CONTRIBUTIONS OF EDUCATIONAL THERAPY TO THE VETERAN PATIENTS IN THE VETERANS ADMINISTRATION HOSPITALS

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Statement of Problem</td>
<td></td>
</tr>
<tr>
<td>Purpose of Study</td>
<td></td>
</tr>
<tr>
<td>Importance of Study</td>
<td></td>
</tr>
<tr>
<td>Method of Treating Data</td>
<td></td>
</tr>
<tr>
<td>Sources of Data</td>
<td></td>
</tr>
<tr>
<td>Organization of Study</td>
<td></td>
</tr>
<tr>
<td>II. THE ROLE OF EDUCATIONAL THERAPY IN VETERANS' HOSPITALS</td>
<td>9</td>
</tr>
<tr>
<td>Third Phase of Medicine</td>
<td></td>
</tr>
<tr>
<td>Education Disrupted by War</td>
<td></td>
</tr>
<tr>
<td>Advantages From Educational Courses</td>
<td></td>
</tr>
<tr>
<td>Overcoming Social Inadequacies</td>
<td></td>
</tr>
<tr>
<td>Raising Fund of Knowledge</td>
<td></td>
</tr>
<tr>
<td>Teaching Adjustments</td>
<td></td>
</tr>
<tr>
<td>Accomplishing Objectives</td>
<td></td>
</tr>
<tr>
<td>Outline of Courses and Tests</td>
<td></td>
</tr>
<tr>
<td>III. WHAT EDUCATIONAL THERAPY IS DOING TO AID THE HOSPITALIZED VETERAN PATIENTS OF VETERANS' HOSPITALS</td>
<td>25</td>
</tr>
<tr>
<td>Tuberculous Patient</td>
<td></td>
</tr>
<tr>
<td>Neuropsychiatric Patient</td>
<td></td>
</tr>
<tr>
<td>Neurological Patient</td>
<td></td>
</tr>
<tr>
<td>Cardiac Patient</td>
<td></td>
</tr>
<tr>
<td>Diabetic Patient</td>
<td></td>
</tr>
<tr>
<td>Arthritic Patient</td>
<td></td>
</tr>
<tr>
<td>Amputee</td>
<td></td>
</tr>
<tr>
<td>Malaria Patient</td>
<td></td>
</tr>
<tr>
<td>Disabilities Resulting from Accidents</td>
<td></td>
</tr>
<tr>
<td>IV. CONCLUSIONS AND RECOMMENDATIONS</td>
<td>48</td>
</tr>
<tr>
<td>Conclusions</td>
<td></td>
</tr>
<tr>
<td>Recommendations</td>
<td></td>
</tr>
<tr>
<td>BIBLIOGRAPHY</td>
<td>57</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

Educational therapy is not a new educational experiment with hospitalized veterans. Immediately following World War I, as today, there was a developing interest in increasing rehabilitation opportunities for the disabled. Unfortunately, this interest died in many quarters in the years between the wars. From it, however, did come some pioneer institutions and some needed legislation, such as the Federal Vocational Act of 1920.\(^1\) The failure of the movement to gain sufficient stature to become an accepted part of medicine can be attributed to the fact that it was restricted largely to guidance, trade training and the purely vocational aspects of rehabilitation. Few provisions were made for physical restoration or reducing the physical disabilities of the patients or trainees. When the physical condition became static, a program of vocational rehabilitation was planned, "training around" the disability rather than attempting to reduce or to eliminate it through medical procedures.

\(^1\)M. J. Shortely, Rehabilitation of the Disabled Civilian, Annals American Academy Political and Social Science, p. 239.
Until the advent of World War II medical care, psychological problems, and the vocational retraining of the disabled veterans to the point where they could resume productive work, were too frequently considered as separate and distinct processes having little relationship to each other. That they are interdependent and inseparable has been demonstrated by the successful programs in military and veterans' hospitals, and has been recognized in civilian rehabilitation by the Barden-LaFellette Amendment, which expanded the federal-state vocational rehabilitation program to include physical restoration, psychiatric service, and medical care, as well as vocational guidance and training.  

Adapting these ideas after World War I and with further impetus from the experience of the Armed Forces during World War II, the Veterans' Administration has implemented what is now termed a Physical Medicine Rehabilitation Service in each of its hospitals throughout the nation with trained physicians, known as physiatrists and with trained therapists as his assistants.

The educational program offered as a part of the Physical Medicine Rehabilitation Service in Veterans'

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Hospitals was initiated in May, 1946, under the name "educational retraining." The mission of this type of program was to give patients a wide range of educational opportunities as part of their medical therapy. Many persons, however, took the name to mean vocational training and educational achievement rather than therapy. To emphasize the medical significance of this activity, the name "educational therapy" was officially adopted in November, 1947. Efforts are being continued to impress upon doctors, therapists, and patients the concept of treatment and therapy rather than teaching and retraining.

The patients of the Veterans' Hospitals who are World War II casualties look for such a program and the opportunities it offers because they become conditioned to the idea which began with the Rehabilitation and Convalescent Service Program in the hospitals of the Armed Forces. They actually expect such activities to be a part of their hospital treatment.

Statement of the Problem

The question arises, "What is educational therapy contributing to the rehabilitation of the disabled veteran patients in Veterans' Hospitals?" The answer to this question is the problem for the study.
Purposes of the Study

It is the purpose of this study to bring together the history of the development of educational therapy as one of the phases of Physical Medicine Rehabilitation Service for disabled war veterans in Veterans' Hospitals, the aims of the educational therapy, its functions, and the therapeutic values to the patients while they are hospitalized and following discharge from the hospital.

Importance of the Study

This is the first time that such a program has been developed on a scale sufficiently large to allow for the evaluation of results. The successes of this work in the rehabilitation of disabled veterans have given new hope to millions of civilian men, women, and children with crippling disabilities. The work of the Veterans' Administration with disabled veterans might well be a model for similar projects in civilian hospitals and clinics which could enhance the rehabilitation of people whose disabilities range from amputations to cardiac conditions.

Sources of the Data

The data for this study were gathered from medical journals, medical books, hospital records, the medical library, bulletins, The Texas Outlook, conferences with
doctors, nurses, staff members, psychologists, psychiatrists, Chief of Physical Medicine Rehabilitation, psychiatric social workers, psychiatrists, patients, chiefs of educational therapy, and administrative officers of six Veterans' Hospitals in Texas, and materials from the North Texas State College, Rice Institute, and University of Houston libraries.

