibility for interpretation of her function rests with the worker. The patient's willingness or reluctance to accept her help may be greatly affected both by her approach and the amount of interpretation which has been given by the referral person. The patient's reaction to the worker's offer of help usually, although not always, indicates whether or not referral has been made on a sound basis.

The patients in this study were seen by the worker either during clinic attendance or while they were on the ward. Altogether 13 patients received a visit from the worker for the first time while they were being hospitalized, whereas 17 were introduced to her while receiving treatment at either one of the two dermatology clinics.

Sources

The customary source of referrals in the Royal Victoria Hospital is through the doctor. A study of the referral sources among this group indicated that 21 patients had been referred by the dermatologist, and that the remaining number of patients had been referred by a variety of other sources. These included psychiatrists, community agencies, nurses and two patients who approached the worker on their own.

Table XV indicates the number of patients who were referred by these various sources:-

TABLE XV

Sources of Referral of 30 Skin Patients to Medical Social Worker.

Sources of Referrals	Number of Patients.
Total	30
Dermatologist or Interne	21
Psychiatrist	3
Community Agencies	2
Nurse	2
Self-referrals	2

With the exception of five patients who could not accept case-work help and broke off their contact with the worker, the remaining patients seemed very pleased and grateful at being allowed this opportunity to vent their feelings and talk about their problems. This would indicate that most of the patients had been prepared for her visit and that the worker was able to approach these patients with confidence in her role. In general, these findings give a sense of smooth cooperative work between the physician and the social worker on the dermatology service.

These referrals were made over a period of three years and it was interesting to note that certain changes had taken place during this short time. No referrals were made by the psychiatrist previous to 1952, however, since then he has shown a steadily growing interest in the social worker's contribution. On the whole, referrals from the

two dermatology services have increased with each year. It was found that in 1952 twice as many skin patients were seen by the social worker as in 1950, and there was every indication that this trend was continuing.

Table XV shows that only two patients had been referred to the medical social worker by agencies in the community, despite the fact that 15 patients were known to these agencies. This may be evidence of lack of cooperation between the agencies and the hospital or insufficient knowledge of the medical worker's contribution. From an analysis of the degree of cooperation which took place in cases which were known to the worker, the latter would more likely appear to be true.

Reasons for Referral

The reasons for referral of the skin patients to the social worker were extremely varied. However, it was found that the largest number of patients, approximately nine, had been referred for help with discharge planning. At least seven of these patients were women and two were men. This would indicate a fairly keen awareness on the part of the medical staff of a problem which many patients were facing in finding suitable living accommodation. This problem has been analyzed in Chapter III, where it was shown that the majority of these patients were women.[1]

In seven cases the patients were referred to the social worker as a result of financial difficulties. Three patients had expressed

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[1] Supra, p.6

concern over their hospital bill, and two patients were unable to pay for medicine, bandages and other medical expenses. In one case a patient was referred to the worker by the psychiatrist for social planning and evaluation of his financial condition. In all other cases, however, referrals from the psychiatrist were made only for the purpose of a brief social evaluation, rather than for help on a continued basis. One patient was referred to the worker by a welfare agency for the purpose of obtaining a medical certificate so that the agency could apply for Q.P.C.A.[1]

In approximately five cases the patients were overtly upset over their conditions and this seemed to interfere with their ability to follow treatment. They were referred to the worker for interpretation and assessment of underlying problems.

A small number of patients were referred to the worker for help regarding arrangements for admission to hospital, placement of the patient on a job or evaluation of his ability to work and social evaluations for patients who were being referred to psychiatry.

In almost all cases the reasons for referral which have been described here coincided with real problems which these patients faced. However, the problems they showed on referral were not always indicative of major difficulties in their lives. In addition, although they had been referred for one specific reason, most of these patients had problems in several other areas. Nevertheless, the referrals were made

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[1]Quebec Public Charities Act designed to allow grants-in-aid to various institutions in the Province of Quebec.

on a sound basis from the social worker's point of view and showed evidence of a good understanding of her role on the Dermatology service.

Nature of Services Given

The worker's total responsibility on the dermatology service can be described in terms of the nature and number of services given. An analysis of the nature of these services showed that the worker's skills were directed toward helping the patient by a variety of means. These means included help based on the concrete or manipulative action of the worker, such as assistance with financial difficuties or living arrangements, interpretation regarding referrals or medical treatment, and certain psychological techniques such as giving the patient support, advice and insight into personal problems. In almost every case, the worker attempted to employ several of these means in order to help the patient. Her help, however, was limited in some instances owing to the patient's inability to relate to the worker and accept her services.

