SOCIAL FUNCTIONING AND RHEUMATOID ARTHRITIS

An Experimental Study Applying Role Theory to Social Functioning Assessments of Married Female Arthritis Patients

by

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ABSTRACT

Team members in medical rehabilitation centres are focusing more attention on devising new means for the establishment of a more precise evaluation of the patient's total functioning. The evaluation of the patient's social functioning is critical to team planning and treatment. It is also critical for the assessment of the success of the rehabilitation program. This experimental study was carried out under the joint auspices of the Vancouver branch of the Canadian Arthritis and Rheumatism Society and the School of Social Work at the University of British Columbia, in order to devise specific criteria for the assessment of the patient's social functioning. This in turn, would enable a more accurate assessment of the patient's total functioning.

The study is limited to a small group of married female patients who received residential treatment at the Vancouver C.A.R.S. medical centre during the period between January 1962-May 1964. Role theory was used as the main frame of reference for this study and social functioning was equated to the sum total of roles performed. A three-point rating scale and scoring was created to represent the assessed performance of each role. An experimental approximation represented by a percentage figure was obtained of the subjects' social functioning levels at four specific points in time. Three sets of ratings were collected from (a) data found in the C.A.R.S. social service recordings, (b) data obtained from the subjects and (c) data collected by the writer from the subjects.

The findings point out that although the research model demonstrated changes in levels of social functioning, these results were not conclusively established. The results were at best tentative, since the C.A.R.S. social service records could not meet the demands of the research instrument and the study involved only a small number of subjects. However, there was strong indication that application of role theory to social functioning assessment formulations does provide a meaningful and systematic method for evaluating the patient's total functioning. In future sequential research, it has been recommended that social service records be utilized which employ role theory as the basis for social assessment formulations. Further, it has been suggested that one way to overcome the crudeness of the present research model, is to expand this study's three-point rating scale to a five-point rating scale, which would then reflect more accurately the patient's social functioning.
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CHAPTER I

BACKGROUND AND INTRODUCTION OF THE STUDY

Research programs in arthritis\(^1\) are being rapidly expanded in Canada and other highly developed countries of the world. In the United States arthritis is receiving increasing attention as a subject for research, since it has been reported that 10,845,000 persons or approximately 6.4% of the population\(^2\) have some form of this complex disease. Reliable statistics concerning the prevalence of arthritis in Canada are not available. However, since there is a great similarity in trends of diseases in Canada and the United States, it may be estimated that approximately the same proportion of Canadians are affected by arthritis and related diseases. The subject matter of arthritis, with particular emphasis on rheumatoid arthritis, will be enlarged on in Chapter II.

The study reported here is part of an extended social work research program, related to arthritis, which was initiated in 1949 by the School of Social Work, University of British Columbia. In that year, Mr. Mickelson prepared a thesis\(^3\) which explored the social and emotional problems of arthritis, which have a significant bearing on the treatment and rehabilitation of the patient. Certain aspects such as social welfare problems were also examined. In 1953, Miss Donna Hunt evaluated the effectiveness of casework treatment in the team approach to rehabilitation of rheumatoid

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1 For the sake of brevity, the term arthritis is being used here synonymously with rheumatism and rheumatic diseases. Definition of these terms will be given in Chapter II.


arthritis patients.  

Further social work research was undertaken by Mr. John Rohn who prepared a thesis in 1953 under the joint sponsorship of the Vancouver Branch of the Canadian Arthritis and Rheumatism Society (C.A.R.S.) and the School of Social Work, University of British Columbia. Mr. Rohn made a descriptive study of the physical and psychological manifestations of arthritis. The adequacy of the C.A.R.S. rehabilitation program, including its facilities were also assessed. In 1958 Miss Margaret MacInnes focused her attention on a particular patient population, namely a group of male patients, who had received residential treatment during the 1952-1955 period, at the C.A.R.S. medical centre. An assessment was made of certain socio-economic factors and their effect on the patient's potential for rehabilitation.

