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A study of problems presented to the social worker by poliomyelitis patients at the Children's Medical Center; September, 1949

BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF PROBLEMS PRESENTED TO THE SOCIAL WORKER BY POLIOMYELITIS PATIENTS AT THE CHILDREN'S MEDICAL CENTER: SEPTEMBER, 1949

A Thesis

Submitted by

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CHAPTER I

INTRODUCTION

The word "poliomyelitis" may be broken down into three parts---"itis", meaning inflamation, "myel", meaning or pertaining to the spinal cord, and "polio", or grey. Thus, the word "poliomyelitis" means the inflamation of the grey matter of the spinal cord. The number of poliomyelitis patients in recent years has increased, and in 1949 there were 42,375 persons in this country who were diagnosed as having this disease.[1]

The year 1949 saw the greatest epidemic in the United States of this dreaded disease. All illnesses and epidemics are dreaded, but poliomyelitis fills the public with a unique fear. Its etiology remains essentially unknown; it strikes swiftly and with little warning at individuals of all ages and in all walks of life; there is no way of foretelling how serious will be its after-effects.

The normal activities and functionings of a person are disturbed by poliomyelitis. His adjustment to the illness, the convalescence, and the recovery, whether it be partial or total, is affected by many elements other than the type of

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1 National Foundation for Infantile Paralysis, Polio, pub.No. 35, p.6.

consequences which may be produced by the disease. The patient's reactions to his disease are affected by his personality and constitutional structure, his social and economic circumstances, and the vast number of factors which make each human being an individual. Thus, in dealing with the poliomyelitis patient, and indeed any ill person, one must consider that person as a whole.

The team concept found in the hospital and clinic setting is aimed at working with the patient as a whole person. The medical members of the team, including the doctor who heads the team, the nurse, the physio-therapist, and occupational therapist, deal with the actual physical needs of the patient because of their specialized training. In a like manner, because of her specialized knowledge and training, the social worker is best suited to work with the patient and his family in dealing with the practical problems which may arise in connection with hospitalization, discharge and convalescence plans, and the various other social problems which may be presented. Too, she is often best suited to deal with the emotional and psychological needs of the patient during the illness and the patient's adjustment to the various implications which may be presented by the disease. Although the trend is toward greater individualization of the patient and his needs by the members of the team, and each team member may have a part in meeting practical and psychological needs of the patient, it is generally accepted

that the medical social worker plays the greatest part in working with the patient and his family during the illness, the convalescent period, and the general adjustment.

Purpose

It was the purpose of this writer to study the problems presented by patients of the three major types of poliomyelitis, paralytic, non-paralytic, and bulbar. Through the study of the problems, an attempt was made to learn if there were specific problems peculiar to each type, to learn of the reactions and attitudes of patients and their parents, and to learn if the focus of the social worker varied according to the type of poliomyelitis.

Scope

The cases which were used in this study were selected from those which were admitted to the Children's Medical Center in September, 1949, during the severe epidemic. A total of thirty-three cases, eleven cases each of paralytic, non-paralytic, and bulbar poliomyelitis were studied. They were selected at random from a list of cases which had been known to the Social Service Department of the hospital during that month. Each case was abstracted. Of the total thirty-three cases, five cases of each type of poliomyelitis were selected as being representative of the group. These were studied intensively, and it is on these fifteen cases that the findings of this study are based.

A detailed picture of the Medical Center, its Social

Service Department, and the medical aspects of poliomyelitis will be presented. The polio epidemic of 1949, a description of the National Foundation for Infantile Paralysis, the Massachusetts clinics, and an overall picture of Social Service at the Medical Center during the epidemic will also be included. Each of the fifteen cases used for intensive study will be summarized, presented, and discussed.

Sources of Data

The material used for this study was taken from the Social Service, house, and clinic records of the Children's Medical Center. Medical books were used and various other books, pamphlets, articles, and publications were used for information regarding poliomyelitis. Information was also obtained from hospital personnel and the Massachusetts Department of Public Health.

Values and Limitations

Due to the great number of poliomyelitis admissions during the month of September, 1949, as well as during the entire epidemic, a state of stress and emergency existed at the Medical Center. It was attempted to have a member of the Social Service staff contact the family of each patient. This was a tremendous undertaking when, for example, the number of admissions reached as many as twenty in one day. As a result, the social workers were unable to record fully or show the actual case work process. Each contact with a patient or his family was not separately recorded, but rather

the contacts were summarized, so it is impossible to include the number of contacts with the cases used in this study.

In Chapter III, Medical and Social Aspects of Poliomyelitis, four types of the disease are described; these are abortive, paralytic, non-paralytic, and bulbar. In this study, no abortive cases of the disease are included because none were diagnosed as such at the Medical Center.

Although the Medical Center is primarily for the care and treatment of acutely ill children, there were a few adults who received care at the hospital. Four adults were included in the sampling for this study and two adult cases are presented. The problems and related findings of the study deal for the most part with those of children who were diagnosed as having poliomyelitis, however.

There was no attempt made to evaluate the services rendered through the Social Service Department or other members of the team. It was the effort of the writer to determine if there were problems peculiar to each type of poliomyelitis which might be anticipated by the medical social worker.

CHAPTER II

THE CHILDREN'S MEDICAL CENTER

> Dedicated to the prevention of suffering and the saving of lives of infants, children and youth... to the training of doctors, nurses, and medical workers... and to research for the benefit of children... tomorrow's world citizens.[1]

The Children's Medical Center has as its nucleus the Children's Hospital founded in 1869 by Dr. Francis Henry Brown. Sisters of St. Margaret, an Episcopalian nursing order in England, came to this country at the request of Dr. Brown to nurse at the Children's Hospital, and this order continued its invaluable services until 1917. In 1889, the School of Nursing was founded. Graduates and students of Children's Hospital School of Nursing, nursing schools in the various states, and those in foreign countries now care for the nursing needs of the patients.[2]

> Eligibility for care open to Boston residents unable to pay... the 'really poor' accepted free... those able to pay... and those residing outside Boston pay rates decided upon by the managers...

was the intake policy during the early years of Children's Hospital.[3] Today children from any part of the world are eligible for care. Rates for those whose families are in

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1 The Children's Medical Center, Report of Progress, p.1.

2 The Children's Hospital, Give Life to a Child, p.27.

3 The Children's Hospital, (The exact source not determined)

the marginal income group are arranged through the budget office.

The first step in the formation of the Children's Medical Center in Boston was realized in 1949 with the merger of the then seventy-seven-year-old Children's Hospital with four other hospitals--- The House of the Good Samaritan, widely known as a specialized hospital for the treatment of patients with rheumatic fever and rheumatic heart disease, Sharon Sanitorium, Wellesley Convalescent Home for Children, and the Infants' Hospital. This merger now also includes the Children's Mission to Children, a social agency which provides case work and placement for children who are under medical care and recommendations.

The purpose of the Medical Center is three-fold; it ministers to the physical needs of infants, children, and adolescents; it is a teaching center for doctors, nurses, and other medical workers, including social workers; an extensive research program is maintained.

A close affiliation exists between the Medical Center and the Harvard Medical School. Children's Hospital's staff includes fifty men of professorial rank at the Medical School, School of Public Health, and the School of Dental Medicine who supervise care and treatment of patients and share in training of pediatricians at the hospital and in the research at the Medical Center. All third-year medical students at Harvard receive their clinical instruction in pediatrics at

the hospital, as do many foreign students.

Children's Hospital was founded on the principle that children required specialized medical and surgical care and treatment. It was the first hospital founded on this principle a principle which once was refuted, but now is firmly established. Various types of treatments, cures, and surgical procedures have been discovered or first successfully used at the Medical Center. In regard to the treatment of adults, a limited number of older people have been treated for poliomyelitis because of the fact that no age limit is maintained by the National Foundation for Infantile Paralysis, and because of the great advances in research and medical care at the Medical Center.

In 1948, 8,563 in-patients were treated, and there were 69,812 in-patient days at the Medical Center. Each year an increasing number of patients are seen and treated in the numerous clinics of the out-patient department; in the same year, 1948, there were 15,190 children who were registered in the out-patient department, and 56,231 clinic visits were made.[4] Social workers are active in all wards of the Center and cover the many clinic which are held.

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4 The Children's Hospital, Give Life to a Child, p.14.

The Social Service Departments at the Children's Medical Center

In 1896, the Out-door Relief Department was established so that nurses could supplement hospital care in the homes and could care for the sick poor in their homes. The Sisters of St. Margaret and student nurses carried on this work. In 1905, a graduate nurse who had had special training in social work was put in charge of this department which was temporarily renamed the Visiting Nurse Department. Emphasis on the work in homes became social rather than medical, although student nurses continued home nursing activities. The staff consisted of the graduate nurse trained in social work and student nurse assistants. In 1917, the home nursing program was discontinued, and its services and duties were transferred to local district nursing departments. The focus of that department which had undergone so many changes during the early years of the hospital now became clearly medical social work.[8]

At the present time the Social Service Department of the Medical Center consists of the director, eleven workers each responsible for a specific ward or service, including Infants' Hospital and Wellesley Convalescent Home, and one case aide. The first medical social work students who received field

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8 The Children's Hospital, chart prepared by the Social Service Department.

work experience at Children's Hospital came in 1917. A Social Service Department is maintained by each of the following: The House of the Good Samaritan, Sharon Sanitorium, and the Children's Mission to Children.

