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Emotional problems of veterans with rheumatoid arthritis at the Veterans Administration Center Dayton, Ohio

Dorothy Monice Robinson

Atlanta University

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EMOTIONAL PROBLEMS OF VETERANS WITH RHEUMATOID ARTHRITIS
AT THE VETERANS ADMINISTRATION CENTER
DAYTON, OHIO

A THESIS
SUBMITTED TO THE FACULTY OF ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
DOROTHY MONICE ROBINSON

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA
JUNE 1961
DEDICATION

With deepest love and sincere appreciation for making my education possible, this thesis is dedicated to my mother, Mrs. Mary D. Robinson, for her constant love, encouragement, and support, and to the most understanding father one could ever wish for, Rev. Thomas Kilgore, Jr., for his confidence and assurance that it could be done.
ACKNOWLEDGMENTS

The writer wishes to gratefully acknowledge the following persons on the staff of the Dayton Veterans Administration Center for assistance given in completing this study, Mrs. Marie K. Oswald, Chief, Social Work Service; Miss Mary J. McHugh, supervisor; Dr. John H. Davis, Chief, Psychology; and all others who contributed to making this study possible. Appreciation is also extended to the faculty and staff of the Atlanta University School of Social Work, and special thanks to Miss Barbara Baskerville, my thesis supervisor, for her assistance and ability to inspire confidence in the writer.
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CHAPTER I

INTRODUCTION

Significance of the Study

Most experts in the field agree that there is a definite psychic influence in the occurrence of rheumatoid arthritis as well as the actual and observable somatic manifestations. It is felt that many of the day-to-day life experiences of individuals contribute toward the emergence and continuance of the disease.\(^1\) Characteristically, many of the persons with the disease have been described as "hostile and fearful of the intensity of their resentment to the point that they unconsciously encase their joints in cement so that they can't strike out against the world."\(^2\) Strong control of emotional expression is noted in adulthood and there is an obvious dependence upon others which is camouflaged by service to others and activity which is overtly masochistic in nature.\(^3\)

A definite tie-up is observable between the emotionally predisposing factors of the disease and the physical manifestations.\(^4\) It seems that

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3. Adelaide M. Johnson et al., op. cit., p. 490.

the disease is precipitated when incidents occur which might increase the
guilt feelings and hostility which previously had not been expressed and
had been handled through self-sacrifice of the patient and services to
others. Because of curtailment of adequate opportunities for self-sacri-
ficing services, the latent hostility and guilt may be mobilized. 1 It is
not unusual then, for an individual who is used to doing things for her
family with her hands to develop arthritis in the hand when there is no
longer a need for her services.

Rheumatoid arthritis is a disease that can be almost totally incapaci-
tating. The crippling effects may be so extensive that the individual is
completely bed-ridden. 2 It is believed that there are certain predisposing
tendencies, and these, coupled with the environmental forces, may cause a
person to be a victim of rheumatoid arthritis. 3 Those facets of the per-
sonality that seem most threatened by the onset of the disease are the
self-confidence of the individual and his sense of security. When there is
a serious threat, and there is indicated a noticeable decrease in either or
both areas, it is the duty of the social worker, along with the physician,
to provide substitute measures for those activities which had previously
kept the individual occupied. 4 Supportive casework services and casework
in relation to making new physical adjustments in terms of limitations

1 Ibid., p. 327.

2 James T. McLaughlin et al., "Emotional Reactions of Rheumatoid Ar-

3 Ibid., p. 188.

4 Ibid.
imposed by the disease might be indicated at this time as services that could be provided by the social worker.

In considering the personality problems which might face the rheumatoid arthritic, it is important to look at behavior that is regarded as normal or usual for persons with this diagnosis. Most of the theories regarding the psychosomatic nature of the disease are based on Freudian principles and are, consequently, related to the individual's performance in terms of sex. The findings are interpreted in the light of psychoanalytic beliefs also.  

The chronic nature of rheumatoid arthritis tends to create a social problem of dependency for persons afflicted with this condition. The dependency, in turn, seems to create complications for those attempting to treat the condition. It was at this point that the social worker at the Dayton Veterans Administration Center, as a member of the professional team, could often be of help in attempting to assist the rheumatoid arthritic in accepting treatment and understanding something of the nature of his disease. Referrals from members of the medical staff indicated that the rheumatoid arthritic patients were exhibiting problems in the areas of their family situations; accepting and responding to medical treatment; and maintaining good interpersonal relationships with hospital personnel or others outside of the family. An interest in these problems, as seen in

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the referrals, coupled with an interest that had been stimulated by written materials on the subject, provided the initial motivation for the writer to undertake this study.

Purpose of the Study

The purpose of this study was to describe the means of expression of the emotional problems found to be existent among those veterans in the sample with rheumatoid arthritis as their primary diagnosis. Emphasis in this study was placed upon showing the problems that were observed in male veterans at the Dayton Center with rheumatoid arthritis as their primary diagnosis.

Methods of Procedure

The group that was studied consisted of twenty cases of rheumatoid arthritic veterans at the Veterans Administration Center in Dayton, Ohio. The cases were studied by examination of clinical records made available by the Medical Records Library and case records of the Social Work Service department of the Center.

Material was gathered by the use of a schedule which was employed to gather facts pertaining to the personality characteristics exhibited by the veterans in the sample, and the means of expression of the emotional problems found to exist among the various veterans. The material that was obtained from the schedules is presented descriptively. Excerpts from the Social Work Service records are used here as illustrative material for the various personality problems that were found to exist. Psychologists, psychiatrists, and other members of the professional team were used as consultants for purposes of interpretation and clarification of the phenomena.
found to exist. The cases studied were taken from recordings done between September, 1958 and August, 1960.