Method of Treating Data

Following the introduction, statement of the problem, purpose of the study, importance of study, and the sources of data, the treatment of the problem will be taken up as follows:

1. The role of educational therapy in veterans' hospitals. - An attempt will be made to show that educational activities on medical prescription have become an integral part of treatment in Physical Medicine Rehabilitation Services of all Veterans' Hospitals, and the therapeutic value of medically prescribed and supervised activities during hospital treatment aims to restore the patient to the best physical and mental state. By providing interesting and constructive stimulus through educational courses, they prevent lethargy and resulting deterioration experienced during periods of enforced inactivity. As a patient attains the goal of each separate lesson unit, he develops
new, desirable habit patterns. The patient gains much confidence in himself and in his ability to adjust to society in spite of his handicap. The patient's satisfactory achievement in educational activities creates favorable response to other therapy and to the hospital.

2. What educational therapy is doing to aid the hospitalized veteran patient of Veterans' Hospitals and restore him to normal life. - It is recognized that medically prescribed physical and mental activity, used as therapy and guided intelligently, may prevent many tuberculous and neuropsychiatric patients from returning to the hospital again. Approximately two-thirds of the patients in tuberculosis hospitals throughout the country have had relapses under the strain of unsatisfactory living and working conditions. A large per cent of the mental cases discharged from the neuropsychiatric hospitals may be expected to return, partly for the same social and vocational reasons. These facts suggest that therapeutic activities in the hospitals, which help direct patients into employment consonant with their disabilities, may be sound preventive medicine as well as far-sighted economy.

3. Conclusions and recommendations. - This study was made in the Veterans' Hospital located at the edge of Houston, Texas. During World War II this was a Naval Hospital and was built to accommodate approximately 650
patients. Since the Veterans' Administration has taken it over, the bed capacity has increased to approximately 900; there has also been an increase in personnel.

Patients have come to this hospital from all parts of the country and they are men and women of many different nationalities.

Because educational therapy is only one part of the medical treatment received by the hospital patients, one can not offer concrete evidence of physical and mental improvement attributable to this activity alone. It is encouraging to note, however, the increasing number of referrals, an average of fifty patients per month, by ward physicians, and the evident satisfaction of doctors and patients with the results obtained.

As for the extent of the educational therapy program and the educational accomplishments of the patient concerned, it is possible to present figures and case histories which can be ascertained with certainty.

Organization of the Study

Chapter I gives the events that stimulated organization of the educational retraining program in Veterans' Hospitals; how the department was set up in hospitals; the place it takes in the treatment program of patients; how it is directed and coordinated by the Chief of Services,
who is a physician, known as a physiatrist. Chapter II is an attempt to show the various phases of practical and successful educational activities which contribute directly to the medical rehabilitation objective of the patient, and how to achieve maximum benefits from educational therapy courses prescribed for the patient's rehabilitation program. Chapter III reveals the work of the therapist in Educational Therapy with tuberculous, arthritic, neurotic, paraplegic, hemiplegic, multiple sclerotic and orthopedic cases. In Chapter IV, the study is concluded with a discussion of the values derived from this phase of rehabilitation; its importance from a monetary standpoint; and the number of handicapped persons taking training showing an increased yearly earning after discharge and program rehabilitation.
CHAPTER II

THE ROLE OF EDUCATIONAL THERAPY IN PHYSICAL MEDICINE REHABILITATION

The Medical Rehabilitation Service, speaking comprehensively, has been called the third phase of medicine, following logically after the first and second phases, namely preventive and acute. Preventive medicine is concerned with personal hygiene and public health measures to prevent or isolate disease. In the acute phase, the surgeon or physician diagnoses and administers definite treatment to the patient. The third phase is the evaluation and correction of social, mental, or physical disabilities that may have been left in the wake of sickness or injury.¹

Where complete correction is not possible, this third phase consists of assisting the patient in learning to do without, with what is left, or with what is added, to the end that he may be returned to the community in a personally satisfying and socially useful condition.

¹George Walker, "Hospital Program Works Miracles For Veteran," Texas Outlook, XXXII (June, 1948), 25.
In the past there were too many instances where patients who had been capable of indulging in constructive mental and physical activities had instead spent their time in ways which not only did not speed their recovery but actually retarded it. In too many cases "rest" had resulted in deterioration, and had contributed to atrophy, physiologic disfunctions, and the development of emotional disturbances. It is hoped that use of the Medical Rehabilitation program activities will eliminate many of these evils.

The expansion of the concept of rehabilitation has been brought about by the realization that a patient is more than a physical being. Most programs of rehabilitation have relied for success upon physical reconstruction alone. Too often the psychologic aspect of medical rehabilitation has been treated as a plus factor, added to the services of others. Effectiveness demands an integration of the physical and psychological processes into the total rehabilitation experiences, for an important problem is related to the patient's ability to accept and live with his physical handicap and develop a positive desire to be a self-supporting, responsible, and civic-minded individual.
It is difficult to teach the young veteran patient his responsibility to the community since his relations to it and his home were disrupted during the formative period of his life. Military life, with its enforced regimentation and dependency, often nipped the budding efforts toward responsible living in those who had prepared for it. There were many others, however, who had not received adequate or proper preparation in their homes or in schools. Still others assumed responsibilities during the war years for which they were not ready, such as marriage, family, and home. Boys returned from the army still boys with the responsibilities of men. When on this is superimposed physical disability with its accompanying sense of helplessness and insecurity and the undesirable fellow-travelers of illness—pensions and dependency, the outlook can become most discouraging.

This problem is being approached in the Veterans' Hospitals through education. With the emphasis in the present-day treatment on the "whole man", and not just the disease, the newer type of treatment is being carried on in the Veterans' Administration Hospitals. Educational activities on medical prescription have become an important part of the treatment in the Physical Medicine Rehabilitation Service. The results of this treatment, fairly evaluated by physicians in close contact with the
patients, fully justify its name—"educational therapy."
The therapeutic value of medically prescribed and super-
vised activity during hospital treatment is now generally
accepted by the medical profession. Modern medicine not
only treats the localized condition, but aims to restore
the patient to the best possible physical and mental state.
It provides a laboratory for group experience in objec-
tive thinking, tolerance, and understanding, for broaden-
ing the view of human relationships, and in general, for
equipping the veteran patient with perspective through
which he can better relate himself to society.

The educational part of the program is not only diver-
sional but it furnishes motivation to raise educational
level, develop occupational competency, and raise new
interests aimed to help the patient and make a better
citizen of him on his discharge from the hospital. The
concept of such a program, of course, is based on the idea
that convalescence does not mean "bed rest" and that "bed
rest" alone is contra-indicated in many cases, as has
been proven through work with patients in the hospital.
The objective studies, such as those carried on by Van
Ravenswaay and others, with groups of typical pneumonias
patients in AAF Hospitals, have clearly demonstrated that
groups taking active part in such educational programs
under proper medical supervision recover more rapidly and
suffer fewer readmissions than those groups not actively participating in the program.\(^2\) The results of such activities on over-all patient outlook and morale can be seen by experiments in many hospitals.