Concrete services

In this study, the concrete services of the worker refer to direct steps which were taken on the patient's behalf in order to change or modify some situation in his environment. It was pointed out in Chapter IV that environmental stress can have considerable influence on the patient's personality development and may even bear some relationship to the onset of skin disease. Any help which was directed toward relieving such stress would, therefore appear to be extremely important. Although it is preferable for the patient, himself to make these changes, the caseworker's efforts are required to a greater extent when dealing with patients who are sick or emotionally insecure. According to Dunkel:

> Such assistance is valuable since it arouses least anxiety, demonstrates the worker's sincerity and interest, and forms the basis for working through a closer relationship.[1]

An analysis of the steps which the worker took on behalf of the patients in this group showed that her aim was to relieve problems concerning financial difficulties, employment, and difficulties in finding living accommodation. Table XVI indicates the kinds of help which the worker offerred in reducing these pressures and the number of cases which were affected in each instance. More than one service was usually given to each person. Use was made of resources in the community such as convalescent homes, institutions, employment and rehabilitation centres and Family Welfare agencies. The worker also availed herself of facilities in the hospital such as occupational therapy, placement services and funds which covered certain medical expenses.

According to the analysis in Table XVI problems which rated highest in this group of patients arose as a result of financial difficulties. An attempt was made by the worker to secure financial aid for approximately 15 patients. As shown in Table XVI the worker took steps on their behalf in altogether 21 instances. Since the hospital is limited in the amount of help it can offer the patient, it is necessary to refer him to an agency in the community for more adequate assistance. The worker was unsuccessful in her efforts in only two cases, as one patient was unable to secure compensation and another was ineligible for agency assistance. A description of the financial problems of these patients was given in Chapter IV[1] and it was found

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[1] Supra, p.8

TABLE XVI

Analysis of Types of Service given to Relieve Financial, Employment and Living Accommodation Problems of 30 Skin Patients, according to Sex. (a)

A	Financial Assistance	Total Services	Male	Female
	Total extent of services	21	12	9
	Facilitating medical treatment (carfare, etc.).....	4	4	-
	Facilitating receipt of QPCA.....	4	1	3
	Facilitating receipt of compensation...	1	1	-
	Referrals to Welfare Agencies.....	8	4	4
	Cooperation with Welfare Agencies.....	4	2	2
B	Employment	Total Services	Male	Female
	Total extent of services	11	7	4
	Referral to hospital placement office ,.	3	2	1
	Referral to occupational therapy.....	1	-	1
	Referral to employment and rehabilitation centres in the community.....	7	5	2
C	Accommodation	Total Services	Male	Female
	Total extent of services	14	5	9
	Referral to institutions.....	3	-	3
	Referral to convalescent homes.....	6	2	4
	Exploration of other resources.....	2	1	1
	Transfer of patient to another hospital.....	3	2	1

(a) There is overlapping between the total extent of services and the total number of skin patients since in some instances more than one service was given to the same patient.

that at least 23 patients had made some mention of being unable to meet medical expenses or living costs owing to lack of an adequate income. Since seven patients had been receiving assistance prior to their referral to the medical social worker, this meant that 20 of the 23 patients who were in financial distress were in receipt of some form of help. In view of these findings, it appears that the worker's services were well directed in helping these patients deal with many of their financial problems.

A study of the employment histories of these patients has shown that 15 employable patients were without jobs at the time of their referral to the social worker.[1] Some of these patients claimed they could not work owing to their age or skin conditions, and instead applied for financial assistance. The majority, however, were anxious to find jobs. The social worker made an attempt to help ten patients with their employment problems, and in six cases her efforts were either directly or partly responsible in their obtaining work. Many of the remaining patients were unable to find employment owing either to their skin conditions or difficulties within their personalities. This indicates a need for further interpretation on the part of the social worker to employment agencies and employers. It also points to a need for more help from psychiatric or rehabilitation centres in assisting these patients to make a better adjustment, in addition to the worker's contribution in this area. An example is shown of how the worker was able to help a patient avail himself of these facilities-

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[1] Supra, p.8

> Mr. P.H., aged 54, had a history of alcoholism and erratic work habits at the time of his referral to the social worker. He had been fired from his previous job since he had fallen asleep and was now completely destitute. He at first refused convalescent care and showed no willingness to accept any pregressive planning. Despite his unwillingness to cooperate, the worker gave the patient a great deal of acceptance as well as direct aid in the form of meal tickets and carfare. Gradually he began to trust and confide in the worker and a closer relationship was established. He finally accepted convalescent care and at the same time referral to a Rehabilitation Centre. At present he is working and adjusting quite well.