Previous written materials such as books, magazines, pamphlets, and unpublished theses were used to obtain supportive theory for the ideas presented here, and to provide a theoretical basis by which the findings might be evaluated. Through the use of the various research methods stated above, it is the writer's opinion that the purpose of the study was satisfied.

Scope and Limitations

The material that was used in determining the kinds of emotional problems that were exhibited by rheumatoid arthritic veterans at the Veterans Administration Center of Dayton, Ohio, was taken from clinical records and Social Work Service records of twenty male veterans with this as their primary diagnosis.

The veterans represented several age levels, economic groups, and geographic localities. This did not have a bearing on the results obtained because rheumatoid arthritis is found to exist in all age levels, economic groups, and geographic localities.

The period of time allotted for this study included the period of time from October 1, 1960 through February 24, 1961 which was spent on block field work placement at the Dayton Center. Reading materials were taken from the files of medicine, psychology, and social work.

The fact that the group which was studied consisted only of males may have had some effect on the reliability of the conclusions that were drawn because comparatively little is known of the effects of the disease upon
the male personality due to the fact that there has been more study of females.¹

The study was limited in that only those veterans with Social Work Service records were studied. The study was limited further by the fact that the records were not written for purposes of research, and some data were incomplete. A final limitation of the study was the lack of research experience of the writer.

¹ Adelaide M. Johnson et al., op. cit., p. 492.
CHAPTER II
AGENCY SETTING

The Veterans Administration

The original bill that established care for disabled veterans was signed by President Abraham Lincoln on May 3, 1865. At that time, the facilities designated were referred to as National Asylums for Disabled Volunteer Soldiers. Dayton was one of the first three Asylums authorized, and the name "National Asylum" can still be seen engraved in stone on the outside wall of the present Protestant Chapel. The name was officially changed to the National Home for Disabled Volunteer Soldiers on March 9, 1872. By an act of Congress, July 3, 1930, the National Home for Disabled Volunteer Soldiers was incorporated, with other federal agencies operating in behalf of veterans, in the Veterans Administration.¹

The Dayton Center

The Dayton Center today is one of the largest field stations in the VA service. It is located on a 600 acre tract at the western edge of Dayton. The Center consists of two hospitals and a Domiciliary program. Brown Hospital, which is a general medical and surgical unit, has 630 beds, and Patrick Hospital, which is devoted specifically to the care of the chronically ill, has 182 beds. The hospitals are equipped with excellent modern medical facilities. The medical program is affiliated with the

¹ High Lights - Dayton VA Center, (Mimeographed Information Sheet, VA Center, Dayton, Ohio) n.d.
The Domiciliary has 1,600 beds, organized in eight sections. Members are housed in seven buildings. Four of the sections - Sections 18, 19, 20, and Miller Cottage, have their own dining rooms. Miller Cottage is for women who have served in the Armed Forces. Sections 18 and 20 can accommodate wheel chairs, blind, and members who, in general, are physically unable to live in the other sections.

The Domiciliary provides a sheltered environment in which the individual member has considerable responsibility for his own treatment and participation in activities of a therapeutic, rehabilitative, and recreational nature. Help is available for medical, social, psychological, economic, and rehabilitative problems. It is necessary for the members to seek this assistance. It is not possible to provide continuous observation of members and there are no areas provided of a security nature, except as a very temporary measure. Members are free to come and go from the Center, except as they are scheduled for medical appointments, constructive and activity assignments, and bed checks. They can discharge themselves from the Domiciliary at any time at their own request.

The veterans who live in the Domiciliary present many different medical problems. Several of the members have physical disabilities which would hamper their attempts to function adequately on the outside. Rheumatoid arthritics comprise a large number of those veterans living in the

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1 Fact Sheet 15, Revised, Veterans Administration Center, Dayton, Ohio.

2 Information Regarding Domiciliary, Veterans Administration Center, Dayton, Ohio.
Domiciliary, although some had secondary diagnoses, because of an inability to manage elsewhere due to the crippling and incapacitating effects of their disease.

Social Work Service

Today, Social Work Service is an integral part of the medical program at the Dayton Veterans Administration Center, although this was not always the case. Social work received its beginnings during World War I when the American National Red Cross served in the National Homes. From that time until the late forties, when the entire social work set-up was reorganized, there were many shifts and varying focuses of interest. The publishing of the Manual for social work in 1950, and the Program Guide which followed in 1956, completed the process of establishing standards for social work in the Veterans Administration and serve as guides for good social work practice. Today, the procedures followed by social work in the Veterans Administration are regarded by many as the standards for the country, and these standards are widely imitated.¹

The Chief of Social Work service is directly responsible to the Chief of Professional Services, and, through him, to the Manager of the Station. (See Chart I, p. 10). She is a member of the Administrative Staff, the Domiciliary Admissions Board, and the Dayton Community Welfare Council.

The services of the Social Work Service department are extended to patients on all wards of the hospital units, and to the members of the Domiciliary. In addition to the Chief of the service, there is also an

¹ Interview with Mrs. Marie K. Oswald (Dayton VA Center, Dayton, Ohio, January 17, 1961).
Assistant Chief; two full-time workers, who are also student supervisors; four other full-time caseworkers; one part-time worker; and four clerical personnel. (See Chart II, p. 12). At the time that this study was conducted, there were three students from accredited schools of social work who were completing their second year of training on block field work assignments, and one student who was completing his first year of concurrent field work training.

Social Work Service attempts to help patients and Domiciliary members to make maximum use of the VA benefits available to them while they are in the hospital or Domiciliary. As many Domiciliary members as possible are helped to return to normal community life, and those who will receive prolonged care are helped to create plans that will enable them to carry out medical recommendations made at the Center, and to effect a favorable transition to home and community life.