Educational therapy can assist in overcoming social inadequacies if pursued forcefully and intelligently. In addition to the academic subject content of the courses taught in education, much of the subject matter can be exploited to teach patients a greater awareness of the world in which they live, to encourage them to evaluate themselves in relation to society, and to help them to think about human relationships. Successful completion of prescribed educational activities may sometimes be the first tangible evidence to the patient that he can accomplish something.

The educational program consists of projects and activities which stimulate and activate the patients through education, orientation, and shop activities, thereby encouraging the development of mental attitudes conducive to health and normal activity. The program activities are supplemented by pre-vocational and guidance work and measurements in an endeavor to offer each patient the activities from which he derives the most good. Of significance also is the fact that the material which is

\(^2\) A. Keys, "Deconditioning and Reconditioning in Convalescence," Southern Medical Journal, XLI (April, 1945), 44.
available can usually be adapted to the particular educational level of the patient. Naturally, the problem varies in many cases with the individual patient, and in other cases with the type of hospital. Education can foster better relationships between the patient and his fellow patients and between the patient and his total community.

Educational therapy can secure the more practical results of vocational training which are best taught simultaneously with physical restoration activities. The third objective of educational therapy is to raise the patient's store of information to that commensurate with his new occupation or social environment.

One way to improve the social adjustment of the patient is to teach him to accept and live with his disability and remaining abilities. This requires a reorientation of his philosophy of life to calmly resign from all activities no longer within the range of his ability. This is very difficult and requires considerable assistance from a psychiatrist or psychologist at the beginning. These patients will frequently need a spiritual advisor who may be a chaplain, social worker, vocational counsellor, therapist, nurse, or even another patient; this advisor must be patient and know how to sympathize and when to criticize without undoing the work of someone else striving toward the same ends. The process of inculcating social ability
and self-sufficiency is the first phase of educational rehabilitation and may take so long that it will overlap the rest of the program and therefore require thorough integration with it.

As soon as a patient is admitted to a Veterans' Hospital, he is given appropriate vocational tests to determine what he wishes to do and what he can do in terms of his mental or physical abilities. As soon as he is ambulatory, and in some cases even before that time, an extensive program is made available to him. Complete and well equipped physical therapy departments assist him in the restoration of the function of an injured leg or arm.

In addition, the more seriously injured is assisted in his recovery by corrective therapists. These men are extremely important in such work as teaching amputees or cripples to put on and take off braces, or to acquire the difficult and new techniques of crutch walking. They assist the paralyzed in reaching the independent state of self care.

Educational courses are offered to the patient. There are therapists assigned to the Physical Medicine Rehabilitation Service who teach classes and assist with individual study in hospitals. There is a difference between a therapist and a teacher. As therapists, the instructors work under the guidance and direction of a physician, executing
his prescriptions and administering purposeful activities directed toward total rehabilitation. They are not teachers under the Board of Education.³

Conducting an educational therapy program in a hospital is not as easy as ordinary school teaching. The students, being patients, have a natural lethargy resulting from long hospitalization. Then, too, the patient's illness or disability makes him distracted, and the concentration necessary to success is achieved only by unusual effort on the part of the patient as well as the therapist. Courses cannot be started, pursued, and ended in the customary way, for there are patients entering and leaving the hospital every day, with absolute disregard of terms and semesters. Equally difficult is adherence to a fixed daily programs, since clinical appointments or other medical treatments frequently interfere with class attendance or ward schedules.

To meet these problems a progressive plan known as "go-your-own-pace" education is recommended. Self-training texts or correspondence courses are supplemented with reference books, charts, films, models, and practical visual aids. Therapists serve as group coaches, helping each patient as he studies the course of his choice. The friendly counsel of the therapist often encourages and stimulates the patient to efforts he might never exert in

³Howard A. Rusk, and Eugene J. Taylor, New Hope for the Handicapped, p. 46.
a class room of the usual type. The patient covers as much of the subject and words as hard as in conventional school, but he is on his own as far as progress is concerned. His motivation, capacity, and effort determine the time necessary to finish a course, rather than a time schedule based on average performance.

Another advantage of the "go-your-own pace" method is the variety of courses offered by a single therapist. In mathematics, for instance, a single therapist may supervise patients in the class room or on the wards studying various branches of mathematics, all the way from arithmetic to calculus. The same would be true of social studies, commercial subjects, or any other group of related courses.

Progress notes are kept on all patients for whom educational therapy has been prescribed. The therapist makes comments and observations concerning the attitude, degree of cooperation, physical tolerance, habits, and emotional reactions of patients to different situations, and on the work units of the course itself. Poor or unsatisfactory progress by the patient is noted and referred to the Chief of the Physical Medicine Rehabilitation Service. This may occasion a change of prescription of technique in approach. When the prescribed educational therapy has been completed, a brief summary of aims achieved is included in the progress notes. These are available to ward physicians, psychiatrists, or other staff physicians through proper channels.
In attempting to raise the patient's fund of knowledge it is also possible to raise his standard of living, even though his level of intelligence may prevent elevation in social status. A severely disabled common laborer must be trained for work requiring more thought and less action, for a skilled or semi-skilled job. Some of these skills may seem to be within easy instructional reach; however, one must not underestimate the need for collateral education in subjects related to or essential for vocational training. In the course of collateral education, latent talents may be uncovered. This was the case with a truck driver whose education was interrupted early in life due to financial need. Testing at the hospital showed aptitude for commercial art. When the training for this craft is completed, this patient will require much non-technical education to make him acceptable to a community of people earning similar incomes. He might even be rejected if it were learned that he had not gone beyond the fifth grade in school. Such a patient deserves the social protection which additional preparation may afford.

The problems of rehabilitation are closely allied to motivation, of which there are two kinds. Internal motivation is something which cannot be taught or destroyed any more than its chief components, ambition and drive. External
motivation is "second best" and attempts to stimulate the patient in terms of security, honor, respectability, and satisfaction of a job well done.  

In accomplishing the objectives of the Physical Medicine Rehabilitation Service, educational therapy aids in the treatment of the patient by:

1. Furnishing practical and purposeful activities which:
   a) Contribute to the medical rehabilitation objective of the patient.
   b) Serve as means of measuring his work capacity.
   c) Provide motivation for further rehabilitation.
   d) Aid in decreasing the convalescent period through a planned program of activities.
   e) Promote new vocational interests.
   f) Create self-confidence in the patient.
   g) Build patient morale.
   h) Encourage wise use of leisure time.
   i) Furnish socialization activities which develop desirable habit patterns.
   j) Assist the patient in his readjustment to normal community life.
   k) Develop occupational competency.
   l) Provide opportunities for exercise of the patient's resourcefulness.

\footnote{Robert W. Boyle, "The Role of Educational Therapy in Rehabilitation," Occupational Therapy Rehabilitation Journal, XXVIII (February, 1949), 31.}
2. Offering to the seriously disabled patient incentive and opportunity to explore new interests in practical fields commensurate with his abilities and disabilities, in order to insure the optimum social and economic readjustment necessary for his rehabilitation.