Reference has already been made to the problems this group faced in finding suitable living accommodation. It was shown that 15 patients were living with relatives, strangers, in boarding homes or institutions, and that 11 of these patients were women. Nine patients had been referred to the worker prior to their discharge from hospital for help in finding living quarters. Two patients requested help in this area while attending the clinic. The worker was successful in helping altogether seven of these 11 patients. Four received convalescent care, two were placed in institutions and one found a more suitable room.

In the following case the worker was able to help the patient accept institutional care:-

> Miss F.A., aged 53, had been referred to the worker as she required help with discharge plans. As her only living relatives, she had two cousins, both of whom were widows, and who showed little interest in the patient. She was given considerable support and interpretation

> regarding her discharge from hospital and transfer to a home or institution. The worker encouraged her to express the hostility she felt toward her relatives, and finally the patient was able to accept institutional care. A scanning was made of community resources and she was referred to the L'Aide de Femmes.

Interpretation

Both the validity of the caseworker's efforts to help the patient and the appreciation she receives of her role on the medical team depends to a great extent on the use she makes of interpretation in her day-to-day routine. It may be necessary for her to interpret her function in the hospital and to show evidence of this both to the doctor and to the patient. If the patient is not obtaining maximum benefits from medical care, the social worker may help him understand the doctor's role as well and the implications of the medical treatment. At the same time it will be necessary for her to share her knowledge of the patient with the doctor and others who are interested in his welfare so thay they may also be aware of the factors that are involved in his recovery. Her use of interpretation may extend outside the hospital to the patient's family, agencies in the community or the patients employer. She may need to hold interviews and conferences both in and outside the hospital in order to carry out this function.

The duties of the social worker on the dermatology service, as on all other services, are carried on in the same way as has been described in the preceeding paragraph. Specifically, interpretation to this group of patients has been directed mainly toward helping them to follow medical recommendations especially after their discharge from

the hospital, explaining the implications of their condition to family or friends, and helping the patient, and in some cases his family, accept referral to a psychiatrist or to an agency in the community. Table XVII gives some indication of the extent of the worker's role in giving interpretative services. However, it must be pointed out that this function is often carried out on an informal basis and may not always be included in the recording. Since the information in Table XVII was obtained only from records, it is, therefore, not a complete and accurate picture of her role in this area.

TABLE XVII

Analysis of Interpretative Services given to 30 Skin Patients, according to Sex.(a)

Nature of Interpretation	Total Services	Male	Female
Total Services	34	14	20
Interpretation to patient re medical treatment.....	8	2	6
Interpretation to patient re psychiatry,.....	9	3	6
Interpretation to family and friends.....	7	4	3
Interpretation to employer.....	2	1	1
Conferences with doctor or psychiatrist (not referral)...	8	4	4

(a) The total number of services is greater than the number of patients since some patients received more than one service.

A large number of the patients in this group, approximately 13, were known to a psychiatrist during the period between 1950 and 1953. Table XVII shows that the worker's role in helping these patients accept psychiatric treatment was a significant one. Of the

nine patients who received some interpretation regarding this referral, only two patients refused to consider this and one patient broke off contact with the psychiatrist after the first interview. Of the entire group who were known to the psychiatrist, six are presently still receiving treatment, and appear to be responding.

The reaction of the patient to illness and to medical treatment has been discussed in Chapter V.[1] In this analysis it was found that 15 patients were worried, depressed or sensitive about their conditions, and that 10 patients were uncooperative regarding treatment and were using their illness to satisfy obvious needs. The family and friends of the patient were shown to have considerable influence on his attitude toward illness and his capacity to recover. Interpretation is one of the means by which the worker helps the patient achieve a more satisfactory adjustment to his illness, and a more positive attitude toward treatment and recovery. The worker's role as described in Table XVII shows that she helped only eight patients in this respect. The actual extent of these services, however, was probably much greater since it was found that in a study of the group's reactions, approximately 19 patients showed improvement in their skin conditions and their basic patterns of adjustment. Nevertheless, a study of the work adjustments of these patients indicated a need for much more interpretation to employers. On the whole, these findings emphasize the importance of the worker's function in giving interpretative services to skin patients.