Patients with rheumatoid arthritis are served by workers in all units of the Center, although most of the patients with rheumatoid arthritis as their primary diagnosis may be found on the medical service of the hospital or in the Domiciliary. Generally speaking, services provided to these patients fall within the usual range of services offered by the department.
CHART II

SOCIAL WORK SERVICE ORGANIZATIONAL CHART, JANUARY, 1961

Chief, Soc. Wk. Serv.

Secretary (Steno)

- Clk. Steno.
- Clk. DMT

Clk. Steno.


Sr. Cl. Soc. Wkr.

- Dom. Supvr.

Sr. Cl. Soc. Wkr.


Resident Supvr.

Cl. Soc. Wkr.-Dom

Cl. Soc. Wkr. - NP, NS, Adm.

Cl. Soc. Wkr. - TB (FT)


Resident Supvr.

Cl. Soc. Wkr. - Patrick

Cl. Soc. Wkr. - TB (FT)
CHAPTER III

RHEUMATOID ARTHRITIS AS A MEDICAL PROBLEM

There are many definitions to be found for rheumatoid arthritis; however, for the purpose of this study, the writer felt that the definition found in Cecil and Loeb's Textbook of Medicine was most comprehensive. These authors defined rheumatoid arthritis as:

...a systemic disease of unknown etiology in which symptoms and inflammatory changes predominate in articular and related structures. Course is extremely variable, but tends to be chronic and to result in characteristic deformities. ¹

Determining Factors in Occurrence

Precipitating factors in the occurrence of rheumatoid arthritis seem not to have a general nature. It appears that any stressful or traumatic life experiences may serve as precipitating factors. It has been found that the first symptoms often will appear after strenuous emotional or physical experiences. Fatigue, worry, exposure to dampness and cold, and chronic infection, as well as a general lowering of physical resistance, also often precede the onset of the disease.²

Familial tendencies toward rheumatoid arthritis.-There is some evidence that the tendency toward the disease is inherited and "runs in the family."³ Consistently, however, studies have shown that the disease is


³ Ibid.
more prevalent among females and seems to be passed to the females in a family.

Of the twenty cases studied at the Dayton Center, it was observed that four veterans reported a history of rheumatoid arthritis in the family. In two of those cases, the person having had the disease was the mother and in the other two, the father. None gave a history beyond the generation of their own parents. These figures would not lend support to the genetic theory of the disease, but this may be explained by stating that in most other studies examined by the writer, the subjects were females, and the sample in this study consisted entirely of male patients.

In keeping with the theory that there is a strong emotional overlay to the disease, even in relation to familial tendencies, it has been found that, in studies conducted previously with female patients, certain family situations were found to exist and to be typical. Usually, there was found a strong, domineering, demanding mother and a more gentle, compliant, or absent father.¹

In the group studied, there were indications that there had been strong, dominant women in the early lives of these patients, who were either mothers or older sisters. One such case that illustrated this was that of Mr. K., a forty-eight-year-old patient. The caseworker's recording stated that:

Veteran claims that his mother was always babying him, watching over him like a hawk when he was little. She seemed to go from one extreme to another of over-pro-

¹ Adelaide M. Johnson et al., op. cit., p. 491.
taction to a critical attitude if the vet did not succeed. Love and perfection were always demanded.

This case illustration showed, in part, the family background of one patient. In six of the other cases, there were also other indications of dominant females in the formative years of the veterans' development.

Physical or emotional experiences connected with onset.—Among the generally accepted theories regarding causes of onset, it has been found that certain physical and emotional experiences rank high as contributing factors. The influence of certain psycho-dynamic factors has been given a great deal of consideration in some areas. Several of the veterans studied for this presentation gave some indications of connecting certain physical and emotional experiences with the onset of their conditions.

In four of the twenty cases, there was no specific incident or experience related, but the symptoms of the condition seemed to have appeared while the veterans were serving in the Armed Forces. Because it is generally accepted that life under military restrictions is quite different from civilian life, with many new and unusual experiences, it is possible that stress factors played a part in the occurrence of rheumatoid arthritis in these veterans. However, this cannot be stated definitely and conclusively because of the fact that the causes of rheumatoid arthritis have not been settled upon and it is currently felt that no one factor serves as a cause for the condition.

Two of the veterans attributed the onset of their conditions directly to sleeping on damp, cold ground, and having to cope with unsanitary living quarters and conditions while in service. These factors, too, are

1 Ibid.
in keeping with the theory postulated in the publication of the Arthritis and Rheumatism Foundation, *Diet and Your Arthritis*, which proposed that "exposure to cold, dampness, and chronic infection" often precede the onset of the condition.

Of the three other veterans who traced the onset of their conditions back to a particular incident or experience, it was found that one attributed the onset of his condition to an injury to his foot; another felt that his condition started when his wife divorced him, and he began to experience severe pains in his legs; the last veteran stated that his symptoms appeared immediately upon his discharge from the Army. In this case, it was quite possible that the Army had provided a place of security and safety for the veteran. The caseworker's recording indicated that prior to his induction into the service, he had lived at home with his mother. This is the case of Mr. M. that was cited previously.

Since his discharge from the Army, Mr. M. has experienced a great deal of pain as a result of his arthritic condition. Although he does not get along well with his mother, he repeatedly insists upon being given passes to go home while he is in the hospital, but returns each time in worse condition. The patient shows every indication of being almost completely dependent upon his aging, but very domineering mother. He has never married or spent any time away from home except for his period in the Army and his periods of hospitalization.

This illustration represented the classical picture of the strong dependency needs of the individual, as well as the family situation in which there appeared the strong, dominant female.