The effective education process for both normals and subnormals is contained in Dewey's comprehensive dictum, "We learn by doing." 5

Teaching Adjustments

The following suggestive teaching objectives will be helpful for the purpose of utilizing effective educational approach to problems of therapy:

1. Set up therapeutic teaching situations that are natural, desirable, real-life situations for the program.

2. Provide situations which stimulate wholesome self-expression and emphasize individual responsibility.

3. Adjust situations to varying conditions such as climatic conditions, approaching holidays, and outside attractions.

4. Let patient exercise his initiavitiveness and resourcefulness and use his ideas as much as possible.

5 John Dewey, Interest and Effort in Education, p. 35.
5. Treat the patient as an adult and not as a child. Give him assignments and let him work them out with as little aid as possible.

6. Make the program progressive and stimulate progression in achievements.

7. Provide ample opportunities for retrials, correction of mistakes, and repeated practice for the formation of improved habits.

8. Apply sound educational psychology as an aid in the therapeutic practice.

9. Acquaint the patient with performance tests.

10. Devise ways of influencing the twenty-four-hour-day health behavior of the patient.

11. Devise ways of using every minute of class time most effectively.

12. Set up for attainment such standards as knowledge, skills, and attitudes, to promote progress toward educational and reeducational objectives.

13. Follow a systematic plan for maintaining the health and social efficiency of the therapist by avoiding overfatigue, utilizing opportunities for recreation, and conserving nervous energy.

14. Utilize appropriate prescriptive mental activity to prevent or minimize the deconditioning
phenomena and general deterioration which frequently accompany an extended period of "bed rest."

Courses and Tests

The educational material used in the Veterans' Administration's educational therapy program are obtained from the United States Armed Forces Institute (USAFI). These courses, approximately 150 in number, are especially suited for hospitalized patients who wish to qualify for secondary school credit. Selected elementary school subjects and a number of college courses are available. In addition to the academic and business courses, a wide variety of technical subjects are offered. These are especially useful for patients receiving manual arts therapy or patients who have worked at trades without technical preparation. A carpenter, plumber, electrician, or mechanic may have only a brief stay at the hospital; however, if he occupies his leisure time with blueprint reading, theory of electricity, or some other suitable subject, he leaves the hospital with knowledge which makes him a better workman. Further, he Acquires a taste for self-improvement which may lead to vocational advancement. Some of these courses are:

1. English and Mathematics

(These subjects aid the patient in preparing for the general Educational Development Tests for a diploma or a Certificate of Equivalency.)
2. Miscellaneous high school courses.

3. Courses prescribed by the patient's own high school.
   (Often this includes a history or civics course.
   High schools accept courses completed in the
   hospital because they know the final examinations
   in such courses are graded by the University of
   Wisconsin.)

   (Many of the patients plan a future job in the
   commercial field. Bookkeeping, typing, shorthand,
   salesmanship, business arithmetic, and office
   management are among the courses most often
   studied at the hospital under observation.)

5. Courses preparatory to college work.
   (For the patients who plan to enter college for
   the first time or continue college training, there
   are courses in English that will aid in freshman
   English courses. Mathematics courses (algebra,
   geometry, trigonometry, and slide rule) and com-
   mercial courses as mentioned above are also in
   this category of courses.)

6. Technical courses.
   (Patients who have started courses in radio,
   electricity, automechanics, and other technical
   subjects are usually eager to continue their
   study.)
7. Miscellaneous courses.

(Some patients ask for courses in farming, poultry raising, psychology, French and Spanish.)

The success of educational therapy depends upon the personality and ingenuity of the therapists who treat the patients. In most hospitals, personnel is limited and the variety of courses requested by patients is extensive. Because of the self-teaching nature of the USAFI texts, instructors have been able to teach widely diverse subjects satisfactorily.
CHAPTER III

WHAT EDUCATIONAL THERAPY IS DOING TO AID THE

VETERAN PATIENTS OF THE VETERANS' ADMINISTRATION HOSPITALS

When thinking of the physically handicapped, most people are prone to think in terms of orthopedic and neurological disabilities, disabilities which are readily visualized. Amputees, paraplegics, hemiplegics and the cerebral palsied suffer disabilities which are generally recognizable even to laymen. For many years rehabilitation was centered around this group. Their disabilities and needs for physical rehabilitation and vocational training were obvious.¹

There are thousands of other persons, however, who are similarly disabled by medical conditions not readily recognizable. These conditions are just as handicapping in terms of the medical, physical, social and economic effectiveness of the individual as those conditions which are readily recognized. As their disabilities are not visible, such persons themselves do not consider themselves handicapped, such as the person with tuberculosis.

The following are case reports of patients with whom the writer worked during the course of the study.

¹Howard A. Rusk, New Hope for the Handicapped, p. 3.
Tuberculous Patient

Educational therapy has a definite place in the treatment program of tuberculous patients; because of the long period of hospitalization involved with tuberculosis, perhaps these patients are rendered the greatest service.

Because of the chronic nature of the disease, the rehabilitation of the tuberculous is a complex problem in which the social, emotional, and economic aspects are frequently as important as the medical aspects. The results obtained through complete and prolonged medical care can easily be destroyed by an emotional conflict, a difficult home situation, or the lack of a suitable job.

Rest is the first and one of the most important parts of the medical treatment for the tuberculous. Complete rest is the doctor's goal—mental and physical rest. The doctor knows, however, that putting a man's body at rest does not necessarily mean putting his mind at rest at the same time. The old adage that an idle mind is the "devil's workshop," is applicable in the care of the tuberculous patient. The patient lying in bed with nothing purposeful to do has time to think of his illness; to worry about himself, his family, and a myriad of other things; and to imagine all sorts of non-existent situations to cause additional worries. The monotony of day after day of resting becomes all but unbearable. There are those to whom
rest brings restlessness and irritability. The tuberculous patient cannot "work it off" or "walk it off". To help overcome some of the boredom and monotony of enforced rest and divert the patient's attention from his illness, educational therapy may be prescribed early in hospitalization because the classroom studies can be brought to the patient's bedside at whatever time the doctor may prescribe. The course or courses can be readily adapted to the educational background and the mental capacity of the patient.

One patient referred to the educational therapy department by the ward physician discovered that he had a special aptitude in bookkeeping. This patient completed five courses including advanced bookkeeping and then began to work in advanced accounting. His interest increased from day to day and more than once he remarked to the therapist, "I want to get well and be as good a bookkeeper as I am a musician." His rating as a musician was excellent. Another patient who was a day laborer with a construction company pursued a course in radio by correspondence but discovered that he did not know mathematics. That patient has learned the fundamental principles of mathematics and is now studying algebra. Since the review in arithmetic, the patient has discovered that radio is not so difficult as he had at first thought.
Many tuberculous patients have discovered latent talents such as art, writing newspaper articles, and making reports to the newspapers. These patients receive instruction in English from the therapists. Patients also explore courses such as salesmanship, accounting, radio, farming, small business management, poultry raising, law, psychology, insurance, and real-estate.