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[1] Supra, p. 56

The following case illustrates how the worker was able to help a patient accept psychiatric treatment by interpreting this service both to the patient and her husband:-

> Mrs. G.L., aged 28, had developed a dermatitis in the groin which was spreading and for which no cause could be found. She improved on hospitalization but broke down when discharged home as she failed to follow treatment. When approached by the worker on the ward, she was found to be depressed, crying frequently and extremely tense. She confided that she had no friends, that she was jealous of her husband and unable to experience any sexual pleasure. The worker consulted the doctor and he advised that the patient be referred for psychiatric treatment. The patient and her husband were both seen separately, some of their marital difficulties were discussed and they were given interpretation as to how treatment might help this situation. The patient was finally able to accept this referral and was seen by the psychiatrist for a period of about three months. During this time it was noticed that her relationships with her husband improved, she made a better adjustment at home and her skin condition cleared.

In the following example, the worker helped the patient accept hospitalization although this was later found to be unecessary:-

> Miss W.M., aged 62, had been referred to the social worker since she had been worried about the doctor's recommendation for admission. It was found that she had an excellent job as housekeeper for a sympathetic employer, and that she was afraid of losing this during hospitalization. The matter was discussed with the doctor who felt that the patient would not require longer than one week in hospital. On the patient's wish, the worker called the employer and interpreted the doctor's recommendations. The employer was

> extremely understanding and stated that she could manage until the patient's return. Miss M. was considerably relieved and willing to move ahead with admission plans. On her following clinic visit, however, her skin condition had improved to such a degree that the doctor advised postponement of these plans.

Psychological Methods

The term "psychological methods" refers to still other means by which the social worker helps the patient achieve a better adjustment. The use of this term is based on an article by Florence Hollis on the techniques of casework. In this article, Miss Hollis points out that:-

> casework has used a twofold approach: it has intervened in the client's environment in his interest and it has employed various psychological methods- the influence of mind upon mind-to decrease the individual's emotional burdens and increase his inner capacity to meet life's frustrations and make use of its opportunities.[1]

To achieve this, Miss Hollis uses three main techniques-"psychological support", "clarification" sometimes called counselling and "insight development". In all three instances these techniques take place through contact directly with the client, that is, through the process of the client-worker relationship. "Psychological support" is directed toward the building up of ego strengths and release of tension and anxiety so that the patient can be enabled to deal more effectively with his situation. It consists of helping the patient to

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[1]Florence Hollis. "Techniques of Casework" Journal of Social Casework, Vol. 30, No. 6.(June, 1949) pp. 235-240

express his feelings, to talk freely and of giving him considerable acceptance, encouragement and recognition. Through "clarification", the worker helps the patient to think more rationally, to make major decisions and to plan more realistically. It is largely but not entirely an intellectual process and includes such steps as giving advice or information, and helping the patient to gain a more objective understanding of himself and the people around him. "Insight development" is a deeper and more involved process usually undertaken only under the supervision of the pychiatrist and will not be referred to in this study since the limitations of the data do not permit an analysis of the worker's role in giving insight.

Table XVIII indicates the role played by the worker in giving services which involved "clarification" and "psychological support". In Casework practice these techniques are always used together. This table does not show the total number of patients helped, but rather the extent of her service in each instance. The analysis has been broken down according to the main issues which patient and worker discussed. These concerned marital difficulties, conflicts regarding dependency needs, and attitudes of the patient toward his illness, his family and his work.

TABLE XVIII

"Psychological" Techniques used by the Worker in Helping 30 Skin Patients, Showing extent of Service to each Sex.(a)

Types of Help	Total Help	Male	Female
Total extent of help	54	22	32
Psychological support.....	22	7	15
Clarification re marital situation.....	3	-	3
Clarification re dependency conflicts.....	9	8	1
Clarification re attitudes toward illness, work, family, etc....	20	7	13

(a) There is overlapping between the total extent of help and the number of patients since some patients received more than one type of service.