**Treatment Methods**

*Medical treatment.*—The basic treatment for rheumatoid arthritis has remained rather conservative. Relieving the everyday pressures of modern living is an integral part of this plan. One purpose is to improve the
general health so that the patient will be able to resist and overcome the disease himself. Rest, relaxation, and a nutritious diet are a part of this effort. Drugs are used to lessen pain and inflammation. Physical therapy helps to prevent deformity and maintains muscle power and joint motion.¹

There is, so far, no cure for rheumatoid arthritis. However, medical science can do a great deal to control it, to reduce its pain and crippling effects. Serious crippling can be prevented in seven out of ten cases, provided treatment is begun promptly.² Of the twenty cases in the study that were treated at the Dayton Center, nine patients were observed to have had severe crippling. However, in all but two of these cases, the crippling had taken effect prior to the veterans' admission to the hospital. In the other cases, the crippling process could not be controlled by methods employed in the hospital.

For pain, the salicylate compounds - the commonest of which is aspirin - are still the safest, cheapest, and among the most useful of drugs in its treatment. Doctors believe that these drugs do more than just control the pain of arthritis and that they exercise some beneficial effect on the ailment itself.³

Certain hormones, such as cortisone, can diminish inflammation, thus reducing pain, swelling, and stiffness. Injection of gold compounds may


² Ibid.

³ Adelaide M. Johnson et al., op. cit., p. 297.
temporarily curb development of the disease in some cases. There are certain other new drugs such as chloroquine and butazoladin that are being used in attempts to alleviate pain and other symptoms of the disease.\(^1\) All of the latest methods of treatment are being employed by physicians at the Dayton Center. Each case has to be treated individually. Doctors sometimes prescribe medications, remedial exercises, bed rest, and heat treatments. In advanced cases, casts, splints, or surgery are sometimes found to help.

Of the twenty cases studied at the Dayton Center, five veterans were receiving medications only; four received physical therapy only; four were being treated with bed rest and medications; six were receiving physical therapy and medications; and only one was receiving bed rest, physical therapy, and medications.

Response to medical treatment.—Because rheumatoid arthritis is such a difficult ailment to treat, and so little is known concerning causes, there are few predictions that can be made concerning expected gains from treatment. All but one of the cases in the sample that was used for this study showed some gains from the various types of treatment methods discussed above. The one case that did not show improvement was in the category of those receiving treatment of bed rest and medications. In the doctor's opinion, that veteran had progressed too far for anything other than some relief from the pain which was provided by the medications.

Social workers' role in facilitating treatment.—It has been stated that arthritic patients generally show resistance to taking help either verbally.

\(^1\) Ibid.
or in tenseness of their bodies. In such instances, the physician may encounter a total defense of mind and body.\(^1\)

Generally, because the physician is concerned with and engrossed in administering medical attention, he does not have the time to treat the emotional problems. In a setting such as the Dayton Center, where the team concept prevails, it is the social worker who then becomes active on the case to help treat the whole patient.

Areas in which the social worker might be of help, according to Bessie G. Schless, include:

...helping the patient to accept the realities of the hospital and the health services it is designed to render, and providing clarification around specific medical recommendations made by the physician. In order to do her job effectively, the worker must deal with the patient's unconscious feelings about his illness and be aware of unconscious motivation for behavior. The worker does not attempt to displace the psychiatrist by dealing with the patient's intense feelings on other than the conscious level. Acknowledging differences between herself and the psychiatrist, she shares with the patient that difference and confines the scope of her helpfulness.\(^2\)

It was found that the approach used most often by the workers at the Dayton Center was that of using the limits prescribed by the physician as a basis for their discussions with the patients and taking back to the physicians an evaluation of the ways the patients were using the recommendations. Through a sharing by the physician, of the patients' physical reaction to illness, and giving full recognition to the emotional factors at work in the situation, treatment became dynamic and an integrated use

\(^1\) Bessie G. Schless, op. cit., p. 214.

\(^2\) Ibid., p. 220.
of therapeutic measures was evolved which was geared to the individual needs of the patients.

Patients' responses and attitudes toward workers.—Although none of the veterans refused to cooperate, only five gave indications of active participation; nine were apathetic; and six cooperated unwillingly. One of the problems usually encountered in arthritics is that of dependency. This characteristic was illustrated in the group that was employed for this study by the various attitudes that were found to exist regarding the degree of cooperation with the social worker and the willingness to cooperate with treatment plans.

One important goal in the treatment plan is the avoidance of deformity. The patient must be helped to accept full treatment and cooperate totally with his physician. Because of the incapacitating effects of the illness, it was often found that patients reacted with prolonged periods of depression. One such case was that of Mr. T., a sixty-eight-year-old veteran of World War I, who was seen at the request of his physician in an attempt to help rid the patient of his depressed feelings. It was found that Mr. T. would spend long periods of time sitting in his wheel chair, speaking only when spoken to, and sometimes not at all.

Mr. T.

At this time, he does not know what his future can be. He knows he and his wife cannot manage alone. He does not believe they can find anyone who will take care of them in the home. He cannot see living with his daughter because of the son-in-law. He does not want to sell their present home. Patient raised objections to every possible plan at this time.

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1 H. M. Margolis, "Care of the Patient With Rheumatoid Arthritis," op. cit., p. 326.
In this case, talking with the worker seemed to help the patient with his problems, although there were no changes in his home situation. The veteran remained hospitalized, while his elderly wife went to live with their daughter and her family, but the veteran no longer exhibited the behavior that had been indicative of the depression that he had shown prior to his contact with the worker.

Another case in which the primary cause of concern to the physician was depression, was that of Mr. S., a fifty-two-year-old World War II veteran who was referred to Social Work Service by his physician.

Mr. S.

Patient is observed to be underweight and nervous. He has very little to say to other patients on the ward or to ward personnel. Several contacts with this patient have uncovered the fact that he is extremely unhappy about divorce proceedings that are being initiated against him by his wife. Mr. S. feels that he is being done an injustice and fears the prospect of growing old alone.

Although the literature on the subject stated that the reactions seen most often in females are hyperactivity and restlessness, a difference was found in the reactions of these male patients studied. In all but three of the twenty cases studied, there were indications of a depressed reaction prior to hospitalization and during the period of hospitalization.