Rationale of this Study

The above examples demonstrate that in the past, social work research related to arthritis has been characterized by a fragmentary approach. The above studies have been primarily concerned with particular aspects which influence the social functioning of persons with arthritis. In medical multi-disciplined settings there has been a shift, in recent years, away from a fragmented approach. Increasingly, new ways are being sought to facilitate a holistic approach, in order to gain better and more accurate understanding of the patient's total functioning. The need for a holistic approach, in related social work research, has been expressed by both the Vancouver C.A.R.S.

3 The abbreviated form C.A.R.S. will be used throughout this thesis to designate this society's Vancouver medical centre.
medical and social work administrators. This year, these administrators made a request that a social work research study be undertaken, which would have as its primary focus "the development of more specific criteria for assessment of social functioning, particularly as it relates to the arthritis patient." Objective means are now available to the physician, the physiotherapist and the occupational therapist, for obtaining an evaluation of the patient's medical and physical functioning. But as yet, a holistic approach in evaluating the patient's total functioning cannot be fully instituted by the C.A.R.S. multi-disciplined team, because a standardized method of assessing the patient's social functioning is still lacking.

Purpose of this Study

The purpose of this experimental study developed directly out of the above need expressed by the C.A.R.S. medical and social service administrators. The chief emphasis of this study is concentrated on developing a research instrument for assessing and measuring the social functioning of persons treated at this medical centre. This research instrument is not intended to produce a precise rating of social functioning. It would be fatuous to attempt such a task, with our present state of knowledge, skill and ability to assess human functioning. Rather, the study's intent is to produce a research model which may be utilized as an instrument that provides a group of fairly specific and also fairly practical devices for obtaining a summary casework assessment.

More specifically, it is the main purpose of this study to develop a method for assessing a person's social functioning by means of a separate

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1 Dr. H. S. Robinson and the late Miss Margaret MacInnes.
2 Appendix A.
evaluation of their major role performances and the corresponding role performance changes. One vital assumption, which was made in the construction of the research model is that a person's social functioning can be assessed from a profile of the major roles performed. It is important to note, at this point, that social role theory was used as the main conceptual frame of reference for this study. The relationship of the concepts of role theory to the concepts of social functioning will be discussed in Chapter III. Related literature by Werner Boehm, Jessie Bernard and other writers, which have relevance to these concepts will also be discussed in Chapter III.

Objectives of this Study

The primary objective of this research study is to devise a research instrument by which an experienced social worker could (a) assess and graphically portray the major roles performed by a person, at a given point in time, (b) note changes in role performance and (c) give a summary assessment of a person's social functioning.

A number of general objectives, which are important to social work practice have also motivated this study. They are as follows:-

1. The writer wishes to devise a schedule which can be used as a guide for securing important information that is needed for the assessment of the client's social functioning. The model devised for an assessment of the client's total role performance, portrayed graphically might help to point out to the social worker, some of the missing information which should be secured. If this proved to be helpful, then a corollary to this discovery of gaps in social work information may be, that the research model may become a useful aid in sharpening a social worker's skill and ability in
casework assessment formulations. It is well recognized that the assessment phase of social casework, like the on-going fact-finding in scientific research, is vital to the rest of the problem-solving process. Most social workers would probably agree, that it is from the diagnostic conclusions the social worker draws, that his ensuing methods and goals are fashioned.1

2. This study's research model may have practical implications for social casework, if it can be utilized to determine social functioning levels at particular points in time. Furthermore, if these levels can be demonstrated graphically, it follows that movement or changes in social functioning would then be more readily discernible.

3. The C.A.R.S. medical and social work administrators are not entirely satisfied with their current method of social service recording. Another alternative is sought, because the present recording does not lend itself for use in the team evaluation of the patient's total functioning. It is the intent of this study to offer a systematic plan for recording a summary social assessment, which is based on the use of the research model devised here.

4. A systematic device for collecting social functioning data might suggest leads for a more meaningful and uniform method of casework recording. This might then facilitate medical and social work research undertaken at a future date.

5. One of the reasons for casework recording is that it helps to provide continuity of service, regardless of changes in the social work personnel. It is projected here, that this continuity could be facilitated, if a systematic summary assessment recording is made after the first few interviews, again when the patient is discharged and at a later point when the patient is

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1 Perlman, Helen H. *Social Casework*, University of Chicago Press, 1957, p. 163.
readmitted or interviewed for a follow-up study.