CHAPTER III

MEDICAL AND SOCIAL ASPECTS OF POLIOMYELITIS

During the early decades of 1900, American archeologists, excavating a tomb in Egypt, found drawings of a deformed and crippled man engraved on the walls. Further study of these drawings indicated that the crippling had perhaps been caused by poliomyelitis and that this disease had perhaps existed in the world for at least 4000 years.[1]

The disease has been called by many names. In the late 1800's, it was known as "Heine-Medin Disease", named for Dr. Heine who first declared that the crippling was the result of damaged or destroyed nerve cells, not due to a bone disease, and for Professor Medin of the University of Stockholm who worked through two epidemics in Sweden and gathered a great deal of invaluable information. When the term "infantile paralysis" was first used in the 1800's, the disease was seen only in infants. It still is seen only in infants in many parts of the world, but includes all age groups in the more civilized countries of the world.[2]

"Poliomyelitis" is the most recent and also the most satisfactory name for this illness. Inflamation of the gray matter of the spinal cord is the outstanding characteristic

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1 National Foundation for Infantile Paralysis, Poliomyelitis, pub. No. 61, p. 2.

2 Ibid., p. 3.

of this disease.

(Polio, the popular shorter term, has come into common usage during the past few decades. The word is an abbreviation of "poliomyelitis". In this thesis the writer has eliminated the continuous use of quotation marks when the word is used.)

Polio is caused by a minute virus, the size of which has been estimated as being approximately ten to fifteen one-millionths of a millimeter. It is extremely difficult to isolate because it will grow in very few kinds of animals besides the human being; all races of man seem to be susceptible to it. Triumph for science was achieved in 1908 when Dr. Karl Landsteiner at Vienna first succeeded in infecting a monkey with polio, thus making possible new ways of study and research.[3]

There are differences of opinion in regard to how the virus enters the body, but it is now most widely believed that the portal of entry may be the alimentary canal, particularly the pharynx and the intestinal mucosa. Although the way in which the virus gains entry has not been definitely established, it is quite certain that the virus, once it has gained entry, travels through peripheral nerves to the central nervous system. Then it spreads by neuronal pathways to the sensory and motor nerve cells which are located in the anterior horn cells of the spinal cord and in the brain stem.[4]

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3 Ibid., p. 5.

4 National Organization for Public Health Nursing, Nursing for the Poliomyelitis Patient, pp. 9-11.

The virus attacks only nerve cells of the medulla or spinal cord, or both, and feeds, grows, and multiplies, living on the material within the nerve cells. These cells may be so affected that they are no longer able to control the muscles of the various parts of the body. Paralysis, or inability to move the muscles which these neurons control, becomes apparent. There is no real cure for this muscle paralysis which occurs when nerve cells are destroyed by the virus.[5]

If the nerve cells attacked by the virus are not destroyed and retain some of their activity, they may recover eventually. The exact mechanism of transmission is unknown, but it has been seen that this infection frequently runs through families and it is an epidemical disease. The infection of poliomyelitis is a common one, probably as widespread as measles, but the paralytic stage is relatively rare.

A defense against the acute phase of the disease is built up through repeated exposures to the virus. This explains why children are more susceptible to the acute disease; adults have long been exposed to the infection and have developed varying degrees of immunity. Although a baby is born with approximately the same resistance to the disease as his mother, this resistance is relatively transitory and antibodies disappear within a period of six months to two years. Then the child's system must build up its own immunity.[6]

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5 Poliomyelitis, op. cit., p. 6.

6 Maxine Davis, "First Handbook on Infantile Paralysis", Good Housekeeping, August, 1950, p. 58.

The carriers of the virus are not easily recognized. They may be individuals who are only slightly ill for a few days with fever, nausea, and headaches. The poliomyelitis virus may be harbored in a person's body without causing any disturbance or symptoms of the disease whatsoever, yet he as a carrier is a menace to others. Therefore, until more is learned, it is impossible to prevent the spread of the virus in a community.

The virus has been found in sewage, and for this reason health authorities during epidemic of the disease discourage swimming in waters where there is a possibility of contamination. Body cleanliness and a rested body are both good protection from any disease.[7]

Poliomyelitis is more prevalent in the summer and tends to die out as late fall and winter approach. Epidemics of the disease seem most common in temperate regions, although cases are reported in all regions of the world in every month of the year.[8]

The most common type of poliomyelitis is known as abortive polio, the type where only the systemic stage occurs. The symptoms are headache, sore throat, nausea and vomiting. No evidence of paralysis is seen. These symptoms are often overlooked or considered to be some other disease, and a diagnosis of polio may never be made. It has been estimated that there

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7 Poliomyelitis, op. cit., p. 10.

8 Ibid., p. 11.

are twenty times as many cases of this type as there are of cases which have been diagnosed as polio. It is this kind of polio which helps to build up immunity for a great many individuals. On the other hand, individuals with abortive polio are also carriers of the disease. There is no nerve injury or involvement in abortive polio.

Non-paralytic polio is seen when the virus reaches the central nervous system and carries on pronounced activity; the recognizable symptoms of polio are seen. The nerve cells may be injured but not destroyed; the muscles may be weakened but not paralyzed. There is stiffness of the back and neck, and the systemic symptoms of fever, headache, and nausea are seen. The nerve cells recover in most cases, and muscles which have been weakened can be retrained and strengthened although the process may be long and extremely discouraging at times.[9]

Paralytic poliomyelitis, the more dramatic form, occurs when the virus attacks the nerve cells with such strength that the cells are seriously injured or destroyed. These nerve cells, usually located in the spinal cord below the medulla, are not capable of reproducing themselves when they are destroyed; the muscles governed by these neurons are unable to function and paralysis of these muscles occurs. A person may become paralyzed in the arms, the legs, or in any part of the body controlled by these nerves. Muscles of the chest which

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9 Ibid., p. 7.

make breathing action of the lungs possible may be affected; when this occurs, the iron lung may be used to mechanically expand the lungs, thus saving the life of the patient.

Bulbar polio occurs when the virus attacks the neurons in the medulla. In this part of the brain located at the upper end of the spinal cord, are many of the vital nerve centers of the body. The muscles of the throat may be affected thus making it difficult or impossible to swallow or to speak plainly. Muscles of the face controlling the eyes, mouth, and various facial expressions may be paralyzed or weakened. The muscles controlling the breathing apparatus of the patient may be paralyzed. In bulbar cases where respiration is affected, the "iron lung" is of little use, for it is the actual mechanics of breathing rather than chest muscles that are rendered useless. Bulbar polio is relatively less common than the type where the virus localizes lower down in the spinal cord.[10]

All types of polio are primarily the same disease; they differ only in the location of the virus and extent of damage done to the nerve centers which control the various muscles and organs of the body. The incubation period is relatively short; it does not exceed about twelve days except in rare cases.[11]

There are three stages of poliomyelitis. The symptoms of

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10 Ibid., p. 10.

11 Nursing for the Poliomyelitis Patient, op. cit., p. 13.

the acute stage may at first resemble those of many other diseases. They may include fever, general malaise, loss of appetite, nausea, vomiting, headaches, gastrointestinal complaints, and sore throat. These symptoms may be present for one or two days, and then a period may occur of from one to seven days when the patient seems quite well. The patient becomes sick again, and evidence is present of central nervous system involvement. This is usually when the illness is first noticed. Stiffness may be present in any muscle but is found usually in the neck and back, arms and legs, or in the chest when deep inhalations are taken. Severe pain may be experienced even when there is no fever.

Paralysis, if it is to occur, reaches its extent seventy-two to ninety-six hours after symptoms of polio have first been noticed. When the patient's temperature has dropped to normal for forty-eight hours, the chances are that no further paralysis will develop. The degree of fever has no bearing on the amount of paralysis to be expected.

The convalescent stage begins when the fever has subsided finally, and lasts until the "spontaneous recovery" of muscle function is complete and the affected muscles have improved to the greatest possible extent, usually in about eighteen months. The convalescent period actually has two parts depending on the presence or absence of tenderness and spasm. In the sensitive phase the muscles are still tender and tight, and pain is present.[12]

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12 Davis, op. cit., p. 59.

In the non-sensitive phase, the pain and discomfort are gone, but muscle tightness may remain.

The chronic stage of the disease is that period after the recovery of nerve cells and muscles has reached the maximum degree possible, and the stage where it is known that no further recovery is to be expected. This is the stage in which the physician knows which muscles of paralytic patients are permanently paralyzed and plans the reconstructive and rehabilitative measures to be taken.[13] Braces, crutches, and other appliances may be used; surgical procedures may be employed as soon as it is feasible in cases where such steps are indicated. The main goal is to make the patient as effective a person as possible in all aspects of his life, in spite of the residual involvement which may be present. Continuous supervision and follow-up are essential, especially of children, since deformities may progress due to disturbances in growth. Functional and gait training are also very important.[14]

Knowledge of poliomyelitis is increasing, but thus far, there is no known cure for this disease. However, physicians and physio-therapists can reduce pain and discomfort during

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13 Ibid., p. 197.