Secondary Diagnoses

As was the case in other studies reviewed by the writer, a few of the veterans in the sample had other diagnoses that were being treated and which might have produced symptoms and problems unique to the secondary diagnoses themselves. In some of the cases having secondary diagnoses,

\[\text{Ibid.}, \, p. \, 327.\]
the findings that were observed seemed not to agree with the general trend of problems found in other veterans in the sample. Both physical and psychiatric disorders were encountered as secondary diagnoses among these veterans.

One case of a veteran with a physical secondary diagnosis illustrating a pattern that differed from the others, in that the veteran was fiercely independent, agreeable with others, and able to plan and cooperate with the worker was that of Mr. G., a seventy-year-old- World War I veteran who had a diagnosis of Parkinson's Syndrome, a disease that affects the nervous system, and which produces marked reduction in coordinated functioning.¹

Mr. G.

Veteran seems to have always been able to function independently. The family relationship was always a warm and friendly one, and consisted of three brothers who, according to the veteran, were willing to help each other whenever some type of help seemed to be indicated. Veteran stated that he felt that he could turn to his brothers for assistance if it were necessary, but he was desirous of making his own plans with the worker. He exhibited no difficulties in relating to others. Veteran stated that he had a very good and warm relationship with his children who were grown and had families of their own.

Although this veteran exhibited problems, and required help, assistance could be given, but in a different area from the others.

Appel and Rosen state that the occurrence of psychiatric disorders is rare with rheumatoid arthritis² but the following case excerpt illustrates

some problems experienced by a person having a psychiatric diagnosis of a "schizoid personality with many passive-dependent features." It is the case of Mr. P., a thirty-nine-year-old veteran of World War II.

Mr. P.

Veteran has always held minor jobs. He apparently had difficulty in adjusting to life without his parents, and has always relied heavily upon his older sister. He states that he doesn't particularly like his sister, but can't seem to get along without her, and defends her against other members of the family who think that she is too "bossy." He is unable to stand up to his sister — feels that he must submit to her wishes.

Possibly because of the deeply-rooted feelings of this veteran around needing the guidance of his sister, the worker was not able to treat the case to the point that he felt that he could function independently, or without his sister. Evidently, the problems of this veteran were more serious than those of the other veterans who could deal with their dependency needs and adjust to them or shift the dependency to some other object. This veteran required psychiatric treatment, which he was able to receive.

Accompanying the problems of dependency and negative attitudes encountered by the social workers in dealing with the arthritic patients, there often existed other emotional problems that manifested themselves in various areas of the veterans' lives. Among the other areas that were seen as problematic were interpersonal relationships with family members and others, and economic problems. The next chapter deals with some of the problems found to exist in these areas.
CHAPTER IV

THE EMOTIONAL FACTORS OF RHEUMATOID ARTHRITIS

Literature on the subject generally agrees on the age of onset of rheumatoid arthritis being middle age - the late thirties and early forties. The group that was employed for this study gave indications of differing from the usual age range. The symptoms of twelve of the veterans appeared between the ages of the late twenties and thirties; six began experiencing symptoms between the late thirties and late forties; and four did not experience any symptoms at all until they were past the age of fifty. These figures differ from those of other studies, but, again, it must be noted that this was an entirely male sample, and the writer was unable to find previous materials based on studies conducted with males for comparison.

Family Situation

Living arrangements other than with wives and children. In some of the cases that were studied, it was found that the veterans and their families sometimes had to move in with other members of their families, or had relatives other than wives and children living with them. Still other veterans lived in situations such as the YMCA and Salvation Army Shelter. Arrangements such as these seemed to be the source of problems for a few of the veterans, and, in other cases, the arrangements had resulted from social problems.

1 Adelaide M. Johnson et al., op. cit., p. 491.
The case of Mr. Z., that of a forty-eight-year-old single veteran of World War II, was an example which illustrated several of the problems that were observed in patients living away from their families.

Mr. Z.

We found that Mr. Z. shared information readily, but became uncomfortable when we pursued any topics into the area of his feelings and attitudes about them. This patient is the youngest of two boys of a farm family. He related that both parents came from farm families. Patient told us that he liked farming very much as a boy, helping his father with various chores when not attending school. He had never given consideration to any other type of occupation until his father committed suicide when veteran was twenty years old. Veteran became quite uncomfortable in talking about his father's death, and maintained that it was a shock for the entire family since they had all considered the father to be a very stable, industrious, and prosperous farmer.

He was seen by Social Work Service prior to a psychiatric exam and we felt he was a very dependent, inadequate person who had a very poor living situation at the "Y" and saw himself as being totally disabled. In view of patient's poor living situation and inability to see himself as being useful to society, we felt he could benefit from Family Service contact regarding a change of his living situation and the possibility of considering part-time employment since this was medically recommended to him and considered wise, because it was not healthy just to lie in bed all day, as he had been doing.

This case illustrated the inadequacy of the veteran's own personality and acceptance of his diagnosis as a final and conclusive situation.

Emotionally, the veteran was quite upset and unstable. He substantiated the theories regarding other findings of traits found in female rheumatoid arthritic patients.¹

Five of the twenty veterans lived in their own homes with their wives and children; six veterans lived in rooming houses (including the YMCA and Salvation Army Shelter); two veterans lived with older sisters and their

¹Ibid., p. 492.
families; three veterans lived with their wives' families; one lived with his mother; two veterans lived with their daughters and their families; and one veteran had his father-in-law living with him and his wife.