6. A systematic summary assessment based on the research model, may also have intrinsic implications for the entire treatment team. Graphic portrayal of the patient's social functioning could more readily facilitate communication among the treatment team members. It might also facilitate the team evaluation of the patient's total functioning and thereby influence the planning for team intervention in terms of the patient's rehabilitation.

7. It is projected that the information in the rated summary assessments completed at specific points in time, such as (a) before the onset of arthritis, (b) at admission, (c) at discharge and (d) at the time of a follow-up interview, could be accumulated for research purposes. Information completed in this manner could be used for comparisons of the changes in social functioning levels for one patient or for groups of patients. Furthermore, this standardized information might help to discern any significant patterns and trends in the social functioning of arthritis patients. For example, tables using graphic symbols to represent the rated summary assessments, could be employed to make comparisons between younger and older age groups, between groups of patients having different medical classifications of rheumatoid arthritis and so on. The rated summary social assessment could also be employed to ascertain the success of the rehabilitation program. For example, the summary assessments formulated at specific points in time could be compared to determine whether the patient continued to progress or retrogress in social functioning during and after rehabilitation treatment.

8. One of the long-term objectives of this study is that this research model could be adapted for use in other medical centres concerned with
chronic diseases. It has come to the writer's attention that a similar need for systematic summary assessments of the patient's social functioning exist in medical centres which focus attention on disablement caused by heart disease, multiple-sclerosis and so on.

9. There is a paucity of research on the behavioural problems of the disabled from the perspective of social role theory. One of the objectives of this study was to try to apply role theory and test its relevance for assessing the social functioning of persons disabled by arthritis. Furthermore, an attempt has been made to apply role theory to casework practice.

Scope of the Study

The study is limited to a small group of married female arthritis patients who received residential treatment at the Vancouver C.A.R.S. medical centre during the period between January 1962-May 1964. Details regarding the criteria used in selecting these patients will be discussed in the chapter devoted to the methodology of this study, Chapter IV. The setting of this study, the Vancouver C.A.R.S. medical centre, will be enlarged on at the end of Chapter II.

A schedule has been developed which delineates nine roles that, taken together, are assumed to represent the social functioning of the subjects. A guide for the determination of role performance and rating scales for measuring the performance of each role was devised (Appendix C and D). Graphic rating scales have been created to represent the assessed performance of each role (Appendix E). These scales provide the data for

2 Appendix B.
each of the nine delineated roles, which are then scored. The scores represent the summary assessment of the person's role performance. The level of social functioning, at four specific points in time (referred to earlier in this chapter) is established by totalling the scores for each specific point in time. Representing the level of social functioning by an experimental percentage figure has been developed by assigning a numerical value to three of the rating scales. A sample illustration of a fictitious Mrs. X, has been devised before the interviewing began, to test the possibility of using this model to demonstrate changes in the performance of various roles by the subjects (Appendix F).

The purposes of this study have been outlined earlier in this chapter. The general purpose of this study has been introduced in lay terms to the patients concerned by letter (Appendix G). Data for the ratings on each of the subjects have been obtained by means of an interviewing schedule (Appendix H) which was completed at the time of the home visit. The interviewing schedule has been designed to collect data for three sets of ratings. These data have been collected from three sources: (a) data based on the subject's retrospective estimate of the performance of her various roles, at specific points in time, including her estimate at the time of the follow-up interview, (b) data recorded about the subjects at earlier periods in the social service files at the Vancouver C.A.R.S. medical centre, (c) data the writer has collected, first-hand from the subjects during the individual interviews. Data have been collected and scored, first from source (b) and then from sources (a) and (c).

Since this study involves only a small number of subjects the findings are, at best, tentative. Therefore the criteria herein developed are presented
as an experimental summary assessment device. Its usefulness still needs to be tested on a larger number of cases.

The following chapter describes some of the historical sequences which lead to the adoption of a team approach in the rehabilitation of arthritis patients, related medical information regarding arthritis, the contemporary team approach to rehabilitative services and the setting of this study.
CHAPTER II

THE TEAM APPROACH IN REHABILITATION OF ARTHRITIS PATIENTS

Historical Perspective

The emergence of increasing need to use the services of a social worker in a medical setting can best be understood by reviewing the development of an inter-professional (team) approach, for promoting the well-being of the patient.