14 William Green, M.D., "Present-Day Status of Poliomyelitis," The New England Journal of Medicine, January, 1948.

the early stages of the illness, and then can reduce greatly the chances of the patient's being crippled or limited in his activities. Much seems to depend on how quickly and promptly the patient is placed under proper medical supervision. The most effective care is given in hospitals where the latest equipment and methods of treatment are available. The long and often slow process of retraining weakened muscles or training some to carry on new functions begins as soon as the patient is ready, while he is still in the hospital in many cases, and continues for months and often years in severe cases.

The total or partial recovery of muscle function depends on the extent of nerve damage. While some patients recover completely from paralysis and muscle weakness, others must use braces, crutches, or wheel chairs for the rest of their lives. All patients, however, can be helped to overcome some of the effects of the disease.

Polio has its greatest incidence in children under ten. Though commonly called "infantile paralysis," incidence of this disease among adults has recently risen rather sharply. In 1949, one of four of those with polio was over fifteen years of age. The greatest fear which arises in regard to this disease is the fear of crippling, yet of every one hundred individuals who contract polio, fifty will recover completely, and twenty-five to thirty will show slight after-effects, but not serious enough to interfere with their leading

relatively normal lives. Fifteen to twenty will be left seriously crippled, and five to ten will die.[15]

As is true with any serious illness, there are varying psychological factors which may be presented by the polio patient.

Hospitalization is not a particularly pleasant experience for anyone, but it is a most traumatic experience for young children. A child below the age of three responds strongly to pain, is greatly dependent upon his mother, has not had a chance to learn how to make satisfactory social relationships, in unable to "play out" his feelings or anxieties in the hospital setting, and develops certain fears. These fears may include the fear that the mother has deserted him, a fear of defenselessness, and fears of doctors and nurses who, of necessity, cause him pain and discomfort through treatments and examinations.

Older children can be reasoned with and can be helped to some extent to understand the need for hospitalization and treatment. They have had chances to make social contacts and it is easier for the older children to relate to hospital personnel.

Adolescent children are trying to become independent, to develop more fully their own potentialities, and in short, to "grow up." With illnesses and hospitalization they are

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15 Poliomyelitis, op. cit., p. 4.

made to feel quite dependent. There is great striving to be like others, and the fear of being "different" as a result of crippling is very strong. Many adolescents are self-conscious, and even a slight handicap is most disturbing.

An adult is made dependent during hospitalization; he experiences a loss of status and may find himself in a permanent state of incapacity if involvement is great. He may feel he has become a burden to his family, may feel guilty about his illness, and may feel he has failed his family, if he is the bread-winner of his family. He may have to adjust to a completely new type of occupation, living arrangement, financial status, and a new way of life.

The parents and families of polio patients may display varied and numerous reactions to the patient's illness and possible limitations. They may feel guilty that their child or relative has contracted polio; they may be over-anxious, panicky, and despondent. The parents may be over-protective of the patient when he is discharged to his home, and may cause him to become over-dependent and unable to develop to the fullest his own abilities and potentialities. Parents may be either over-confident or fearful of their ability to manage physical care of the patient in the home.

A child and indeed a patient of any age easily senses the feelings of his parents and family toward his illness and any involvement which may result. If the family can be helped to accept and understand the various implications of

the illness and the possibility of limitations and can realistically adjust to these, the patient, too, is better able to satisfactorily adjust to his illness and possible limitations.

A handicapped person needs to realize that because he is handicapped, he must not lose faith in himself or give up plans he might have for the future. He can be encouraged to take into account the assets he possesses and made to realize he will be able to live a relatively normal life. He may have to alter to some extent his plans, but he is capable of having a full and happy life, for his potentialities are not lost through the loss of the use of a limb. He can be encouraged and helped by the members of the team during the early period of illness to realize his handicap, and through repeated supportive contacts with the social worker during the long months of convalescence and readjustment, he can be helped in his acceptance of his limitations and in planning for his life to be rich and meaningful.

CHAPTER IV

THE POLIOMYELITIS EPIDEMIC OF 1949

The National Foundation For Infantile Paralysis

Franklin D. Roosevelt contracted polio in 1921, and in 1927, he and a group of friends formed the Georgia Warm Springs Foundation, a non-profit institution for study and research of this disease. From this developed the National Foundation for Infantile Paralysis which became incorporated under the laws of New York state in January, 1938. It is supported through contributions, and annually sponsers the March of Dimes, its fund-raising campaign. A chapter has been established in each state and clinics are held in various parts of each state. Fifty per cent of funds realized through contributions is used for research, education, and epidemic aid; the remaining fifty per cent is retained to provide medical care for patients, or, in emergencies, to supplement the national epidemic aid fund. Assistance to patients may include payment for hospitalization, nursing, physio-therapy services, orthopedic appliances, and transportation to and from hospitals and clinics. Age, race, or creed are no barriers to receiving aid; assistance given is based solely on need. Funds are granted to the states and administered to the individuals through local chapters. Statistics show that in 1949, during the greatest epidemic of polio in this country, approximately 33,900 of the 42,375 patients were

helped in part or in total by funds of the Foundation.[1]

The Massachusetts Infantile Paralysis Clinics

The Massachusetts chapter of the Foundation is located in Boston and the main clinic is at the Children's Medical Center. Treatment clinics providing physio-therapy and medical supervision are maintained in Arlington, Beverly, Dedham, Haverhill, Lawrence, Lowell, Malden, Medford, Quincy, Somerville, and Waltham. These clinics are staffed by personnel from the main clinic who also hold appointments in the isolation, orthopedic, and physio-therapy services of the Medical Center.

The average attendance at the clinic in Boston reached a peak of eighty-five patients a day during 1949. There were 743 new patients seen in the clinic and there were 1895 cases receiving care under the Massachusetts clinics during that same year. Clinic visits totalled 17,053, 13,400 of which were made to the clinic at the Medical Center.[2]

Admission Of The Patient

Admission of the patient to the Children's Medical Center followed, in general, a planned routine. He usually had been seen by a local physician before being sent to the isolation building of the Center. There he was seen by an admitting

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1 National Foundation for Infantile Paralysis, Polio, pub. no. 35, p. 7.

2 Annual Report of the Massachusetts Infantile Paralysis Clinic, 1949.

clerk, a physician from the Medical Service, and then by a physician from the Orthopedic Service. When a diagnosis of polio was made or questioned, the patient was taken to a ward in the isolation building, and regulations regarding the isolation period, visiting rules, and gifts and articles which might be used by the patient were explained to the family as well as any precautions which might be necessary in the home. Data for the Infantile Paralysis Foundation form card was obtained from the family. Next, the family was seen by a social worker and then by someone in the credit office. In most cases, within two weeks of the admission the family was contacted by a representative of the National Foundation, and a home visit was made by a public health nurse.

The patient remained in isolation during the acute stage of the disease, usually about two weeks. During this period, no visitors were allowed. Then, depending upon the patient's condition, and the ability of his family to give adequate home care, he was discharged home, transferred to the orthopedic ward of the hospital, to the Wellesley Convalescent Home, or to another hospital for convalescent treatment.

Social Service At The Children's Medical Center During The Epidemic

In July, 1949, a social worker was sent on a three-month assignment by the National Foundation to the polio wards and clinic at the Medical Center. In September of the same year, another worker was sent by the Foundation on a permanent basis.

During the epidemic of 1949, the Social Service Department made an attempt to maintain one hundred per cent social service coverage through mutual agreement with the chief of Orthopedic Service at the Medical Center.

During July, August, and September, the admissions were covered by the worker on the three-month assignment and by another worker. The worker who was to be permanently assigned to the service came in September. Four workers from other services within the hospital worked on a rotating basis in the polio wards for varying lengths of time. In October when the epidemic had subsided, these other workers gradually terminated their services in the polio wards, and the full responsibility became that of the permanent polio worker.

From June through November of that year when one hundred per cent coverage was attempted, there were 570 patients admitted; three patients died, and two patients were found to have some other disease. Of the total number of admissions, 570, Social Service was able to contact 495 patients and/or families. Most referrals to the Social Service Department were made by the physician who admitted the patient; some families who had not been seen at the time of admission were referred through the credit office when payment of bills was discussed. Social Service learned, through the use of the files on the wards, of other families who had not been contacted when the patient was admitted.

No contact was made by the Social Service Department with

seventy-five patients and/or families for various reasons; a large number of patients were admitted at night and during the weekends when nc social worker was available. An attempt was made to see each family when the patient was admitted, and when this was not possible, the Social Service Department tried to get in touch with the family by mail or phone. Those who lived nearby were usually seen by appointment, but many families who lived a great distance from the hospital found it impossible to talk with a worker. There were a few families who were not seen at the time of the patient's admission and who made no attempt to contact Social Service despite letters and phone calls made by the Department. Some families were not referred or were not seen for other reasons, but the vast majority of families with whom no contact was made were those who lived quite some distance from the hospital. The Public Health Department was most cooperative in offering medical social workers to those families in remote areas.

The purpose of one hundred per cent review was two-fold; it was to gather pertinent information regarding the patient himself, and to gain an over-all picture of his family and social environment; it was attempted to evaluate the family's ability to handle convalescence. The purpose of the Social Service review was explained to each family, and it was made clear that the information obtained would be helpful to the doctors and nurses in caring for the needs of each patient, and also in making discharge plans. The review was generally

TABLE I

CASES ADMITTED TO THE MEDICAL CENTER ACCORDING TO TYPE OF POLIOMYELITIS: JUNE-NOVEMBER, 1949

Month	Diagnosis			Total
	Paralytic	Non-par.	Bulbar	
June	15	7	0	22
July	34	15	16	65
August	132	90	37	259
September	80	47	16	143
October	34	24	8	66
November	9	5	1	15
Total	304	188	78	570

accepted by those who were interviewed.