**Exhibited difficulties in interpersonal relationships with family members.** Flanders Dunbar observed instability in the early home life to be a rather common factor in a study that she conducted with female rheumatoid arthritis patients. She found that most of her patients were reared by females. Although the mother was often harsh and punitive, there was a definite preference for mothers over the fathers.¹

The veterans who were employed in the present study indicated problems similar to those observed in Dunbar's study. Of the twenty cases in this study, twelve indicated that they had had problems with either their immediate families or had experienced difficulties with family members in the process of growing up. Of the seven veterans who reported difficulties in early family situations, all but one stated that they were raised by both parents, but felt that the mothers had been the dominant persons in the family groups. The prevailing atmosphere in these homes was general lack of togetherness and rigidity of parents, and punitive attitudes toward children were exhibited.

The case of Mr. Z., previously cited, was one in which there were strong ties between the veteran and his mother. Although Mr. Z. did not live at home, with his mother, he felt that his mother should always be consulted, and visited her and his step-father each weekend, from his place at the YMCA.

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¹ Flanders Dunbar, *op. cit.*, p. 263.
Five other veterans indicated that they were experiencing difficulties with members of their families, but had experienced pleasant and warm family relationships while growing up. Difficulties in this area seemed largely to be between the patients and their wives, although one veteran was experiencing difficulties with an older sister with whom he was living.

One veteran, Mr. A., a sixty-five-year-old World War I veteran, experienced rather severe emotional problems because of his difficulties with his wife. The veteran exhibited a marked depressive reaction and his physician referred him to Social Work Service because he saw the veteran's wife's rejection of him as being the prime factor in the cause of the depression.

Mr. A.

Veteran's daughter told us that vet had married her mother about thirty-five years ago, and had two children, although the marriage culminated in divorce when the children were quite young. Mr. A., who is quite a pessimistic, discouraged individual, is also self-depreciative and attributes his divorce to his excessive drinking. The son, who identifies with the mother, agrees that this is the reason that vet has never amounted to anything - because of his excessive drinking. However, his daughter, who identifies with the vet, minimizes the vet's drinking problem and describes the mother as a flighty individual who has always enjoyed chasing men, but can never remain true to one man for very long.

About fifteen months ago, vet and his wife decided to effect a reconciliation and lived together for about three months. The wife left the vet then and now is reported to have several new boyfriends. Subsequent to this separation, vet has become increasingly withdrawn, stopped drinking and smoking entirely. Mr. A.'s daughter, quite concerned about her father's marked weight loss and apathy, brought vet to live with her about seven months ago. However, his downward trend seemed to continue.

In this case, contacts were continued with the veteran and his daughter and he was finally able to realize that his daughter really wanted him in her home and that he could have an active voice and participating role in her family. Although there were still feelings about rejection by his
wife, the veteran's physical condition improved, and he was able to leave the hospital.

Economic Situation

Economic problems may be expected to accompany any period of illness today, due to the rising costs of hospitalization. Persons with rheumatoid arthritis may expect to have an unusual amount of difficulty with the management of their economic situations because, often, the person afflicted, is unable to continue working and must depend on someone else to provide for the family. In addition, to this, when the head of the household is no longer responsible for providing for the family, he loses the status that accompanies this position, and not only is unable to make decisions for the family, but is also allowed a greatly reduced amount of participation in deciding upon vital family issues. Situations such as these, create even more problems, and definitely hinder the treatment and rehabilitative processes.

Employment of veterans or other means of income.—Thirteen of the twenty veterans had been employed prior to their admission to the hospital and were able to return to work upon discharge. In two of these cases, however, it was necessary for the veterans to change the type of work that they had been doing. Three of the veterans had not been employed prior to admission, but were able to go to work on a limited basis after discharge. The other four veterans were maintained by insurance checks, retirement pensions, and government pensions.

1 Bessie G. Schless, op. cit., p. 213.
In those cases where changes were necessary regarding the employment capabilities of the veterans, the service provided most often by the social workers was in the area of helping the families to adjust to a new plan, while helping the veteran into an active role in the family. Although many of the patients exhibited strong dependency needs, the workers attempted to show the veterans and their families that they could be depended upon as necessary persons in the family. In one case, that of Mr. L., a forty-two-year-old World War II veteran, the worker was able to help the veteran and his wife see the curtailment of his working as a partial advantage. Because he could no longer work full-time, he was spending more time at home and had guilt feelings about not working. The worker's contacts with the family were in the area of involving Mr. L. more in the child-rearing process and helping him to accept his limitations as not being all bad because he was provided an opportunity to spend more time with his children. After many contacts with the worker, the veteran and his wife were helped to accept this attitude, although the wife had resisted initially because she had some jealousies about her role with the children.

Persons other than veterans employed in the households.—In four of the twenty cases studied, wives were working to help provide for the families. In one other case the veteran was living with his sister who was responsible for the financial burdens of the home. Those cases that presented working wives had certain factors in common. In each case, there were initial feelings of extreme resentment by the veterans that they were dependent upon their wives for support. One case that illustrated the types of disagreements and conflicts found to exist among the patients in this category.
was that of Mr. T., a forty-two-year-old veteran of World War II who had to resume employment on a limited basis upon his discharge from the hospital and his wife had to go to work to help provide for the family of five children.

Mr. T.

Yet is seen as a very dependent person, but one who wants others to be dependent upon him and appears to gain satisfaction by being of service to them. He appears composed emotionally and seldom expresses feelings overtly.

When vet was admitted to hospital, he had been working as a foreman in a steel mill and was building a home for his family and buying a new car. The idea of having to let these things go was very difficult for the vet to accept. Vet and his wife are having conflict over the necessity of her going to work in order that the family may continue with present plans, although this may be worked out, with wife gone from the family for a short while each day. Mrs. T. appears able to handle and accept the dependency needs of her husband. She recognizes his feelings of wanting to be the dominant person in the household and makes an attempt to bolster his feelings by giving him her pay check each week and allowing him to budget the family's expenses.