In England, it was first recognized in the 1880's that discharged mental patients required special after-care in their homes to help prevent recurrence of their illness. "Visitors" were employed to make home visits and advise the patient's family about the necessary care of the patient after his discharge. In London, in 1890, Sir Charles S. Loch, encouraged the "lady almoners" in English hospitals to serve as volunteer receptionists. Further, these ladies made social investigations regarding the patient's ability to pay for hospital care and suggested charitable organizations which might be called upon to assume the patient's support.

On this continent, in the 1890's, some of the New York hospitals learned from the experiences of the Henry St. Settlement House, that home visits could facilitate the effect of medical treatment. "Visiting nurses" from the hospital staff were organized to make home visits and supervise the after-care of discharged patients.¹

Dr. Richard Cabot of the Massachusetts General Hospital was the first to recognize that a medical specialist could no longer expect to be as well acquainted with the patient's home situation, interpersonal relationships, economic conditions, as was the family doctor. In 1905, when Dr. Cabot invited a social worker to join the hospital staff, he defined the social worker's function as follows:

- to complete my diagnosis through more careful study of the patient's malady and economic situation and to carry out my treatment through organizing the resources of the community.

Thus, Dr. Cabot was responsible for initiating the rudimentary beginnings of social work in a medical setting. At that time, to be sure, emphasis was placed on the social worker being physician-centred rather than patient-centred and it took many years for the team approach to develop as we understand it today.

The social work profession, still young in terms of an older established profession like medicine, may be characterized by four spiraling types of movement within the last sixty years. It has progressed dynamically, defined, synthesized, and resynthesized its methods and goals. This has been done in terms of both new knowledge gained from the social sciences, psychiatry, medicine and in its adaptation to a rapidly changing society. The four discernible changes in focus were:

(a) In the early years, influenced by social reformers like the Webbs and the practical demonstrations of settlement house leaders like Jane Addams, the social worker's focus was largely on the patient's environmental situation.

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Gradually, under the influence of Mary Richmond, Ida M. Cannon and others, the pendulum began to swing away from total focus on an environmental viewpoint. Social workers in North America became involved in the formulation of a social diagnosis and in initiating therapy. This was based on a thorough investigation of the facts concerning the patient's social and personal difficulties.

After the late 1920's, when Freudian concepts gained greater and wider acceptance, the fundamental interests of the social worker shifted from economic and sociological emphases towards psychological and emotional problems of the patient. During the next twenty years, social workers focused their considerations on the emotional make-up of the patient, almost to the exclusion of social factors. For example, some social workers were actively engaged in serving as lay psychoanalysts. Others over-stressed the psychiatric aspects of human behaviour and actually withdrew from interest in the outer social situation.

Since the 1950's, the task of putting "social" back into its proper perspective, as the caseworker's chief area of concern, has been championed by Helen Perlman. She has aptly pointed out that:

the client sees and feels his problems in terms of social mal-adjustment, because it makes itself known to him as he plays out his social roles and engages in his social tasks. Our role in "social" work is to enable or facilitate the client's ability to carry his social roles and his normal life-functions. The person in interaction with some problematic aspect of his social reality is the focus of the social caseworker's concern.

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Thus, the social caseworker's area of concern has made a full circle from emphasis on environmental influences back to the importance of social factors. But it must be added that important concepts regarding the determinants of social functioning\(^1\) have been synthesized along the way. The modern focus of the caseworker is on the totality of the individual and the social factors, which may influence his functioning or dysfunctions.