During the isolation period or acute stage of the disease, which lasted approximately two weeks in most cases, the Social Service Department gave assistance in three ways---through social review, through acting as a liaison between the patient and his family when visiting was prohibited, and through making plans with the family for the convalescent period.

Of the 495 families who were seen, there were at least 116 cases where more extensive Social Service was required and given following the isolation period and the acute phase. No real criterion for defining services was available because of the number and rapid turnover of both patients and workers. The services offered were given to three groups of patients---those who were discharged to their homes immediately after the two-week isolation period, those who were transferred to the orthopedic ward of the hospital, and those who were transferred to the Wellesley Convalescent Home. A more detailed discussion of types of service will be found in the following chapter.

Other Agencies Participating In Meeting Needs Of Polio Patients

The Red Cross was and continues to be of invaluable service in providing transportation for patients and in many cases, an accompanying parent or relative, to and from the clinic or hospital. Often parents had to bring children from outlying areas where there was no transportation if the family had no car. Travel by means of busses, trains, or subway

would have been impossible for many handicapped patients.

The Visiting Nurse Association in various towns and cities aided parents and families through supervising convalescent care. The Boston VNA has a special unit of physio-therapists who were used to instruct parents regarding exercises and also to do the more extensive exercises with the patients. The VNA was also used to supervise diets, evaluate the adequacy of homes, and so on.

The Massachusetts Department of Health saw that quarantine precautions were carried out by families, cooperated in sending social workers to homes of patients in remote areas, and as part of the state program in regard to polio, a nurse usually visited the home of each patient.

Family agencies, workers in other hospital Social Service Departments, school nurses, teachers, and other agencies were contacted for joint planning regarding patients, consultation, and referral of cases when it became apparent that the medical social problems could be relieved by their participation in the case.[3]

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3 Elizabeth Maginnis, Annual Report of Social Service With Poliomyelitis Patients of the Children's Medical Center, 1949.

CHAPTER V

CASE PRESENTATIONS AND DISCUSSIONS

Over-all Picture of the Cases Used in the Study

Of the thirty-three cases studied, eighteen were male and fifteen were female; they ranged in age from one year to twenty-five years; two adults, both female, were included; ten cases, or nearly one-third of the total number, were in the one-to-three-year-old group. The greatest number of cases in any age group during the entire month of September, 1949, was also in this age group.

The yearly salary range of the families of these patients was $1000 to $5000 with the exception of one case where the salary was $15,000. Twenty-seven families had Blue Cross, Blue Shield, or some type of insurance covering hospitalization. The National Foundation for Infantile Paralysis contributed to twenty-seven cases, including sixteen cases where the Foundation assumed total financial responsibility. The bills of six patients were paid by their families, all of whom had hospital insurance of some type.

There were patients of numerous national origins and religious faiths. The racial background of each patient was not recorded at the hospital.

The fifteen cases used for intensive study and the ones on which findings were based included nine males and six females; the age range was two years to twenty-five years. These

cases were representative of the thirty-three in regard to salary range, age distribution, and financial aid given by the National Foundation.

TABLE II

SEX AND AGE OF THE THIRTY-THREE CASES STUDIED ACCORDING TO TYPE OF POLIOMYELITIS: ADMITTED TO THE MEDICAL CENTER SEPTEMBER, 1949

Age		Sex					
Years	Total	Male			Female		
		Paralytic	Non-para.	Bulbar	Paralytic	Non-para.	Bulbar
1-6	17	5	3	2	1	5	1
7-12	11	2	1	4	1	0	3
13-18	3	1	0	0	1	0	1
24-25	2	0	0	0	2	0	0
Total	33	8	4	6	5	5	5

TABLE III

SEX AND AGE OF ALL CASES
ACCORDING TO TYPE OF POLIOMYELITIS:
ADMITTED TO THE MEDICAL CENTER
SEPTEMBER, 1949

Age		Sex					
Years	Total	Male			Female		
		Para-lytic	Non-para.	Bul-bar	Para-lytic	Non-para.	Bul-bar
1-6	70	23	16	2	15	12	2
7-12	48	17	9	5	10	3	4
13-18	17	4	3	1	5	3	1
19-24	1	1	0	0	0	0	0
25-30	7	1	1	1	4	0	0
Total	143	46	29	9	34	18	7

Case Studies

Five cases each of the three types of poliomyelitis, paralytic, non-paralytic, and bulbar, are presented. A discussion of the problems presented and the role of the social worker follow each case. It was on these fifteen cases that the findings of this study are based.

Paralytic Cases:

Case 1.

Mary D., a seven-and-one-half-year-old girl, was hospitalized for five weeks at the Medical Center and then was transferred to the Wellesley Convalescent Home where she remained for seven weeks. No contact with the family had been possible when the child had been at the Center, although several attempts had been made to do so. The doctor at Wellesley referred the case to the social worker for discharge planning. The child had considerable involvement of both legs and was in casts. There was a two-year-old sister, the family had a very limited income, and the home was not felt to be very adequate.

The worker made an appointment with the father, and learned that at the onset of the child's illness, the mother had left the father, taken the younger child, and had gone to live with relatives because, according to the father, she was so upset over Mary's illness. She had since returned to the home. Both parents were fearful of having Mary return to the home, and felt insecure and inadequate in having to care for a sick child. The parents showed some resistance to the worker at first, but as they gained confidence in the worker's genuine interest in helping them, they both became cooperative. The worker gave the parents a great deal of interpretation of the illness, the treatment, and the convalescent period. Through further evaluation, the home was found to be adequate.

Mary was discharged from Wellesley and returned to her home. Arrangements for a home teacher

were made, and the Visiting Nurse Association provided a physio-therapist once a week to help the parents with the necessary exercises.

Three months later it was noted that the child had made a good adjustment, her physical condition was satisfactory, the parents felt confident of their ability to carry on the convalescent care, and good family relationships had been re-established.

This case illustrates the fear and panic that often are seen in the patients of polio or their families. The worker played a great part in allaying their fears and in interpreting to them the various implications and significance of the disease and its treatment, and the necessary care. She played a supportive role by showing her interest in helping them, and aided the parents in gaining confidence in their ability to handle Mary's convalescent period; the worker helped the parents face the problem of the illness realistically.

The importance of the cooperation of community resources is shown in this case; the Visiting Nurse Association provided a physio-therapist which aided in the physical rehabilitation of the patient; the school department sent a home teacher who helped the child keep up with her education as well as provide a certain amount of occupational therapy.

Case 2.

Louise A., a twenty-four-year-old married woman with an eighteen-month-old daughter, was hospitalized at the Medical Center for three weeks and then transferred to another hospital for part of the convalescent period. At the time of her admission, she was four months pregnant.

The home was adequate and was an apartment in the home of Mr. A's parents. The income was also adequate.

Mrs. A. made a good adjustment to her hospitalization and the worker visited her frequently. At times, however, she was quite apprehensive about the long period of convalescence.

The patient's daughter was admitted to the hospital with non-paralytic polio, and the mother was not told until a diagnosis of non-paralytic polio was made. She accepted the fact that the child, too, was ill, but the worker was able to give her a great deal of support at this time. Mrs. A. also had great faith in the treatment she and the little girl were receiving.

When it was necessary to transfer Mrs. A. to another hospital, she was quite disturbed, but the worker interpreted to her the impossibility of handling convalescent patients for any length of time at the Medical Center. The worker was instrumental in helping Mrs. A. adjust well to the second hospital.

Mrs. A. was transferred to a third hospital for the delivery of her baby. The child was normal and well. Mrs. A. remained at the third hospital for several weeks, and the new baby was cared for by relatives as was the older child who had no serious after-effects of non-paralytic polio.

Mrs. A. was readmitted to the second hospital for further convalescence where she remained for about two weeks, and was then discharged home.

After a month at home, she had not adjusted well, was very dependent on her husband, and was rather discouraged. The patient felt that the home situation presented a practical problem in that the A.'s apartment was on the second floor; Mrs. A. had involvement of the muscles of the legs and was at the time of discharge just learning to walk with crutches and braces. The worker referred the patient's husband to several places in an effort to help them find a more suitable home.

During these months and the various hospitalizations, the worker maintained contact with the A's, giving encouragement, reassurance, and support to both the patient and her husband.

A few months after Mrs. A. had gone home, the family was able to find a suitable home, Mrs. A. was able to ambulate more easily, became less dependent, and able to do more for herself. Eighteen months after discharge, Mrs. A. was able to walk without braces or crutches, but was still to continue exercises. She was able to assume greater responsibility for her home and children, who had been cared for by relatives during the mother's convalescence.

This case shows the long, slow experience and process of the convalescent period of polio. This case was rather unusual in that it was complicated to some degree by the patient's pregnancy. The patient no doubt had a great many conflicts and fears as she contemplated the approaching birth of her child and the long months of convalescence.

The worker played an important role in giving the patient and her husband the support and understanding they both needed during the long hard months. The continuance of the relationship which had been built up during the first days of the patient's illness was undoubtedly of great value to Mrs.A.