Many of the older patients, or patients of World War I, are hesitant about enrolling because they think the program is intended for the World War II veterans. These older men need a great deal of encouragement. One patient was unable to read or write. The doctor prescribed educational therapy, but the therapist was unable to interest the patient in learning to read or write until he was able to go into the classroom. He was timid about learning the ABC's before the other patients in the ward.

"What can I do when I get out? Can I go back to my old job? I have never had a job; what will I be able to do when I am discharged?" These and similar questions are put to the doctor by every tuberculous patient. The truck driver knows that he cannot go back to truck driving; the shipping clerk who has had a thoracoplasty knows that he must find a less strenuous job; and the man who quit school in the seventh grade knows more than ever now that he needs
additional education. The educational therapist assists the patients in finding the answers to these questions. Specific courses which might help the patient toward his objective while he is still in the hospital could be suggested for the tuberculous patient. For a great many of the patients in tuberculous wards, as in the other wards, one of the first educational goals indicated is securing a high school diploma or a certificate of equivalency. Many patients with as little as a fifth grade education have successfully passed the test for a diploma or certificate.

Besides offering opportunities for men to explore new possibilities with reference to post-hospital jobs and to actually engage in activities that are geared to their new objectives, educational therapy offers the man who does not have a job that he can go back to, an opportunity to spend some of the long hours reviewing courses or learning new skills.

In addition to motivating the patient to want to get well and providing him with essential knowledge and skills for his post-hospital job, these purposeful educational activities provide for the doctor a measure of the patient's physical capacity. From the beside-the-bed class of fifteen to thirty minutes while still on strict "bed-rest", the patient, as soon as he is ambulant, may be assigned to
classes in the educational therapy building. In typing, for example, the doctor may request a periodic report from the therapist on the patient's reaction to exercise involved in walking to and from the class, and in performing gradually lengthened typing exercises. For patients who are planning to enroll in college after discharge, the doctor may request the educational therapy department to set up a routine of classes, study, and walking to and from classes, approximating as nearly as possible an actual college situation. This is done in order to check on the patient's physical fitness for such a routine, and to condition him for it.

Neuropsychiatric Patient

The program for the treatment of the mentally or the emotionally ill is planned so that every physician, nurse, therapist, social worker, recreational leader, and aide who comes in contact with the patient is familiar with his case. Each worker is taught to demonstrate a consistent attitude, such as "unsolicited affection, active friendliness, firmness, denial of sympathy, or matter-of-factness," toward the patient.²

Well selected work must become the bridge that leads from the ruins of disease to health and life. Latent

capacities and new interests must be developed, and pathological attitudes must be replaced by the attitudes of the normal worker. The reshaping of the patient's whole activity is one of the most important aspects of educational therapy. The recommendations for the education are made by the patient's ward physician and sent to the education department.

This recommendation is called the consultation. On it is a brief diagnosis with a character sketch and the objectives desired for the therapist to review before enrolling the patient. The patient is brought to the clinic by an attendant and put in the therapist's charge while taking mental treatment. Individual attention is given to each patient to see that work is carried out effectively and correctly. Work is introduced by examples rather than by the ordinary form of explanation. For instance, finished products must be shown the patient. In a typing lesson, the lesson is typed out for the patient in order that he may copy it verbatim. Typing can not be taken as slowly as with ordinary patients for the mental patient must see some results immediately or he will become discouraged. He must start typing words and sentences to gain a feeling of effectiveness. The end result and how it is achieved must be shown in a short, clear-cut manner; otherwise, patients of this type are treated as any other patients who are allowed
Pathological behavior is consistently ignored and its correction is sought through any activity which stops it. The two most popular courses for these patients are typing and mathematics.

Art is definitely established in the treatment of the mentally ill patient, especially the schizophrenic. One must think in terms of the "artistic side" rather than in terms of arousing a mere interest or a part-time activity. In this way, the patient finds expression in phantasy plus an appreciation of art itself. Since those things which he enjoys afford an outlet, he may find some relief in the activity. Long tables in the center of the room have been found more effective than individual tables because they allow the individual patient's work to be seen, admired, and discussed by the other patients. This activity stimulates socialization. The room should be attractive in order to stimulate interest. A sense of pride in work can be accomplished and a sense of personal pride in appearance can be developed through neatness of surroundings and neatness of work. In a calm, attractive room a more happy attitude and a more healthful state of mind can be created within the emotionally ill patient.

One particular case has been of great importance in the field of art in educational therapy. The patient was twenty-three years of age with a diagnosis of schizophrenia, paranoid type. He was somewhat shy and sensitive about his appearance. It was learned from the patient that his mother was a religious fanatic, and the patient was reared in a very strict and rigid atmosphere.

The patient's initial production in art was characterized by wide sweeps of vivid red, orange and black. The second drawing showed erupting volcanoes. These drawings suggested the expression of intense emotional turmoil and aggression. The third drawing, after a lapse of three weeks, was very different in that it was a character painting. The hands were those of the patients; the peanut brain within the skull represented the inadequacy of mankind. The eyes protruding from their sockets were so placed to show that man did not use them for seeing. The agonized mouth indicated man's suffering, as did the tear drops. The ever-watchful eye represented to the patient "them goddam cops", indicative of his previous conflicts with the law, his suspiciousness, and his paranoid tendencies.

After this outburst there were conferences with the patient in which he revealed strong hostility toward law and law enforcement officers. The therapist discussed the need of law in a modern society and attempted to orient the
patient to real situations in regard to law and order in
an attempt to encourage him to accept such situations as
necessary.

The patient's relationships with the therapist, the
department, and his fellow patients improved to a marked de-
gree at this point. He executed an oil painting of "The
Last Supper" for his favorite aunt. He also asked to be
allowed to paint a mural for the benefit of the hospital.
The mural proved to be a source of narcissistic gratifica-
tion which had previously been lacking in the patient. He
expressed himself thus, "Isn't it funny how some paint on
a wall can make so many people happy."

A definite clinical improvement manifested by increased
capacity of relationship with others and a better orienta-
tion for reality was soon evident. The discovery of his
talent for drawing and painting produced a desire to further
his abilities in this type of work upon his discharge from
the hospital.