Social work seeks to enhance the social functioning of individuals singly and in groups by activities which constitute the interaction between man and his environment. These activities can be grouped into three functions: restoration of impaired capacity, provision of individual and social resources and prevention of social dysfunctions.\(^2\)

As the young profession of social work grappled with spelling out its area of competency in the last 60 years, a parallel dilemma was and still is being faced by the medical profession. Sixty years ago, when the practice of medicine and the structure of our society were less complex, the general practitioner did in essence, practice a form of 'social medicine'. For the sake of brevity, the history of the development of the concept of social medicine will not be enlarged on in this study. This history is most interesting but it is well stated elsewhere.\(^3\) It is to be understood that 'social medicine' is not the same as 'socialized medicine' sometimes also known as "medicare" in Canada. The broad concept of social medicine has been defined as follows:

Social medicine is concerned with all the inter-relationships of medicine and society as they affect the health of individual or groups of people and includes social epidemiology on the one hand and the social organization of health services on the other.\(^4\)

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1 These determinants will be discussed in Chapter III.
It has become increasingly difficult for medical men to practice a form of 'social medicine', particularly in medical centres, where they may have occasion to see a given patient for brief intervals only, and over a short period of time. There are further reasons other than the limitation of time which prevent doctors from being able to evaluate, unaided, the interactions of the physical, emotional, cultural and social factors of the patient and his family. Our large urban areas are populated by persons from diverse cultures and different social milieux. Added to this complexity, there is the compelling need for doctors to continually keep abreast of the ever-expanding knowledge in medically related fields. In fact, there has been such an explosion of new medical discoveries and treatment techniques in recent years that specialization has become a practical necessity. Thus, the medical team approach, through the various sub-specialties, has become a reality in coping with the multitude of diseases which continue to insult man. Likewise, gradually the doctors have needed to utilize the social services in medical centres, so as to facilitate an inter-professional (team) approach for assessment and treatment of the 'total' patient.

The contemporary viewpoint regarding team approach will be discussed later in this chapter in association with the medical setting for this study. At this point it is relevant to discuss rheumatoid arthritis, since this study deals with the contemporary team approach in the assessment of patients afflicted by this disorder.

Rheumatoid Arthritis.

What is Rheumatism and Arthritis?

Although the advancement of medical knowledge has been dynamic, particularly in recent years, certain broad empirical or nominal definitions
of rheumatism and arthritis are utilized because scientific definitions are still deficient. There is considerable lay confusion regarding the terms rheumatism and arthritis because even medically they are used as follows:

These terms are used synonymously in the broad sense to include the heterogeneous and complex disease groups whose principle symptoms refer to joints and their supporting structures.

Lack of generally acceptable criteria for defining the rheumatic diseases accounts for the inexact and confused statistics reported in the National Health Surveys in Canada and the United States. This confusion, in turn, explains the difficulty in determining the incidence of this disease grouping in the country's population, referred to in the first paragraph of Chapter I.

The above terms have been separately defined as follows:

'Rheumatism' and with it, 'rheumatic disease' are now considered to be non-specific terms usually defined in terms of symptoms of articular origin particularly, but extending to other supporting elements of the musculo-skeletal system. 'Arthritis' is used, professionally at least, to indicate articular inflammation and is a sign of disease and not a diagnosis.

Rheumatoid arthritis has been tentatively classified by the American Rheumatism Association under the heading of polyarthritis of unknown etiology.

Nature of this Disease

To demonstrate how rapid has been the advancement of medical knowledge, as recent as 1949 rheumatoid arthritis was described as a disease.

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consisting of inflammatory lesion(s) in one or more joints of the body. Today, rheumatoid arthritis is defined as a "systemic disease affecting primarily connective tissue." Diseases concerning connective tissue are called collagen disorders and rheumatoid arthritis now is referred to as a collagen disease. Rheumatoid arthritis is especially characterized by joint inflammation which may occur in widespread parts of the body. These inflammatory lesions may lead to varying degrees of disability, from slight to severe impairment and to deformity of the affected joints. In addition, connective tissue in any part of the body may also be affected by a similar inflammatory process causing lesions in the heart, lungs, kidneys and other organs. Thus in rheumatoid arthritis not only the joints may be involved but other organs of the body may also be affected.