Although the worker felt that the home situation was no pressing problem and was quite adequate, she felt that perhaps it gave the patient something to think about and plan for, and helped Mrs. A. to be more content until a home more to her liking could be located.

The family situation was most adequate in that there was no difficulty in the care of the children, for relatives

were able to care for them.

In cases like this, where the convalescent period is so long, often the most important thing a social worker can do is to continue supportive contacts with the patient.

Case 3.

> Jean N., a twenty-five-year-old patient, was at the Medical Center for seven weeks and was transferred to another hospital where she remained for six months. Both arms were paralyzed and there was severe involvement of the hands and legs. She was a nurse, had to come to this country only a few months prior to the onset of her illness, and had been living with a married sister. Home care during the early stages of convalescence was impossible. The patient was completely overwhelmed by her illness; she cried and moaned a great deal, was frightened, and was inconsolable. The worker tried to visit her each day, and although Miss N. did not respond much at first to the visits, she expressed anger if the worker did not visit. Later, when she was able to accept the worker, Miss N. expressed fear of an "emotional collapse". The worker found the patient to be a warm, friendly person by nature, but one who for various reasons, was completely staggered by the illness. Miss N. was in debt to members of her family for her education and her trip from her native country; she had had a job in a hospital, but now had been rendered helpless by poliomyelitis; because she was an alien, there was some difficulty in getting funds from the National Foundation to help in payment of hospital bills.
>
> The worker was able to carry on a supportive role with Miss N., saw her constantly during the seven-week period she was at the Medical Center, and helped to relieve a great deal of Miss N's anxiety. After the acute stage of the patient's illness, she was transferred to another hospital, stayed for six months, and then returned to her sister's home. The worker visited the patient several months after the discharge from the hospital, and found she was able to get around in a wheel chair, and seemed to have made a fairly good adjustment. There was still considerable involvement of both arms and one leg. However, braces and slings were being used. The sister

had been very cooperative and understanding of the patient's illness and limitations. Miss N. seemed to have realistically accepted her handicaps, and was regaining some use of her limbs, although very slowly. At the present time, the worker is trying to make rehabilitation plans with Miss N.

This case, one of the adults included in this study, presented many problems, the greatest, of course, being the seriousness of the paralysis. This woman had had to adjust to a new country, a new home, and a new job; she had perhaps not had a chance to fully adjust to these new situations. The onset of polio and the ensuing severe paralysis must have been a most traumatic experience for this patient. She was a young woman with a worthwhile vocation and life ahead of her when suddenly she was rendered helpless and completely dependent on others for meeting her physical and financial needs.

In the most critical period of Miss N's illness, the social worker was able to help in some of the feelings of fear, anxiety, and hopelessness this patient expressed. Miss N. was helped to accept to a certain extent the illness and its complications through repeated contacts with the worker during the first few weeks of the hospitalization. The worker was also able to arrange for financial assistance for payment for hospitalization.

The worker learned in her most recent contact that Miss N. had made a rather good adjustment, that the sister had been most helpful to the patient in various ways, and at

that time there was no particular need for a medical social worker. Actually, in this case the worker was limited in what she could do. With such severe involvement the patient's adjustment to her incapacity would depend for the most part on her own ego-strengths, together with the supportive interest and concern of others, interest and concern which the worker was able to provide. The worker is now planning a rehabilitative program with Miss N.

Case 4.

> Jimmie R., a two-year-old child, was hospitalized for six weeks at the Medical Center. He had severe residual paralysis of the left lower leg and some involvement of the left hip. The parents described the child as being a "good" baby. There was another son, seven years old. The income was quite limited. The patient had a strong attachment to his father, and the home situation was adequate although it was felt that the mother was of limited intelligence. Both parents were extremely anxious, especially during the first days of the isolation period; they called the doctors and social worker frequently, and the mother told the worker she always felt "shaky" when she called and forgot questions she had wanted to ask regarding the illness and the child's progress.
>
> It was noted by the worker that the father was an amputee, but during the child's hospitalization, no reference to this fact was made by either parent. The father was reluctant to talk to anyone in the credit office in regard to bills, but arrangements were finally made. The parents were willing to talk only about Jimmie's condition, and the worker acted as a liaison between the child and the parents during the hospitalization period.
>
> Several weeks after the discharge, the worker saw the family in the clinic; the father was extremely restless and irritated at having to wait so long for Jimmie to be seen by a doctor. The mother said she had had a great

deal of trouble with Jimmie's exercises, but the worker felt Mrs. R. had perhaps exaggereted the difficulties. The mother was given further instructions for doing the exercises by the doctor and physio-therapist.

During the next few months, the worker saw the parents and the child at intervals when they came to the clinic. From the mother, the worker learned that the father was having great difficulty in accepting Jimmie's paralysis. The father was an amputee of world war II; he had had no preparation for surgery, and he was hospitalized for a year. The mother felt he had accepted his own disability, but could not face a similar disability in his son; all of his old feelings had been revived with the child's paralysis.

The worker encouraged the mother to a fuller understanding of the father's feelings and attitudes, a means through which she could help the patient and his father. The worker arranged for the parents to talk with the doctor in regard to the child's actual prognosis. It was realistically explained to them by the doctor, but it was difficult for the parents to recognize the inevitability of incomplete return of function in the child's leg. Gradually, however, through talking with the social worker and the doctor, the parents began to accept the reality of the situation.

The worker continued to see the parents and by talking with the worker, Mr. R. was able to work through many of his feelings about his own handicap as well as Jimmie's. It was noted by the worker that the father shared thoughts and ideas with patients and families he met in the clinic.

One year after the onset of polio, the parents were seen to be less apprehensive, more mature in their handling of the child, and facing the child's crippling quite realistically. They had confidence in the treatment the child was receiving, but were not relying too strongly on Jimmie's regaining complete muscle function.

> The child had showed very slow but gradual improvement, and fourteen months after hospitalization, he was beginning to learn to walk with crutches.

This case was unusual in many ways and presented several problems. It illustrates clearly the concept of the team where the doctor, social worker, and physio-therapist were active in the over-all treatment of the patient.

The worker was important as a liaison between the parents and the child. She encouraged the mother toward further acceptance and understanding of the father's deep emotional involvement; the father was encouraged to express his feelings, feelings which perhaps he had tried to repress, and was helped to see the connection between the feelings he had about himself and those regarding Jimmie. The worker no doubt helped the father a great deal toward accepting his own disability as well as his son's.

The mother was given reassurance and encouragement in regard to the care of Jimmie, in helping her husband face his problem, and in her ability to help both her husband and the child.

Through contacts with the worker, both parents were enabled to accept the inevitability of Jimmie's being permanently handicapped.

Case 5.

> Jack C., a seven-year-old boy, was hospitalized at the Medical Center for three weeks and then was sent to the Wellesley Convalescent Home for six months as he required extensive physio-therapy several times a week. The parents

described Jack as being a quiet, shy, and obedient child who spent much of his time alone; he was a "fair" student in the second grade. Jack had always been a rather frail child, had had colitis, and a great deal of "stomach trouble". He had a younger sister, Jean, aged two-and-a-half. The income and home were adequate, and it was felt that close family ties existed.

During the isolation period, the little boy expressed great concern and worry regarding his parents and the parents were extremely anxious about the child. The worker talked with Jack frequently, giving him reassurance and acting as a go-between for the child and the parents. While Jack was in the hospital, Jean was admitted with a diagnosis of polio. The children were placed in the same room which helped both of them. When it became evident that Jack would require extensive convalescent care which could not be given at home, the need for him to be sent to the Wellesley Convalescent Home was interpreted by the worker to Jack and his parents. The parents were overwhelmed at the realization that both children would have serious involvement and the worker talked with them and helped them to face the reality of the situation.

While Jack was at Wellesley, the worker visited him weekly. He had difficulty adjusting to the new setting, but Jean was also sent to Wellesley and this helped Jack's adjustment a great deal; but he continued to worry about his parents. Jean was discharged home several weeks before Jack was, and the little boy became discouraged and despondent, worrying constantly about how his parents were, and about the trouble the illness was causing them.

The worker visited Jack each week and was able to relieve some of his anxiety regarding his parents and Jean, so he was able to make a fairly good adjustment to the convalescent home. The parents continued to receive supportive help from the worker in regard to both children.

> Jack had severe involvement of both legs; five months after the onset of polio, he started to stand with crutches, and a month later, he began to learn to walk with them. It was planned to perform surgery in an attempt to reduce the disability.
>
> The family had become reconciled to the serious involvement resulting from the disease and seemed to be handling the situation with a great deal of intelligence and bravery.

The worker helped the members of this family to keep in contact with each other during the isolation and convalescent periods. It was a devastating experience for the parents to have both children stricken with polio, especially when there was serious involvement in both children.

The worker was able to give the parents some reassurance and interpretation of the illness, as well as to keep them informed of the progress of the children.

Jack expressed much concern for his parents' well-being, and the worker was able to allay some of his fears and anxiety by letting him know she was in constant touch with them.

In regard to discharge and convalescent care planning, the worker had an important part in interpreting to both the patient and the family the need for further hospitalization.

<u>Non-Paralytic Cases</u>:

Case 1.