The worker gave help through psychological support to 22 patients in this group, the majority of whom were women. This meant that eight patients, five of whom were men, formed little or no relationship with the worker. The intensity of this relationship or the exact time spent with each patient was difficult to evaluate in these 22 cases. However, it was noted that the worker formed a very close or "mother" type of relationship with eight patients, and that the majority of patients were known to the worker over a two to six month period.

The findings in Table XVIII, which show that many more women than men were able to relate and accept the help of the worker, are in accord with the information obtained through a study of the appearances and relationships of the patients in this group.[I] In this study it

[I] Supra, p.47

was found that five patients were completely withdrawn and unable to establish any rapport with the worker. Almost all these patients were men. It was noted as well that the men generally were more tense and found it difficult to express their feelings whereas the women were able to confide much more easily. Table XVIII shows clearly that the worker's ability to help the patient depended to a great extent on his own willingness to accept this help and enter into a worker-patient type of relationship.

The extent of the worker's role in helping patients with marital difficulties is not in proportion to the number of problems which actually existed.[1] Her services extended to only three patients although at least ten patients appeared to be having difficulties in this area. More help, however, was given to patients who were conflicted between real dependency needs and the desire to be independent, and two-thirds of the patients in the group were helped to adjust either to their illness, new work patterns or new habits of living.

An evaluation of the worker's role on this service was made in terms of the actual outcome of the referrals. It was found that five patients could not accept help and broke off contact almost immediately. Three patients were unable to relate more than very superficially to the worker and showed no change in their patterns of adjustment. Of the remaining 22 patients, 19 patients showed some degree of change or improvement in their ability to adjust to various situations in their lives.

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[1] Supra, p. 52

The following two cases illustrate the worker's ability to help the patient make a better adjustment:-

> Mrs. W.A., aged 63, had been separated from her husband for several years. She was extremely attached/to and over-anxious toward her son. The latter has been away in the States for some time and returned home shortly after the patient's discharge from hospital. Mrs. A. was seen regularly by the worker on the skin clinic and received reassurance and support, particularly around her attitude toward her son. She was helped to relax and obtained some understanding of her own attitudes which enabled her to become less domineering and anxious.

> Mrs. D.V., aged 24, was having difficulty in accepting her responsibility in the home and adjusting to her marriage. The worker established a close "mother-type" of relationship and visited the home to show her interest. The patient was also given continual support and encouraged to express her feelings. Eventually her skin condition improved as well as her relationship to her husband.

The findings in this chapter show that the worker's contribution in helping skin patients is an extremely varied and important one. This was most apparent in the efforts she made to facilitate psychiatric referrals, relieve financial difficulties and help the patient make a better adjustment. Interpretation was found to be very necessary on this service and it was felt that it could be extended still further to the patient's family, employers and agencies in the community. A need for further marital counselling was also evident in this group. In giving these services, however, it was found that the worker's help was limited somewhat by the patient's inability to relate or use this. Nevertheless, 19 patients showed some improvements in their skin

conditions and their capacity to adjust. In view of this, the question is raised as to whether the number of referrals should not be greatly increased and in accordance the worker's role broadened and enlarged to cope with this additional responsibility.

CHAPTER VII

Findings and Recommendations

In this study an attempt has been made to analyze the role of the social worker on the Dermatology Service and to evaluate her contribution on the medical team. This analysis has been based on an examination of the problems and needs of 30 skin patients who were known to the social worker over a period of three years. It was felt that an understanding of the needs of these patients in terms of their significance to the worker's role would enable her to give them more effective help. The findings are of limited value owing to the nature of the data from which the material has been drawn and the size of the sample group on which they are based.

Findings

The preceding chapter has shown that the worker has a definite contribution to make in facilitating the recovery of patients with skin conditions. It is apparent, however, that this contribution is influenced by the patient's ability to accept this help. This was especially true of a small group of patients, approximately eight, who could not accept the worker's services since they were unable to establish any kind of relationship with her. The reactions of these patients is not surprising in view of the fact that more than half of them came from emotionally unstable and deprived family backgrounds where they had been unable to experience a secure and healthy type of relationship with their parents. In spite of the deprivation which so many of the patients in this group had sufferred, the worker's help enabled 19 patients to deal more effectively with their problems and to make a more satisfactory adjustment.