Another interesting case was that of a patient, thirty-
five years of age, classified as a psychopathic personality.
At the time when he started his first course, he had just
been transferred to the Veterans' Hospital from a civilian
hospital. The purpose of the course was to allow him to use
some of his time constructively while hospitalized. He
completed the course in blueprint reading and plan reading in
four weeks. He spent an hour each day going over the completed assignments with the instructor. His work was always carefully and neatly done, and the grades on the completed assignments were high. He soon spontaneously asked for another course of a vocational nature, one that would help him in some work that he might do after leaving the hospital. Meanwhile, the Social Service Department had made tentative plans for releasing him and placing him in a job in a nearby town. The course selected for the patient was practical applied mathematics. He completed the course and soon left the hospital. He is now secure and happy in a field he previously feared was closed to him.

Several months after his discharge from the hospital, the patient was seen by his instructor in town. The patient said, "You have no idea how much that last course helped me in my work. In fact, I could not have done the estimating and figuring that I have to do without it."

Another mental patient was forty-seven years of age, classified as a case of involitional melancholia. This patient was a refugee who had previously been a gynecologist in Bavaria. Early in his hospitalization, he expressed a desire to improve his English. An elementary course called "Plain English" was selected. His progress was somewhat hampered in that he, characteristically enough, felt himself somewhat unworthy of any special therapy or attention.
However, with shock treatment and psychotherapy, he gradually overcame this idea and did excellent work on the course, continuing it after his release from the hospital.

In working with neuropsychiatric patients, the educational therapists have had the whole-hearted cooperation of nurses. The nursing angle is presented by Katherine M. Steele, R.N., formerly Superintendent of Nurses in one of the larger Veterans' Hospitals. She says:

Educational therapy is one of the therapies that should be used in all hospitals, especially with Neuropsychiatric patients. It is effective with many different types of patients, but I think at the moment of the long-term patient who has benefited not only from the standpoint of rehabilitation, but from the creation of a new interest and a constructive method of self-expression.4

Neurological Patients

Patients with hemiplegia are the most common of the paralyzed patients enrolled in the educational therapy clinic for treatment. Most patients who have suffered a hemiplegia are somewhat stunned by the suddenness and effectiveness with which their disability has struck them down. They are impressed with their impotence to combat the disability. If the patient recovers considerable motor and mental capacity, and if the condition was other than traumatic, he

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4 Katherine M. Stelle, "Care of Mentally Ill," Mental Hygiene, XXXIII (October, 1949), 91.
exists in constant dread of recurrence. This greatly affects his attitude toward the future. His ego has suffered a blow. If he is the breadwinner of the family, a feeling of insecurity usually spreads to other members of the family, and the patient needs courage to fight back.

Speech in the hemiplegic is usually deficient. This provides a need for the educational therapist to begin reeducating the patient to use his vocal capacities and make him see the need for relearning the technique for speaking words and making sounds. This takes patients a great deal of time and involves patience, tolerance, and a real understanding of individual likes and dislikes.

The hemiplegic is often taught to write or type in order to gain coordination and control of his arms. The patient works short periods in mathematics, reading, and spelling classes.

The most successful rehabilitation is with the young patient who has received a hemiplegia through trauma, in whom some physical incompetence is present, but in whom mental facilities are unimpaired. This type of individual has a self-limited pathology, has the energy and ambition of youth, is not too old to learn and progress in a new vocation, and can easily be injected into competitive living with enthusiasm, confidence and hope of achievement.
This is the type of case which is being rehabilitated most successfully as post war convalescents.

Any degree of self help on the part of the patient means less diversion of others about him. The patient is given exercise in physiotherapy and corrective exercises to regain his balance, and in mental therapy to gain to a certain degree a feeling of security and independence.

The paraplegic is in much worse condition than the hemiplegic since much of his body is affected. Until the beginning of World War II, little was heard of the paraplegic patients. The majority either died or were bedridden invalids for life. With the new surgical techniques and new drugs, these patients continue to live.\textsuperscript{5} The primary rehabilitation problem with the paraplegic patient is teaching him to walk on braces and crutches. Although many patients will prefer to use a wheel chair a major portion of the time, the great majority of patients whose spinal cord injury is sufficiently low that their upper extremities are not affected, can be taught to walk. Even being confined to a wheel chair permanently does not mean that the person can not continue to lead a useful, productive, and happy life.

An interesting paraplegic case was a twenty-four year old Air Force Navigator, paralyzed from the waist down as the result of a crash at the beginning of the war. He became interested in bookkeeping although he had had no previous knowledge of the subject. At first, instruction was given at his bed. Months later, the patient came to the clinic in his wheel chair for further instruction. This patient completed the course in bookkeeping and became an efficient bookkeeper. He also learned to operate many office machines, learned to type, and developed skill in filing. This patient is now holding a job for a very reputable concern in his home town; although confined to his wheel chair most of the time he is leading a happy and contented life with his family and friends.

Many paraplegic patients pursue exploratory courses in such subjects as electricity, radio, law, or any of the technical courses which provide a great deal of reading. One patient became interested in small business management, completed two courses, passed the tests, and was so enthusiastic that he set up a small grocery business in his home town after discharge from the hospital.

There are many patients suffering from multiple sclerosis, cerebral palsy, and poliomyelitis. Added to the ranks of those who are disabled by these neurological conditions are many who are disabled from Parkinson's
Disease and strokes of apoplexy. Their stories are much the same. Theirs is the problem of learning to live and work with what is left. Each case, regardless of how handicapped the person may be, retains more ability than disability. In order to live the most useful, happy lives possible, each patient of this group must have a chance to develop his abilities. Much is gained from the mental therapy including benefits from socialization. The patients of this group learn to read and enjoy what they read; they learn to correspond with their families; and they learn to do many activities which they had given up as hopeless.

Cardiac Patients

Little can be said of the cardiac patients. They are often prone to "take it easy" and give up everything to wait for termination. One type of cardiac disability is well illustrated by the case of a young man twenty-six years of age. He had always been nervous and was given a medical discharge from the army. The doctors had made complete physical examinations the results of which had made the patient very "heart conscious," overprotecting himself and talking about his condition. The patient wanted to learn to read and write but attended the clinic irregularly until he became so interested in his education
that he forgot about himself and his condition. He then progressed until he was able to write letters and read a great deal of the time. He pursued typing for a pastime, an activity which may become of more importance in future life for him.

This case is typical of many cardiac patients or people convalescing from similar illnesses. They like to read. Often persons not so accustomed to reading seem to display a greater interest in books during hospitalization. This is probably due to the fact that they are faced simply with the problem of filling in spare time. Naturally, the effects of their reading will depend on several factors; prominent among these are the points of "why we read, what we read, and how we read." At this point it is simple to turn to the theme of therapeutic reading. If a patient can give his mind to the written words of a book, he may be able to dismiss his bodily ailment from his thoughts.