> Barbara Z., a five-year-old child, was hospitalized at the Medical Center for eleven days and then transferred to the Wellesley Convalescent Home where she stayed for three weeks. There were two older brothers in the family, the income was quite low, but the home was adequate. The child was described as being obedient, rather shy, and a "good" child. The mother felt that the child

might be uncooperative in the hospital, however, because of her shyness. Barbara proved to be quite homesick; she cried a great deal, was not shy, and was demanding of all staff members. The worker visited her often and talked with the mother by phone frequently. The mother was not thought to be very understanding of the illness or the child.

The worker continued her contacts while Barbara was at Wellesley. When the child was discharged home, there was marked weakness of the right leg and she was in a cast.

Two weeks after the discharge from convalescent home, the mother called to say that she was unable to do the exercises with Barbara. The worker saw her then, and at several clinic visits. The mother was extremely anxious about her ability to care for the child. Mrs. Z. said that Barbara was uncooperative at home, cried easily, and was irritable. The child seemed apprehensive and fearful of staff members at the clinic.

The worker talked frequently with the mother and with Barbara, giving them both reassurance and encouragement. The mother became more confident of her ability to care for the child through talking with the worker and through seeing the physical improvement in the child. Barbara, too, was helped a great deal. She was less fearful of the clinic visits and the mother stated that her behavior at home was more normal.

Red Cross transportation was provided and a VNA physio-therapist went to the home twice a week to help the mother with the exercises.

During the third month after Barbara's discharge, the mother was hospitalized, and the worker helped the mother in making arrangements for Barbara to be cared for by relatives. When the mother was home again, the VNA was helpful in caring for both Mrs. Z. and the child. The mother had been apprehensive during her hospitalization, and expressed appreciation for the coordination of interest between the worker from the Medical Center and the worker at the hospital where she had been.

> By the end of that month, the mother had recovered, and the good adjustment of the family had become re-established. Barbara's improvement was very satisfactory, and she was soon to start walking with short leg braces.

It is interesting to see how Barbara's reactions of fear and apprehension coincided with those of her mother. The anxieties and feelings of discouragement were alleviated by the worker. She also helped Barbara to make a more satisfactory adjustment to the hospitalization at the onset of the illness. Both were given the necessary encouragement and reassurance they required, and were helped by the physio-therapist in doing the exercises.

The worker was active in providing transportation facilities and in arranging with the Visiting Nurse Association for the physio-therapist. She also helped Mrs. Z. in placing the child while the mother was in the hospital, and consultations with the social worker at the hospital where the mother was were held so that the over-all needs of the family could be better understood and met.

Case 2:

> Agnes M., a sixteen-year-old girl, was hospitalized at the Medical Center for eleven days. She was the only child at home, and the home was adequate, although the income was marginal. Agnes was described as being friendly, fond of sports, school, reading, and a child of many interests. She had been badly frightened by the local doctor's interpretation of the illness; the worker was able to allay the girl's fear through talking with her. The father seemed to have defeatist attitude about Agnes' illness. The mother was deeply concerned about the child, and was also worried about a sister who had a

terminal disease and was expected to die at any time. The mother had a great many conflicts about taking Agnes home if much after-care were required, because she felt the need to be with the sister as much as possible.

Agnes had little involvement when she was discharged other than neck muscle weakness, and was to be on bed rest for two weeks. She had various exercises to do. It was interpreted to the parents that the after-effects were slight, that Agnes was able to do the exercises by herself, and could really take care of most of her own needs by herself. The mother need not be confined to the home and would be able to go to her sister whenever it was necessary.

The girl was worried about missing school, and arrangements were made for a friend to help her with lesson assignments. She was able to return to school about a month after her discharge from the hospital.

This whole family was frightened and apprehensive about the illness. They needed much interpretation and reassurance from the worker that the involvement was not to be severe. The child was given encouragement while she was in the hospital, and the parents were made to see that they could adequately handle the convalescent care.

Case 3 and 4:

Tom D., a three-year-old child, was hospitalized at the Medical Center for two weeks.

Sandra, his one-and-a-half-year-old sister, was admitted a day after Tom, and both children were discharged on the same day with slight involvement of the legs.

The home situation was adequate as was the income. There was a one-month-old brother. The father had been given a medical discharge from the service because of a chronic disease, a disease of which he had acute episodes each year, and had to be hospitalized for several months;

> he was chronically in poor health and at times was unable to work steadily. Shortly after the children were admitted to the Medical Center, the father went to the VA hospital because of a flare-up of his chronic disease. A few days later, he was found to have polio, was transferred to another hospital for the isolation period, and then was returned to the VA hospital. He had residual weakness of one leg.
>
> The mother was able to get Soldier's Relief, and was able to manage the children's convalescent care for their involvement was slight. The mother was described by the worker as being a brave, strong, competent person for being able to carry on in the face of so much trouble.
>
> The worker kept in contact with the mother during the children's isolation period and was able to give her encouragement. The mother seemed to gain a great deal of relief from being able to talk with the worker.
>
> This family was referred to the social worker at the VA hospital where the father was still hospitalized when the children were discharged from the Medical Center.

This case was a most unusual one, and the mother on whom the burden of the illness of the children as well as of the husband, fell. She was a person of great inner strength, apparently, but she found comfort and relief in being able to talk with the worker. When the worker saw that it was not within her scope to work further with this family, she referred the case to the appropriate agency, the Social Service Department of the VA hospital.

Case 5.

> George G., a seven-year-old boy, was hospitalized at the Medical Center for two weeks and then discharged to his home. He had a seventeen-year-old brother, a high school student,

and the home situation and income were adequate. The patient was in the second grade and liked school. He was described as being quite babyish, and often cried at night until the mother went to lie down with him. He had been quite upset at leaving his home and having to stay in the hospital.

The child did not adjust easily to the hospital routine; he cried a great deal, seemed afraid, and was apprehensive. The worker visited him frequently, was able to give him reassurance, and the child came to look forward to the worker's visits. George became more content and lost his fear of the staff through the worker's visits.

The parents of the child were both extremely emotionally upset by the child's illness; the father cried uncontrollably on several occasions when the worker saw him; the mother displayed what seemed to be undue concern, and also seemed to have some doubts regarding the staff's ability to care for George. The parents were given the reassurance and interpretation which helped them to better understand the illness. George's involvement was extremely slight, and the parents' anxiety that the child would be permanently handicapped was relieved through their contacts with the worker.

George had some slight muscle weakness, and needed exercises to strengthen the muscles and thus to improve a posture defect. It was felt that perhaps the parents were very conscientious about the after-care, and that they might be over-protective of George, but the whole family was helped to accept and understand the illness and the extent of involvement.

This child, the younger of two children, his brother being ten years his senior, was no doubt over-protected by his parents. The parents were highly emotionally involved in the child's illness, worried about the type of care he was receiving in the hospital, and concerned that he would be crippled. George found it difficult to adjust to

being away from home, and his parent found it hard to have him away from them.

The worker was able to give the child and the parents support during the separation, and the parents needed to be reassured that George was receiving adequate care while he was away from them, and that he would not have serious involvement. Although the parents were felt to be over-protective of the child, they were all helped to adjust to the separation during hospitalization and to the implications of the disease.

Bulbar Cases:

Case 1.

Melvin L., a seven-year-old boy, was hospitalized at the Medical Center for twelve days. He was in the second grade, and was said to be "nervous," easily frightened, and shy; he had a strong attachment to his home, especially to a twin brother.

The family was in the uppermiddle income group, and the parents were both college graduates. The father had a defiant attitude toward all medical care and thought Melvin had " adenoid trouble." Mr. L. could not at first accept the diagnosis of polio. The twin brother also had polio, but "because his case is too mild", according to the father, the other child was kept at home.

The patient had slight nasal phonation; there was no peripheral weakness, but some muscle stiffness. He was able to return to school two months after discharge.

During the hospitalization, the child was quite unhappy and shy, but responsive. The worker was able to cheer him up and to give him some reassurance. The parents needed a great deal of interpretation of the illness in order to understand the diagnosis and to see the need for hospitalization. The mother called the worker several times to learn

of Melvin's "emotional adjustment" to the hospital , and did not seem able to understand the effects that the hospitalization might have on the child.

The worker had no further contacts with this family after Melvin's discharge for the parents were confident that no problems would arise.

The worker was able to help Melvin toward a better adjustment to the hospitalization, and was able to comfort him and to cheer the patient who looked forward to her visits.

The parents evidently did not have much appreciation of the hospitalization, and perhaps never really accepted it. The worker was limited by their resistance to the illness and, apparently, to anything connected with it. She was able, however, to make the child adjust to some extent to the separation from his parents by acting as a liaison.

Case 2.

Raymond V., a six-year-old boy, was at the Medical Center for two weeks. He had two sisters, one nineteen years old, and the other, three years old. The home and income were adequate. Raymond was said to be a friendly child, in the second grade, and fond of school. He was quite upset at the separation from his family, but was able to adjust rather well to the hospitalization period. The worker saw him daily, and was the liaison between Raymond and his family. The little boy knew of another patient in the hospital who had severe crippling, and Raymond became apprehensive and afraid that he,too, would be seriously handicapped. The worker was able to reassure him so that his attitude became less fearful.

The mother was thought to be a competent, capable person, and the family was able to handle the convalescent care, although they were quite upset by the illness. Some of the mother's anxiety about the extent of involvement was relieved by talking with the worker

who reassured her that no serious crippling would result.