Etiology and Precipitating Factors

The etiology of this disease remains an enigma. Over the years, a number of precipitating factors have been proposed as possible causes of this disease. Twenty-five years ago, it was thought that prolonged exposure to cold and dampness was a causative factor. Today, this is no longer considered to be true. Likewise, theories of "foci of infection" playing a dominant role in the causation of this disease have been discarded. Emotional reactions to disturbing environmental events have been considered by a number of authorities to bear some relationship to the onset of rheumatoid

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3 Sokoloff, Leon, M.D., "Cardiac Involvement in Rheumatoid Arthritis and Allied Disorders", Modern Concepts of Cardiovascular Disease, Publication of the American Heart Association, Inc. Vol. XXXIII, No. 7, April 1964, p.847.
Arthritis. Dr. Weiss has commented that:

there is good reason to believe that a significant relationship exists between life stress and the disease of arthritis, with emotional stress, especially poverty, grief and family worry being more than a chance factor in the onset and exacerbation of rheumatoid arthritis.¹

However, the role which emotional factors play in causation is far from clear, especially since so few well-designed studies have been carried out on the problem. Stanley H. King suggests that only continuing controlled experimental studies can provide the answer.²

It has been suggested that personality factors play a role in this disorder. Dr. C. E. Robinson has indicated that persons with rheumatoid arthritis seem to be immature, dependent, perfectionistic people who try to please and that the onset of their illness is often preceded by separation or loss of support.³ On the other hand, Dr. Moos recently concluded that personality factors can be said to play a role in rheumatoid arthritis, but further research is required. He bases his opinion on his review of related literature, in which he found considerable disagreement in many studies regarding the personality traits of arthritic persons. Dr. Moos indicated that all the studies assumed that the particular personality patterns antedate the onset of the disease and also that they tended to over-emphasize negative personality traits.⁴

Thus, causation of rheumatoid arthritis continues to be a perplexing problem, since to date no one or more factors have been found which may be

said to play the dominant role in the genesis of this disorder. Present scientific investigations are concentrating on metabolic and immunity reactions as possible causative factors.¹

**Manifestations of this Disease**

It has been noted that for a minority of patients (1/5) the onset of rheumatoid arthritis can be sudden and dramatic, as evidenced by the development of severe joint inflammation. The majority of cases begin insidiously with ill-defined aching and stiffness, which may occur for weeks or months before any joint involvement is noticed. For most adults, rheumatoid arthritis begins by affecting the small joints of the hands and feet. The disease tends to be symmetrical, affecting the same joints on each side. It generally produces feelings of malaise, weight loss, easy fatigue and morning stiffness of the extremities. One of the hallmarks of this disease is that it tends to affect three times as many women as men. This disease may begin at any age, but four out of five cases occur in the 25-50 year age group, and the most common period of onset is in the fourth decade. For these reasons, married women of this age-range have been selected as subjects for this study.

This disorder is in the majority of cases characterized by its chronicity, that is revealed in symptomatic remissions and exacerbations. These cyclic reactions make it difficult for doctors to accurately predict the course the disease will follow for a particular patient. A minority of patients (1/5) achieve full remission following an acute attack. It has been estimated that 20 to 40 percent of persons with rheumatoid arthritis never seek medical attention. Follow-up studies of patients requiring hospitalization

reveal that one-quarter of them are able to carry on their usual activities with minimal handicap, one-third become severely crippled and the remainder have mild degrees of incapacitation.¹

The severity of this illness does not influence remissions and exacerbations. The mildest cases may have a severe relapse at any time and severe cases have been known to suddenly become arrested. Thus, rehabilitation of persons with this disease continues to be difficult, because of the unpredictable course the disease may follow.²

**Medical Treatment**

The unpredictable nature of this disease influences the medical care to be provided. Medical treatment must be continually adapted to the changing needs of the particular patient. The major objectives of the basic medical treatment plan are geared to relieving symptoms and to prevent further crippling. To facilitate these objectives, "treatment must be begun at the earliest moment".³

The fundamental treatment measures employed are adequate rest, daily therapeutic exercises, good nutrition, proper balance between rest and daily activities, application of heat, accompanied by the daily use of aspirins and other salicylates.⁴ Therapeutic drugs, such as gold, cortisone and other steroid derivatives are sometimes employed for the temporary, and often dramatic relief from pain. Unfortunately these therapeutic drugs may give

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³ Travis, Georgia, *Chronic Disease and Disability*, University of California Press, 1961, Chapter III, pp. 37–49.
rise to undesirable and occasionally serious side effects. A few years ago, it was keenly anticipated that steroids would provide the curative treatment for rheumatoid arthritis. This has not proven to be the case. For the present, there is no specific drug which can claim to cure this disease.