Arthritic Patient

The cause of the common type of arthritis is not known. Because of the aura of mystery that surrounds this condition, the patient grasps at any therapeutic straw which offers hope. A person suffering from arthritis needs first to know as much as possible about the disease, for his attitude while under-going treatment is of major
importance. He must realize that there is no specific
cure, that treatment is tedious and protracted, and that
the type of treatment and the length of time required
depend upon the type of disease and its stage of progress-
ion. With proper treatment much can be done to alleviate
pain, prevent deformity, and in some instances aid in
the actual remission of the disease process. 6

It is often surprising what can be done to rehabili-
tate the severely disabled arthritic. A good example is
the case of a patient who entered the hospital in Amarillo,
Texas, in early 1947. Hospitalized intermittently since
1935 and continuously since 1939, he looked forward
despondently to spending the remainder of his life in a
Veterans' Hospital. He dreamed of a business of his own,
but he knew that his chances were slim since arthritis
had caused calcification of the joints. When the educa-
tional therapy program was started in that hospital, the
patient enrolled in English, arithmetic, bookkeeping, and
other courses. He was then given on-the-job training
with the hospital dietician, cooks, and canteen manager.
When this patient finished his training, he was discharged
from the hospital. A local banker, willing to take a
chance on courage and initiative, underwrote a two-thousand

6 Robert W. Boyle, "Arthritis and Its Effects Upon
Patients," Occupational Therapy and Rehabilitation Journal,
XXVIII (February, 1945), 345.
dollar loan; a real estate agent helped him locate a suitable building; equipment from the post exchange of an inactivated airfield near by was bought through war surplus; and this patient was started in the restaurant business. His business grew and his name was scratched from the list of men destined for a life of inactivity and constant care. Although still confined to a wheel chair, he is independent and on his own. He has been rehabilitated in the broadest sense of the word.

Diabetic Patient

Unlike most other chronic, degenerative diseases, diabetes can be controlled completely if the individual has an understanding of his problem, makes a co-operative effort, and has adequate medical management. It is a disease in which it is necessary for the patient to become a member of the therapeutic team; he must know his condition, its signs, and the basic problems of its therapy. Actually the diabetic suffers from one handicap alone - he has to pay more attention to his health than the average non-diabetic.7

The diabetic patient can learn to live and work with his disability. He must be taught that he is personable, intelligent, and capable of working as hard as anyone else.

7Charles J. Katz, "Experiences in Army Camps as a Background to Therapy," Mental Hygiene, XXXIV (January, 1950), 92.
Educational therapy encourages diabetic patients, who are usually in the hospital for short periods, only to make good appearances while on the job. A few diabetic patients pursue typing for practice in speed and accuracy and review mathematics. They must learn to live not only within the limits of their disabilities, but to the hilt of their capacities as well.

The Amputee

That successful rehabilitation can be accomplished with the most severe cases of amputation is illustrated by two World War II veterans who suffered the loss of both arms and both legs. One of the young men took English preparatory to entering college while hospitalized. This patient was discharged and is now in the University of Texas as a pre-law student. He found it difficult at first to learn to walk on his artificial limbs as he could not grasp his cane. He learned to shave, dress himself, and use an electric typewriter.

The second young patient is now studying farm methods on a farm purchased for him by the citizens of Chicago. He had had no previous experience as a farmer but while hospitalized he took up courses pertaining to farming. He studied arithmetic so he could keep books on his model
farm, and studied means of making it a paying enterprise. He was given a tractor rather than the usual car given to eligible amputees. In addition to raising diversified crops, he has mastered the use of a self-designed shotgun to such an extent that quail and squirrel hunting have become his favorite outdoor hobbies.

The greatest problem facing the newly amputated person is the selection of an artificial limb. To him, the limb is more than an artificial device which will permit him, with proper training, to regain many of the skills and abilities he has lost. It is a symbol of the transition back to normal living. In it, and his ability to wear it comfortably and effectively, lies his future.

Malaria Patient

An example of the rehabilitation of a malaria patient is found in the case of a German-born Army veteran who served in the Pacific. This patient was married and had two children. He was formerly a butcher, but his doctor advised against returning to this work. He had not completed high school and had no hope of further education because of family responsibilities. The ward physician referred him to the educational therapy department, and he took up the study of English and American history. He proved to be an excellent student but worried a great deal
about his inability to return to his former occupation. He was encouraged to prepare for the General Educational Tests, which he passed with credit, receiving a high school equivalency diploma. As a result, the patient received a job in a business firm, is earning a satisfactory salary, and is planning to continue with his education.

Disabilities Resulting from Accidents

Many of the patients enrolling in educational therapy are young men and older men who have suffered disabling injuries in automobile accidents, industrial accidents, and home accidents. Many of these patients do not have a chance for rehabilitation and the opportunity to return to productive work.

Two young men were hospitalized in October, 1949, for injuries resulting from a car wreck. Both of these men were news-script writers for a prominent Texas newspaper. At the present time, they are in body casts and one has been in traction since hospitalization. One man has lost the use of his right hand. Realizing that he would be handicapped if he did not begin then to rehabilitate himself, he requested left-hand typing. The typewriter was made stationary on a bed stand and carried to his bedside for practice with his left hand. The therapist gave him daily instruction until he was able to attend
classroom meetings in his wheel chair. The patient is now writing with his left hand and has acquired speed and accuracy in typing. He is also taking courses in psychology preparatory to entering the University of Texas upon his discharge from the hospital.

The other patient has learned to type quite well and has studied English and letter writing for three months. He feels that his advanced course in English will be of benefit in making him a better script writer.

These two young men, as well as many other patients, are making people more conscious of the fact that very few jobs require all the physical abilities of a man; when workers are placed according to their abilities in jobs not making physical demands which they cannot meet, the disabilities will no longer be job handicaps.

These patients would probably have remained in the hospital much longer if the motivation aroused by educational therapy had not encouraged them to leave and undertake a life of productive effort. This shortened period of hospitalization also meant a considerable monetary saving to the government. A few patients have been referred to educational therapy as a last resort. This referral proved to be the proper stimulus for changing their entire outlook on life.
CHAPTER IV

CONCLUSIONS AND RECOMMENDATIONS

Educational rehabilitation, as well as other phases of rehabilitation, is a continuous process and must be continued in many instances after the patient leaves the hospital. However, educational rehabilitation personnel of Veterans' Hospitals believe that essential groundwork can and must be laid in the hospital itself. The patient can choose for himself from many types of life work; most important, he is free to choose vocations compatible with his particular disability and aptitudes.

The following general conclusions have been reached in this study:

1. Educational therapy is one of the five parts of the medical treatment received by patients in Veterans' Hospitals. Therefore, one can not offer concrete evidence of physical and mental improvement attributable to this therapy alone. There is, however, an increasing number of referrals by ward physicians. There is also evident satisfaction of doctors, nurses, and patients with the results obtained.

2. All disabled veterans from World War I and World War II are entitled to the benefits of medical attention, economic security, and educational advantages offered in Veterans' Hospitals.
3. Through the educational rehabilitation program many men and women leave hospitals with brighter outlooks on life, and with more adequate preparation for jobs or for further educational or vocational training.