The patient had a nasal twang and some muscle weakness at the time of discharge. His activities were gradually increased, and he had returned to school within two months of discharge.

The worker was able to relieve anxiety on the parts of the patient and the parents in regard to the extent of involvement. She was the means through which this family kept in touch with each other during the separation and hospitalization. The child was helped in his adjustment to the separation and to the hospital routine.

Case 3.

Joe L., a nine-year-old boy, was at the Medical Center for two weeks. The parents were divorced, and Joe lived with his mother and a sixteen-year-old sister; an older brother was in the Navy. Joe was in the fourth grade and was described as being a "normal" boy by his mother; his main interest was in sports. The home situation was satisfactory, but the income was not very adequate.

Joe had a nasal twang and some slight facial involvement, but the weakness of facial muscles subsided to some extent during the hospitalization.

Mrs. L. was upset by Joe's sudden illness, by the fact that the older son had been in a serious accident, and by the rather precarious financial status of the family. The worker was able to help her reduce her anxiety concerning Joe's illness, and was able to arrange for financial assistance for the family. She visited Joe on the ward and was able to give him some reassurance, and also some interpretation of what the illness would mean to him.

After discharge, the worker visited the home and found that the mother was confident that no problems would arise.

> The case was reopened when Joe failed to keep clinic appointments for several weeks. The worker visited again and interpreted to the mother the need for Joe to be seen in clinic. The mother seemed to be rather discouraged, and she overlooked many suggestions made by the worker. Joe had been very irritable, cried easily, had difficulty sleeping, and ate constantly.
>
> He was seen in polio clinic, and was referred to a general medical clinic for a complete physical examination; he was placed on a diet. The doctors gave the boy and his mother a great deal of interpretation regarding the diet and the importance of clinic follow-up. The worker was also able to help the mother to see the importance of following medical recommendations including the diet, facial exercises, and clinic visits.
>
> A month later, the worker saw Joe in the clinic. He had been doing his prescribed exercises, had faithfully followed the diet, and had lost seven pounds. According to the mother, the boy had been getting along very well in school, had been sleeping well, was less irritable, and seemed much happier.

The worker acted as a liaison during the hospitalization period, and tried to interpret to the mother the meaning of the illness. When there was no serious involvement apparent, the mother was unable to see the need for follow-up in clinic visits. The worker helped her to realize this need, and was instrumental in getting Joe to clinic again. The mother needed further interpretation by the doctors as well as the social worker in regard to following medical recommendations. Both Joe and the mother were praised when they did understand the necessity for the diet, exercises, and clinic visits, and followed these recommendations. Joe's progress and improvement continued through subsequent months.

Case 4.

Peggy B., an eight-year-old girl, was hospitalized at the Medical Center for ten days. According to the father, Peggy was "nervous" and easily upset; she was a finicky eater and sleeper, and vomited frequently. She was an only child and the paternal grandmother lived in the household. The father said that Peggy was spoiled by the family. She was friendly and sociable, and preferred to be with friends to being at home with her parents.

The family income was rather marginal and the home situation was felt to be adequate for convalescent care.

Peggy had nasal phonation and had had some difficulty swallowing. There was also some slight muscle stiffness.

During the hospitalization, Peggy looked forward to the worker's visits and seemed to gain much reassurance and comfort from talking with the worker. The child found it quite difficult to adjust to the new situations she met in the hospital, and seemed quite emotionally upset by the separation from her parents. She at times seemed to be "jittery". She was helped, however, to a more satisfactory adjustment through the supportive contacts with the worker. The parents were also given reassurance concerning Peggy's progress in the hospital, and interpretation of the meaning of the illness.

The worker saw the family on several clinic visits after discharge, and continued to carry on a supportive role, talking with the mother about the emotional manifestations shown by the child. Four months after the child's discharge from the hospital, it was learned from the mother that Peggy was more calm and her appetite had improved. She was less irritable than she had been, and on the whole, she seemed to have gotten over any after-effects of the disease. Exercises had been done religiously and the muscles had become loosened.

The worker helped this child to a better adjustment in the hospital and gave the family reassurance regarding her condition.

The social history indicated that Peggy's tendency toward high emotionality antedated the illness, but the period of separation from the family and the possibility of the parents' being over-protective in their relief at having her at home again after the discharge would not serve to lessen this tendency.

The mother was able to talk with the worker about Peggy's behavior, was helped to better understand some of the causes, and was helped to accept the child's behavior, thus helping the child to a better adjustment. The fact that Peggy's tension and irritability had lessened and that her eating and sleeping habits had improved was evidence of the value of the mother's contacts with the social worker.

Case 5.

> Henry T., a two-and-one-half-year-old boy, was at the Medical Center for two weeks. There were strong family ties and the income was adequate. Henry was said to be a good-natured little boy who was friendly and obedient; there was one brother who was ten years old.
>
> The child had considerable involvement as a result of polio; he was irritable and lethargic during the first few days of the hospitalization. There was no peripheral weakness or paralysis, but there was palatal weakness on both sides as well as severe right facial paralysis, and weakness of some of the left facial muscles. The child was unable to close his right eye and the right side of the mouth was immobile. When he was discharged, he was on a liberal program of activities and extensive exercises.
>
> The worker saw the parents frequently during the hospitalization, and found them to be facing the illness and involvement intelligently although with deep concern and anxiety. The worker was able

> to give them reassurance and support during the isolation period. It was felt by the worker that the parents were competent and capable of handling the convalescent period and care adequately.
>
> Three months after discharge, the mother saw the worker because she was upset at the severe facial involvement, and because Henry was upset and uncooperative. The worker talked with the mother at the clinic and during physio-therapy visits over a period of several months. She was able to give the mother reassurance and encouragement in regard to the exercises, and made suggestions as to how to help Henry adjust to the involvement. The close family relationships remained strong, and through helping the parents to better understand the child's behavior, Henry was helped to a more satisfactory adjustment. The little boy himself was well aware of his involvement and seemed quite concerned about his appearance. Through the months, with repeated physiotherapy clinic visits, the polio clinic appointments, and carrying out the prescribed exercises at home, Henry's involvement gradually lessened. The worker saw the family continuously, and was able to give them encouragement during the long months.
>
> With Henry's physical improvement, came a lessening of tension and irritability; the parents were able to help him through interpretation given by the social worker, and their own anxiety was lessened.

The worker was active in this case through giving the parents reassurance during the patient's hospitalization, by being supportive, and by giving interpretation of the child's behavior to the parents. She helped the family to better understand the nature of the child's irritability and unreasonable actions. Through their better understanding, they in turn were able to help Henry to adjust more easily to the involvement.

Discussion of the Problems

Paralytic:

The main problems of the paralytic patients were adjustment to the hospitalization and residual involvement. These patients needed a great deal of encouragement and reassurance to enable them to face realistically their limitations. The parents of paralytic patients were often overwhelmed by the thoughts that their child would have permanent involvement. They, too, needed constant reassurance and support as well as help in meeting the problems realistically.

Parents were often unaware of what they could do to help a paralytic child; they, too, had an adjustment to make and possible limitations to face as far as the care of the patient was concerned. The social worker was able to help in the parents' problems of acceptance and understanding the child's emotional and physical involvement. Ways in which the parents could help the child toward rehabilitation and a worthwhile life were explained by the social worker.

Problems regarding discharge planning for paralytic patients were presented. The extent of the problem depended largely on the extent of involvement. It also depended on the physical aspects of the home, practicability of care at home, and parental attitudes. When extensive physiotherapy was necessary to retrain or strengthen muscles,

it was usually necessary for the patient to remain in the hospital or be transferred to another hospital after the acute stage of the disease. Patients and parents were often upset at this, and interpretation of its need was made by the worker.

When the paralytic child returned to his home, there were readjustments to be made by the patient and the other members of his family. Parents who were highly emotionally involved in their child's illness and handicaps often had problems in convalescent care. In this area, too, the worker was able to help the parents assume a more realistic attitude through talking with them and giving them an opportunity to express their feelings and anxieties concerning the child and the illness.

The convalescent period presented problems of discouragement, despondency, and hopelessness on the part of the patient and his parents. In meeting these problems, the worker carried on a supportive role.

Arrangements for home teachers, physio-therapists, visiting nurses, and rehabilitation plans were made, and in many cases, such plans facilitated the adjustment of both the patient and his family.

In follow-up contacts, the worker often had to interpret the need for clinic visits, and was instrumental in having many delinquent patients return to clinic. Transportation problems were presented in cases where no means

of travel was available or where there was severe involvement. The worker was able to make transportation available to these patients through the Red Cross or other volunteer groups.

Non-paralytic:

The non-paralytic patients presented primarily the same problems as those of the paralytic patients. The same fears and anxieties on the part of patients and parents concerning the illness were present. There was a slight difference, however, in that the child did not have paralysis, but the fear that it would develop was a great concern to the parents as well as to the patients who came in contact with paralytic patients on the ward. Both patients and parents needed reassurance that involvement and limitations would not be as great.

The same problems were found in this group in regard to hospital and convalescent adjustment of patients and parents. Separation from the family was difficult, and the patient needed constant reassurance during the isolation period when no visitors were allowed; the worker was also able to relieve parental anxiety and fear during this time, and could keep parents informed of the the patient's progress.