The worker's contribution was also influenced by the age factor. The majority of patients were in the older age groups and, as a result, a change in their attitudes or patterns of living could not be so easily achieved as with a younger group. The question was raised as to whether the worker might not have given more effective services at an earlier period of their lives. It was found that there was a mean difference of at least eleven years between the time that the patient's skin condition began and the date of his referral to the social worker. By this time his condition had deteriorated into a chronic illness, his problems were more numerous and his patterns of adjustment had been set. As a result much of the worker's time was spent giving concrete services or in using other measures of a superficial nature.

The findings which were obtained from a study of the childhood histories of these patients were extremely pertinent to their later adjustments and the way in which they used the worker's help. In the majority of cases their marital, social and sexual relationships were inadequate. An awareness of certain factors in their backgrounds, however, enabled the worker to obtain a deeper understanding of their motivations and the meaning that the illness held for them. It was noted that the worker failed at times to obtain this information or to question the patient about his past history. This was unfortunate in view of the significance that this information had in relation to her ability to help him on a level that would permit him to gain insight into some of his underlying problems.

One of the most striking findings was based on an analysis of

the appearances and manner of the patients in this group. It was noted that, despite the deprivation that many of the patients had sufferred, they gave the impression of being poised and pleasant to the casual acquaintance. These traits were common to slightly more than two-thirds of the patients, and they were usually a facade since many of them were actually suppressing extremely hostile feelings. Due to their underlying hostility, suspicion and distrust, it was necessary for the worker to gain their confidence by taking steps on their behalf and by temporarily gratifying many of their dependency needs. Only in this way could she break through the patient's defenses and allow him to express his feelings and use her help in a more constructive way.

The fact, that several patients were conflicted about the need for dependence and their desire for independence, was important in terms of their reactions to illness and treatment. It was found that one-third of the patients were not following treatment and were using their illness to satisfy these dependency needs. The worker's function in giving interpretive services was helpful to these patients. However, it should be pointed out that in such cases they required additional insight into their reactions before this service could be regarded as really effective. This help which was directed toward enabling the patient to gain some understanding of himself was not always available.

In addition to emotional deprivation, more than two-thirds of the patients had sufferred from financial difficulties and other stressful situations. This was most evident among the older group where the

rate of employment difficulties was extremely high. Their anxiety and inability to face their situations made it difficult for them to cope with these problems on a realistic basis. The worker's help in reinforcing their ego-strengths by giving them support, encouragement and acceptance, enabled a large number of these patients to deal more adequately with their problems than they had done before. It was found that this group responded more quickly to her help than did those patients whose problems were related more directly to emotional difficulties.

Recommendations

The worker had been particularly helpful to a group of older patients who had been undergoing stress in their environments. She had not, however, had the same influence on patients who had emotional problems, partly due to factors such as age over which she had no control. A significantly large number of patients had deeper intrapsychic difficulties which were not within her domain to handle. In such cases a therapeutic type of relationship through which the patient could gain some insight into his problems was indicated. Thirteen of these patients had been referred for psychiatric treatment but only about half of them were responding favorably to this referral. The age factor and the duration of the disease had some significance in their ability to respond to both psychiatric services and casework help.

In view of this, it is recommended that an attempt be made to refer these patients to the social worker immediately following onset of the skin symptoms. To carry this out, it will be necessary for

the worker to interpret the importance of earlier referrals to the other members of the medical team, especially the doctor. This should not be difficult, since her contribution on this service has already been recognized, and since there is a good co-operative working relationship between the worker and the doctor.

The patient's environment, which has been found to play an important part in shaping his personality, should be dealt with more directly by the worker. Many of these patients have been either over-indulged or rejected by their families, and in such cases the parents may require as much insight and help as the patient. This can be done through further interviews and visits to the family, and through contacts with the employers and at times with the friends of the patient.

It has been impossible to make an adequate study of the parent-child relationships of these patients. This is unfortunate since they are of so much significance in influencing their subsequent reactions. Since the majority of parents were between 45 and 64 years of age, it was not expected that they would speak of their backgrounds in any detail. It is recommended, therefore, that a study be made of skin patients known to the social worker on the pediatric service as a complement to the present study. A comparison of the findings would be interesting to note. This would also be a further step toward understanding the needs of skin patients and the pertinence of this understanding in relation to the worker's role.