Worker believes that there are strong emotional involvements in his illness. It took many interviews before he told of his previous difficulties with managing finances, and then, he tended to minimize them. He also said he and his wife seldom discuss their losses.

The focus of the caseworker on this case was on trying to help Mr. T. express his feelings more freely, see his situation more realistically, and motivate him toward recovery. These goals were achieved, in part, in that Mr. T. did get to the point that he could accept the necessity of having his wife employed, as well as the necessity for securing a loan to help the family through an emergent financial situation.

Extent of veterans' cooperation in solving problems. The case illustration employed above indicated a situation in which there was very little active participation on the part of the veteran. In most instances, Mr. T.
was apathetic and allowed plans to be made for him. Figures for the other veterans showed that although more than half of the veterans studied entered in active participation with the workers in solving their problems, nearly all of these patients required a great deal of support in making decisions, or depended entirely upon the workers to plan for them. Only four of the veterans were unwilling to cooperate or refused to cooperate and, in those instances, the veterans usually had plans of their own that they wanted to try. Although the workers were pleased to have patients present solutions to their own problems, it was sometimes difficult when the patient insisted that only his plan could work. One such case was that of Mr. B., who was rather severely crippled by the disease and ready for discharge. Mr. B. had decided that he should get a room in a rooming house and could be responsible for his own food, laundry, and other personal needs. The worker’s suggestion of securing a boarding home was repeatedly turned down by the veteran although his physician had told him that he could not manage alone in a rooming house with full responsibility for his own needs. After much time spent in discussions with the patient, he was helped to accept a boarding home, rather than a rooming house situation.

It was the worker’s opinion that the patient was trying so hard not to appear to be leaning or depending on anyone else that he failed to see the reality of the situation, in that he was physically incapable of caring for all of his own needs. As soon as the veteran was able to accept the fact that he might need some assistance, occasionally, it was not too difficult to find a home where he could be placed. Before the problem was solved, however, the worker had undergone much hostility expressed by the patient. Bessie G. Schless stated that:
...worker must be strong enough to help patient express and bear the brunt of his angry feelings toward her and the medical services with which she is identified. In forcing the patient to feel positively about her and toward the services she represents, she blocks him from full use of a relationship that supposedly gives him freedom to be himself in the experience of being ill.¹

General Evidences of Difficulty in Adjusting to Life Situations

The emotional stress that goes along with illness may produce changes and often involves a re-orientation of the sick person's way of living. It is felt by some authorities that the personality picture of rheumatoid arthritic patients is overlaid by a chronic psychologic adaptation of the personality to the state of being crippled.² This adaptation of the personality, in turn, influences the way in which the individual is able to adjust to life generally.

Difficulties with hospital personnel and others. The majority of the patients studied at the Dayton Center did not exhibit significant problems or difficulties in getting along with other persons. Of the twenty cases studied, only four exhibited the tendency to have difficulty in nearly every situation in which they found themselves, as well as difficulty in getting along well with various persons.

One case of a patient who exhibited this tendency was that of Mr. J., a twenty-nine-year-old veteran. This patient had problems with military personnel while in the service, quarreled frequently with his wife, could not get along with his employer, caused trouble on the ward, and was hostile

¹Ibid., p. 220.
²Adelaide M. Johnson et al., op. cit., p. 496.
with the social worker.

Mr. J.

Vet's symptoms of rheumatoid arthritis developed while he was in the Marines. During that time, he gave his superiors much difficulty, requesting excuses from various work details because of his aches and pains. Military records indicate that Marine companions became very upset and annoyed with these antics.

Vet married early and states that at the time of his marriage he was not ready to settle down. He spent long periods of time away from home, leaving wife and baby. He has never liked his job, and feels that his boss picks on him, and has incurred several large bills, for which creditors are constantly pressing for payment.

Since he has been in the hospital, vet has managed to upset the ward completely, because of not desiring to follow regulations and not wanting to cooperate with the medical staff in treatment plans. Aides have complained about various remarks that he has made and the security guards have complained about vet's car that he insists upon leaving parked on the grounds. Patient's attitude with worker has been that of sullenness and hostility. He seems to feel that he never got a "fair break" and everyone is "out to get" him.

It appeared that the veterans in this sample presented many evidences of having had emotional problems that were a source of concern for those coming in contact with them professionally, as well as family members who had to live with them. Although all of the problems were not of the same nature of those observed in other groups studied, they were the basis for concern and treatment at the Dayton Center.
CHAPTER V

SUMMARY AND CONCLUSIONS

Painful and crippling, arthritis is the most widespread chronic disease in the United States. Rheumatoid arthritis, the most ravaging form of the disease, centers its attack on the joints and connective tissues, and has a destructive effect upon the entire personality. Approximately four million Americans suffer with rheumatoid arthritis. It is recognized as this country's Number one crippler. ¹

As seen by the writer, the emphasis at the Dayton Center is placed upon concerted efforts of the entire professional team in an effort to deal with the crippling and handicapping effects of the disease, and to assist the patient in making the best possible adjustment to the hospital routine and necessary changes in his way of living upon discharge. Because of the emphasis upon treatment of the total person, few patients with chronic diseases, such as rheumatoid arthritis, are ignored, or left alone to cope with their problems. The role played by the social worker is a vital one, and lends much meaning to the treatment process.

Veterans are treated in the hospital units, as well as in the Domiciliary. The emphasis in the hospital is mainly upon the rehabilitative area of treatment, whereas in the Domiciliary, the emphasis is placed more upon providing shelter for those arthritics who are unable to function independently on the outside. Although medical treatment is available to those living in the Domiciliary, those patients must assume the initiative in

securing medical attention when there is indicated a need and also in contacting the social workers assigned to the Domiciliaries.

Occurrence of the disease did not seem to be related to any genetic system with these subjects. Only four of the twenty veterans reported histories of rheumatoid arthritis in their families. This suggests that although the tendency for the disease is thought to be hereditary, this may be the case only with female patients or may not be true at all.