Problems in regard to discharge planning were also presented by this group. Often parents felt they could adequately care for a child at home when they knew there

was no paralysis. In some cases where muscle weakness or stiffness was not present, the patient required extensive physio-therapy that could only be provided in a hospital. This necessity for the patient to be further hospitalized was difficult for many parents to realize, but they were helped to accept it through talking with the worker.

When the child returned to his home with a slight involvement, some parents needed interpretation as to the importance of following instructions regarding exercises, rest, and physio-therapy, as well as clinic visits.

The convalescent period was often difficult for the non-paralytic patient to accept when involvement was not great, but yet his activities were limited and a great deal of rest was required. It was necessary to strengthen weakened muscles through the use of corrective exercises. If a child used weakened muscles to too great an extent, incorrect growth or malfunctioning of the muscle might result. Where involvement was not as apparent as it is in paralytic polio, the patient and his parents found it difficult to accept or understand the necessity for long rest periods and repeated exercises. This need was interpreted by the social worker, the doctor, and the physiotherapist. During long months of convalescence, there was the same need on the part of the patient and his parents for reassurance and encouragement, for the slow process of strengthening and retraining muscles was often discouraging

and trying.

Arrangements for home teachers, physio-therapists to help parents with exercises, and Red Cross transportation were also made for the non-paralytic patients.

There was more need for extensive follow-up in some cases where involvement was slight and families were not aware of the importance of clinic visits. The worker was able to interpret this need to the families.

Bulbar:

The patients of bulbar polio presented essentially the same problems as those of the paralytic and non-paralytic patients. In the majority of bulbar cases used in this study, the involvement was not great and was not very noticeable, and for this reason the parents and patients found it difficult to understand the importance of convalescence, exercises, and clinic visits.

All problems presented by the non-paralytic patients were also presented by the bulbar patients. They included the adjustment of the patient and his family to the separation, anxiety concerning the illness, discharge planning, adjustment to the home after discharge, convalescent period, and follow-up contacts.

One outstanding problem was seen in the bulbar group; there seemed to be a great deal of emotional involvement in adjustment to the illness on the part of the patient.

The children were said to be irritable, uncooperative, easily upset, and had eating and sleeping difficulties. With the exception of one case, this type of behavior had not been seen prior to the illness. The social worker was able to talk with families of the patients and the doctors in the clinic were also able to interpret to the parents the meaning of such behavior. Through such interpretation, the parents were helped to understand the children and to accept the unusual behavior while, at the same time, they, the parents, tried to correct the behavior. The deep concern and anxiety which most of the parents expressed was relieved, and the children's behavior was seen to improve as the parents' tension was relieved.

This high degree of emotional involvement and the inability to adjust well during the first few months after discharge proved to be the one problem which was peculiar to a specific type of polio. The writer found no literature which substantiated this finding, but through talking with the poliomyelitis worker at the Children's Medical Center, it was learned that she had found this particular problem more frequently among bulbar patients than the other types of polio.

CHAPTER VI

SUMMARY AND CONCLUSIONS

It was the purpose of this writer to study the problems presented by patients of the three major types of poliomyelitis, paralytic, non-paralytic, and bulbar. Through the study of the problems, an attempt was made to learn if there were specific problems peculiar to each type, to learn of the reactions and attitudes of patients and parents, and to learn if the focus of the social worker varied according to the type of poliomyelitis. The cases used in this study were those of patients who were admitted to the Children's Medical Center during September, 1949.

Social Service, medical, and clinic records of eleven of each of the types of poliomyelitis were studied, and five cases of each type found to be representative were selected for more intensive study. It was on these fifteen representative cases that the findings of this study were based. Information was also obtained from hospital personnel and the Massachusetts Department of Public Health.

The problems which were presented by patients of the three types of poliomyelitis were essentially the same; these problems included the presence of anxiety, tension, and apprehension in the patient and his family when the

diagnosis was made, and the adjustment of the patient and his family to separation during the isolation period. Plans for discharge, convalescent care, follow-up of delinquent clinic patients, and rehabilitation were other problems met by the social worker.

The fear of crippling was uppermost in the minds of parents and in those of patients who were old enough to realize the possible implications of the disease. Separation during the isolation period and hospitalization was difficult for patients and parents alike. It was more difficult for younger children who were bewildered and frightened by the separation from parents and by the strangeness of the hospital.

Plans for discharge depended to a great extent on the physical condition of the patient, after-care he would require, and the ability of the family to manage further medical care in the home. Parents were often dubious about their ability to handle the care of the patient in the home, and often needed reassurance and encouragement along these lines. When a patient had rather slight involvement yet required extensive physio-therapy and constant medical supervision which could be given only in a hospital or a convalescent home, parents and patients often needed interpretation of the need for further hospitalization after the acute stage of the illness.

The convalescent period brought out further problems in

adjustment. During this period, it is learned in paralytic cases which muscles are to be permanently crippled, and further plans for treatment or the use of appliances are made. Extensive exercises are required in all cases where there is either paralysis or muscle weakness. The activities of patients were limited, depending on the extent of involvement. A great deal of rest was required of all patients. Many patients and families found these months extremely tiresome, discouraging, and at times, hopeless. The return of function of muscles which had been weakened but not paralyzed was very slow. In paralytic cases, there were problems in adjusting to the extent of paralysis when it became known. Parents and patients needed support in realizing and accepting the paralysis and permanent crippling, and in making plans for a life in view of the handicap.

Some non-paralytic patients who had slight involvement, and also the parents of such patients, found it difficult to accept the limitations on activities during the convalescent period, and to understand the necessity for rest, exercises, clinic visits, and other medical recommendations.

The majority of bulbar patients presented a greater problem in adjustment to the illness. Seven of the eleven cases originally studied displayed a great deal of emotional involvement during the convalescent period. Three of the five cases studied intensively and presented in the preceeding

chapter showed high emotionality in adjustment. This was the one problem which was found to be peculiar to a specific type of poliomyelitis. The children were said to be irritable, tense, demanding, and uncooperative. Sleeping and eating disturbances were also noted.

The focus of the social worker was, in all cases, directed toward helping the patient as a whole person as well as his family to adjust as satisfactorily as possible to the illness, its implications, and its after-effects. The worker's role was essentially a supportive one. A great deal of encouragement and reassurance were required of the worker in all cases with either the patient or his family, and in many cases, with the patient and his family.

One hundred per cent Social Service contact seemed to be worth the supreme effort made by the department. The contact with the patient or the family on admission was important in that pertinent information regarding the patient and his family was obtained. This was helpful in anticipating possible reactions of the patient as well as his family to the illness and hospitalization, and in indicating to the staff ways in which the patient and family might be helped in adjusting as satisfactorily as possible to the disease and its manifestations.

An evaluation of the home situation was made including physical aspects of the home, family composition and relation-

ships, attitudes of parents toward the patient and his illness, and the ability of the family to manage convalescence. This was helpful when the time came for discharge planning.

This first contact with the social worker meant a great deal to the majority of families. Many parents were able to relieve to some extent their tension and anxiety regarding the illness. They found in the social worker someone who would be in contact with their child during the isolation period and from whom they could learn of the patient's progress.

During the hospitalization period, the worker attempted to give reassurance and encouragement to both patients and parents; she acted as a liaison between the patient and his family, and was able to keep staff members informed of the home situation and of parental attitudes concerning the illness.

In cases of younger children, the worker was especially helpful as a liaison and in giving the young child the reassurance that his family had not forgotten him.

Many patients and parents were helped through expressing their feelings and attitudes and discussing them with someone who was neither involved in their personal life nor in the direct medical care, yet someone who was understanding and accepting of their reactions to the diagnosis and hospitalization.

When discharge plans were to be made, the social worker's

knowledge of the physical and emotional involvement of the patient, the parental attitudes toward the child and the illness, and the ability of the family to manage the convalescent period was essential in determining whether the patient was to return to his home or was to be sent to the Wellesley Convalescent Home. Some patients were transferred to other hospitals as well as to Wellesley.

During the convalescent period when the patient was often despondent, discouraged, and had some feelings of futility, as did parents, too, the worker was able to help by giving the encouragement and reassurance so sorely needed during the long and difficult months. She was also able to help the family accept limitations and plan for a useful and worthwhile life despite possible handicaps. The worker was also active in making plans for physio-therapists, home teachers, visiting nurses, transportation to and from clinics, and plans for rehabilitation of the patient.

The problems, attitudes, and reactions of the poliomyelitis patients and their families were many and varied; they arose from a multitude of causes and combination of causes due to the complexity of each patient as a person, his family, and the society in which he lives. The worker, in focussing her efforts toward helping the patient and his family to a satisfactory adjustment to the illness, had to consider the patient as a whole person with all the elements and influences in life affecting him, his reactions to his

illness, his ability to face physical limitations, and his total life adjustment.

> Reactions to a given illness in different individuals will be determined by their diverse constitutional and personality structures, and by their economic and social circumstances. The interplay of all these elements produces the individual illness situation for each person. Therefore, the care of the whole patient, rather than treatment of the disease only, becomes the aim of all the professional workers involved.[1]

Approved:
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1 Ethel Cohen, " A Medical-Social Worker's Approach to the Problem of Poliomyelitis," American Journal of Public Health, August, 1948.

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