4. Recovery processes are speeded and the harmful psychological aftermaths that so often accompany prolonged hospitalization are avoided by keeping patients interested in constructive activities.

5. Patients increase their self-confidence and raise their morale by completing the requirements for high school diplomas or certificates of equivalency while hospitalized.

6. Our Veterans' Hospitals today are caring for many men who have been hospitalized since World War I, and who might have been rehabilitated and become useful citizens if a full program had been in effect after the first World War. It has been estimated that each World War I veteran who has been in the hospital these many years has cost the government approximately $40,000. This is the least of the cost; his ability to produce has been lost to the nation, along with his own self-esteem and his ability to take his rightful place in the community.

7. It has been noted that rehabilitation is a continuous process and must be applied in a planned and constructive manner even after the patient leaves the hospital. With this in mind, the Physical Medicine Rehabilitation
Service maintains close contact with other Veterans' Administration services, such as the Social Service and the Vocational Rehabilitation and Education Service. The latter service takes the veteran after hospital discharge and places him in a feasible training program or in a job, as the case indicates.

8. The value of an educational program in Veterans' Hospitals is indicated by fewer readmissions of patients who have received educational therapy. Of a group of 140 World War II veterans hospitalized as general medical and surgical, tuberculous, and neuropsychiatric patients, having participated in the educational program and earned high school diplomas, there were two readmissions during the first six months following hospital discharge. Of a parallel group of 140 World War II veterans hospitalized as similar types of patients, who had not participated in the educational therapy program, there were fourteen readmissions during the first six months following discharge. Although the readmission rate of approximately one per cent as compared with ten per cent was undoubtedly influenced by the willingness of the first group to participate voluntarily in such a program, it can still be concluded that patients ambitious enough to take courses to the extent of earning high school diplomas while hospitalized are more likely to make necessary
readjustments in civilian life and are less likely to be readmitted to the hospital than those not so occupied during hospitalization.

9. In 1948, the average case cost to state rehabilitation agencies was $460.00, or approximately the same amount it costs to maintain a person in dependency for one year. Before rehabilitation, approximately forty-five per cent of the group were dependent upon their families for support; eight per cent lived on their insurance benefits; eight per cent received public assistance; and only twenty-nine per cent were living on their wage earnings. Since the federal-state vocational rehabilitation program was broadened in 1943, 219,039 disabled men and women have been rehabilitated. This is compared with a total of 210,125 for the preceding twenty-three years. These persons have already increased their earnings and the nation's purchasing power by more than $900,000,000. At the same time these persons have, since their rehabilitation, paid more than $67,000,000 into the federal treasury in federal income taxes alone.

10. Educational rehabilitation pays economic dividends. No degree of economic gain, however, can measure the social and emotional satisfactions gained by the successfully rehabilitated and employed handicapped worker and his family. Neither can it measure the value to society in
the transformation of these individuals from dependents into productive, self-reliant persons. With adequate rehabilitation, a disabled person becomes self-supporting; industry saves pensions; labor saves valuable workmen; the government has more taxpayers; relief rolls are reduced; and our democracy maintains its economic level.

11. The Federal Security Agency has proven that educational rehabilitation is well worth while from a monetary standpoint alone. It is reported by that agency that a group of 44,000 handicapped persons taking training in 1944 increased its yearly earnings from $6,500,000 to nearly $78,000,000 after rehabilitation. The entire cost of the program was $6,500,000.

12. The value of even a limited education program is far reaching in the case of the tuberculous patient. One of the most promising developments in tuberculosis rehabilitation is the growth within the past few years of state-wide co-ordination programs involving both health agencies for the public, such as the State Department of Public Health and the State Division of Vocational Rehabilitation, and voluntary groups. Many patients have taken jobs ranging from the unskilled to highly specialized or skilled work following discharge. Educational therapy has made skilled workmen of many patients who were ranged among the unskilled group when hospitalized.
13. With full programs of rehabilitation, the hospitals are not filled with people lying in bed; they are rather filled with people strenuously participating in programs of activity in order to get well and to leave the hospital.

14. Many patients are suffering from multiple sclerosis, cerebral palsy, poliomyelitis, paraplegia, neurological conditions, and cardiac conditions. Their conditions are much the same, for medical science, in most instances, cannot restore the degenerated nerves and make limbs useful and powerful again. Their problem is that of learning to live and work with what is left.

In order to live the most useful, happy lives of which they are able, these patients must be given a chance to develop those abilities remaining. These patients are made happier and more content as they engage in the program of activities. The days pass faster for them and they learn to write, read, and carry on intelligent conversations.

15. By gaining accurate information relative to educational prerequisites, and by actually participating in educational therapy activities, the patient gains a more realistic appreciation of his capabilities in relation to his occupational plans. In many cases, patients leave
the hospital better qualified and with better possibilities for securing more desirable jobs than when they entered the hospital.

16. The study demonstrates that the factors of training, experience, personality, temperament and the other elements that go to make up the individual are the factors that account for success or failure on the job. In only two of these factors does the handicapped person vary from the able-bodied worker. The first is his disability, which has no affect on his ability to perform a task if he is placed selectively on the right job. The second is the fact that he has developed overcompensated skills to overcome his disability.

17. The education department recognizes that the success of educational therapy depends on the personality and ingenuity of the therapists who treat the patients. The therapist attempts to find out what makes a patient react as he does, and then organizes his plans so as to care for the needs of each individual patient. He helps direct the outward manifestations of the inward drives of the patients; in so doing he keeps interest, initiative, and activities flowing in the channels that will lead to worth while work.
Recommendations

A study of this type would be without value unless some recommendations were offered. The following recommendations are direct outgrowths from the study and are supported by the educational therapists, doctors, nurses, executive assistant, and chief of the education department at the Veterans’ Hospital, Houston, Texas:

1. Educational therapy should be started early in the period of convalescence in order that the patient may receive full benefits from the program.

2. Values, other than subject-matter progress, should be considered when making progress notes and when making final summaries for the patient’s record.

3. Academic subject should not be taught in isolation. It is suggested that doctors, nurses, and therapists of the other departments assist the educational therapists in an emerging integrating experience program based on the patient’s needs and interests.

4. The medical staff of the hospitals should be brought into the class rooms or the wards where the educational therapists are working with the patients in order to acquaint themselves with the program. In order to carry out a hospital educational program effectively, it is always wise to use individuals who have something worthwhile to offer.
5. The therapists' loads should be lightened so that each therapist can devote more attention to the individual patient, for it is necessary that each patient be treated with individual care.

6. There should be a definite time set for therapists to contact the social workers and psychologists regarding the social history and mental alertness of the patient.

7. Educational therapists should compile detailed initial reports on patients enrolling in the education department in order to have complete information before actual therapy begins.
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