It was found that of the sixteen veterans who responded favorably to medical attention and treatment, fourteen of them reacted in a like manner with the social workers. Although this was not worked out statistically, there seemed to be a high degree of correlation between these factors.

Although it may be true that the average lay person thinks in terms of rheumatoid arthritis as a disease of old age, this is not true. Studies that have been conducted with female victims have generally agreed upon young adulthood to middle age as being the time when one is most likely to contract the disease. The sample employed in this study, consisting of twenty male patients, showed a slight variation in age of onset in that the veterans tended to have developed symptoms in early adulthood, with a few developing symptoms later. This did not suggest a significant difference, but, rather, a tendency for males to develop the disease earlier, where there is a predisposition to it.

A possible explanation for the preponderance of males contracting the disease at an early age is the factor of stress and the role that it plays in the occurrence and continuance of rheumatoid arthritis. Nine subjects employed in the study indicated that the appearance of the disease occurred simultaneously with, or shortly after, some stressful situation in their
lives. Six of the twenty veterans were service-connected for their conditions, which might have indicated dependency, in terms of using the disease to obtain compensation from the government. These veterans were also quite dependent in their relationships with the workers.

Factors such as mother-dominated homes, or fatherless homes seem to be a major contributing portion of the disease. Parents of those with the disease have been found to be harsh, restricting, and punitive. There did seem to be a trend toward preference of mother over father, although the mother was usually the harsher of the parents.

The findings in this particular study seemed to support the theories that the early childhood environment has a strong bearing on the occurrence of the disease in that twelve of the veterans reported unsatisfactory family relationships while growing up and these seemed to carry over into their own homes and family relationships in some instances. Three veterans reported difficulties with domineering mothers.

In the area of those characteristics that are recognized as being most often associated with rheumatoid arthritis - dependency and hostility - the subjects in this study seemed to conform with the ideas regarding dependency in that sixteen veterans required a great deal of support in functioning. However, there were not very many indications of overt hostility. This might perhaps support McLaughlin's theory that male patients show a tendency to be retiring and female patients show inclinations to remain constantly active.\(^1\) This theory allows for the possibility of the existence of concealed hostility by the veterans, or an absence of it, altogether.

\(^{1}\) James T. McLaughlin \textit{et al.}, \textit{op. cit.}, p. 189.
Problems experienced by veterans in the sample seemed to follow the general types of problems found to exist in rheumatoid arthritics in other studies. The veterans in the sample exhibited difficulties with family members, employers, other patients, and other persons with whom they were in contact throughout life.

Included among the stressful situations that were experienced by veterans in the sample were divorce, discord in the home, and stress related to living and other conditions while in service. Two veterans reported divorces; twelve indicated problems of discord in the home; and nine veterans seemed to have experienced particular stress while in service.

Although there were some areas in which the sample employed for this study did not agree with the findings of the other studies that were examined, it appears that generally, the male patients studied, exhibited the same basic characteristics and problems. Awareness of the problems that the patients experienced enabled the social workers to function most adequately in helping the patients with their problems and a good adjustment to overcoming or dealing with their disabilities in a realistic manner.
APPENDIX
SCHEDULE

Case No._____

Present Age________ Age at onset of illness_____

Family Background
Is there a history of R.A. in family________ If so, who?________
Wore both parents present in the home during childhood?________
If not, specify the living parent________
If neither parent, specify parent-figure________
Number of other children in home________
Specify sex, age and relationship________

What was general atmosphere of family group?
Sibling rivalry (specify)________ Lack of togetherness________
General tone of togetherness________ Protectiveiveness of children________
Punitive attitude towards________ Rigidness of parents or parent-figure________
Give descriptive indications of prevailing atmosphere________

Marital Status
Married________ Separated________ Divorced________ Widowed________ Common-law________ Single________

Family Situation
Number of adults________ and their relationship in family group________
Sex and age of adults________
Number of children________ Sex and age of each________
Is wife employed________ Who is responsible for family expenses?________
State any living arrangements other than with wife and children________

Illness
Specify any other illness in the immediate family________

Treatment prescribed for disease: Bed rest________ Therapy________ Medicine________
Response to treatment: Active cooperation________ Apathy________ Unwilling to cooperate________ Refuses to cooperate________
State descriptively patient's response to treatment________

Number of hospitalizations required: Brown________ Other________
Specify, if pertinent, any physical or emotional experience connected with the onset of disease________

Physical manifestations of disease: Occasional pain________ pain and slight crippling________ Area________ Pain and severe crippling________ Area________
Personality Adjustment

Are there indications of problems with interpersonal relationships with family____ others outside family____ Hospital personnel____

State nature of these problems

Referral source for Social Work Service: Medical____ Self____
VA source____ Non VA source____ Other____

What was seen as problem by person making the referral?

What was seen as problem by the veteran?

State general evidence of difficulty in adjusting to life situations as seen by the worker throughout contact with the veteran

Attitude towards referral and social worker: Active cooperation____
Apathy____ Unwilling cooperation____ Refusal to cooperate____
Give descriptive indications of attitude

Were "flare-ups" of the disease noted with the occurrence of any particular incident or series of incidents?____ If so, when____

Was patient engaged in gainful employment prior to hospitalization____
If not, give income source____ If so, has patient been able to resume employment____ If patient was employed prior to hospitalization and unable to return to work, what arrangements were made?

Extent of patient's cooperation in disposition of problems:
Depended entirely upon worker____
Made some decisions, but required great deal of support____
Made most decisions, required occasional help____
Made independent plans, with no assistance required of worker____

Indicate nature of veteran's cooperation and the areas

Was patient service-connected for his condition?
Was there a secondary diagnosis?____ If so, what?
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