Despite the limitations of the present study, it has been valuable in demonstrating the medical social worker's contribution on the hospital team. Certain factors such as age, referral procedures and duration of illness have been shown to have an important effect on the amount of help the worker is able to offer patients with skin conditions. In addition, it was found that her services could be extended still further in many areas.On the basis of these findings, it is the writer's opinion that, the social worker could make a greater contribution in facilitating the treatment and recovery of skin patients than she now does. This would necessitate an increase in the number of referrals as well as a more broadened and intensive type of casework service.

APPENDIX

A. Tables

B. Schedule Form

SECTION A

Table 1

Classification of SKin Diagnoses for Sample Group of 30 Patients showing Incidence of each Disease, and Meaning of each Diagnostic Term.

Diagnostic types	Meaning of term	total incidence
Total.....		41
Dermatitis group	inflammation of the skin	
seborrheic	excessive discharge from sebaceous glands	5
contact	due to allergy	5
venenata	agent unknown	4
generalized		1
vesicular	of the nature of a vesicle- a small blister or bladder	1
perineum	a space or area between anus and genitalia	1
stasis	due to a stoppage of circulation	1
herpetiformis	resembling herpes	1
atopic	out of place, displaced	1
Eczema group	itching, inflammation and infiltration of the skin	
generalized		3
atopic	out of place, displaced	3
stasis	due to a stoppage of circulation	1
dyshidrotic	disordered state of perspiration	1

Table 1 cont'd.

scrotal	refers to scrotum	1
Other diagnoses		
ulceration	chronic and recurrent	2
herpes zoster	a skin marked by cluster of small vesicles	1
psoriasis	characterized by scaly red patches	1
pruritus vulvae	severe itching of the external female genitalia or pudenda	1
hemachromatosis	skin marked by staining with coloring principles of blood	1
folliculitis of legs	inflammation of a follicle or follicles	1
multiple furunculosis	diseased condition that accompanies appearance of boils	1
erythema multiforme	an acute variety with variously formed papules and tubercles	1
epidermaphytons	a genus of fungi causing tinea cruris (potentially infectious)	1
telangiectases	dilation of capillaries forming spots	1
pemphigus vulgaris		1

SECTION A

Table 2

Classification of Medical Conditions, other than Skin Diseases, in Sample Group of 30 Patients, Showing Total Incidence in each Category.(a)

Categories	Types of Illness	Total Incidence
Total.....		77
Accidents	burns, fractures, explosions	7
Operations	t & a, appendectomy, hysterectomy, hernias	10
Allergies	asthma, hayfever, rhinitis, simusitis	6
Mental and Emotional Disorders	psychotic, anxiety neuroses, depressions	8
Diseases of Genito-Urinary System	Miscarriage, cervicitis, P.I.D., V.D, genital inflamation, vaginitis	11
Diseases of Respiratory System	T.B, pleurisy, emphysema, pneumonia	7
Other Diseases	arthritis, varicose veins, obesity, malnutrition, cancer, cysts, peritonitis, heart murmurs	16
Vague Complaints	fatigue, dypsnea, fainting spells, headache, heart pains, stomach complaints, etc.	12

(a) These categories were arbitrarily selected by the writer.

SECTION B

Schedule Form used to obtain Record Material

1) IDENTIFYING INFORMATION

a. Name
b. Age
c. Residence (on referral to S.S.D.)
d. Nature of record material
e. S.S.I. information
f. Religion
g. Ethnic origin
h. Marital status

2) MEDICAL HISTORY

a. Dermatological diagnosis
b. Other medical conditions
c. History of skin disease
d. Present medical condition

3) REFERRAL TO S.S.D.

a. Date
b. Reason
c. By whom
d. Type and duration of contact
e. Present status

4) SOCIAL SITUATION

a. Physical living arrangements
b. Persons living with patient

5) STRUCTURE OF FAMILY

6) HISTORY, PATIENT AND FAMILY

a. Significant family history
b. Patient's past personal history
c. Work history, past and present

Schedule form cont'd.

7) PERSONALITY FACTORS

a. Caseworker's initial impressions
b. Doctor's impressions, if noted
c. Patient's relationships to others
d. Patient's attitude toward illness, and life in general

8) EVALUATION OF PROBLEMS

9) ROLE OF SOCIAL WORKER

a. Original plan
b. Actual help given
c. Referrals to other agencies
d. Evaluation of help and present status
e. Date of referral to psychiatry
f. Summary: Psychiatric evaluation

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