This brief sketch of certain pertinent medical factors regarding rheumatoid arthritis has been presented because this orientation is important to the caseworker's understanding and assessment of the arthritis patient's social functioning. Since this study is primarily concerned with the caseworker's social assessment of the patient, in the remainder of this chapter, special emphasis will be placed on the social worker's contribution to the team approach in rehabilitation.

Contemporary Concepts in Rehabilitative Multi-Discipline Practice

The history of the development of rehabilitative services for the physically disabled, including services undertaken by the Department of Veterans Affairs in the first and second World Wars, in Canada, England and the United States, has been dealt with comprehensively elsewhere. Most of the earlier rehabilitative services focused on physical retraining and on the vocational placement of the disabled patient. Increasingly the holistic approach in rehabilitation developed out of recognition that more comprehensive care was needed and that this could be provided, if the knowledge and skill of a variety of disciplines were brought together.

Modern concepts of comprehensive rehabilitation recognize that the success of any rehabilitation service is contingent on two interdependent

factors - (a) The patient's physical problems cannot be divorced from their emotional and social implications. An added factor in effective rehabilitative care is the patient's willingness to seek improvement or resolution of his problems. Therefore it is recognized that the patient's co-operation will have to be enlisted through the enhancement of his understanding and the strengthening of his motivation to work on his problem. (b) The patient's efforts are then inter-related with the team's efforts to aid his rehabilitation and the restoration of his capacities. The team efforts are facilitated by the enlistment of medical, educational, vocational facilities, plus the use of other community resources, where needed. Team practice is also contingent on the willingness of the professionals concerned to co-operate in the attainment of mutually agreed on rehabilitative aims and objectives. This has been effectively summed up as follows:

Effective treatment requires a climate characterized by mutual confidence, knowledge of and respect for one's own as well as other disciplines and the conviction that effective diagnosis, planning and implementation can be achieved only through joint endeavours.¹

A further inference in the concept of multi-discipline rehabilitative practice is that these services shall be directed towards certain aims or goals. A review of the literature related to the aims of multi-discipline rehabilitative services reveals certain common objectives. The aims of contemporary rehabilitative medicine have been broadly defined as:

The long-range objective of total rehabilitation is to return the disabled person to useful productive living with happiness, dignity and a feeling of being wanted.²

Further, the specific aims of medical management of arthritis patients have been defined in terms of prevention of disability, to relieve pain or to reduce to a minimum the physical disability consequent on muscle wasting, deformity, and to reclaim function (in the widest sense of the word) in those individuals already disabled.¹

It is clear that these objectives focus on the needs of the whole person and they are not limited merely to the prevention of further disability and to restoration of the patient's physical functioning. Instead these objectives give recognition to the importance of developing and restoring the disabled individual to the fullest physical, mental, emotional, social, vocational and economic usefulness of which he is capable. In fact these medical objectives recognize the need to treat the patient within the context of his total environment.

The objectives of the social worker engaged in rehabilitative services is broadly the same. Mary Hemmy has defined the broad objectives of social work as follows:

Social Work is concerned with the enhancement of the total functioning of the individual as a social being and through the individual with groups and communities because they affect and are affected by the individual in a circular fashion.²

Four important concepts are inherent in effective multi-discipline rehabilitative practice: (a) Agreement that the common objective for each of the participating professions is the welfare of the "whole" patient.

(b) Recognition by each profession that this objective cannot be accomplished by one profession alone. Therefore each member of the team has a particular

contribution to make and it is related to his own area of professional competency. (c) Not only is it important for each profession to understand its particular role, but another basic essential for effective team practice is that it must be able to communicate its data and findings in a language which is readily understood by other team members.¹ (d) Finally, effective rehabilitative practice requires recognition by the multi-discipline team members that the leadership and the final decisions are the responsibility of the physician who heads the treatment team.²

The Role of the Social Worker in Rehabilitative Services

The general purposes of the social worker which are shared with the other team members have been outlined above. The specific purpose of the social worker is a dual one. (i) To help the patient make the best possible use of the total rehabilitative services provided. (ii) To facilitate the patient's adjustment to his physical, emotional and social problems, thereby enabling the patient's optimum total functioning in keeping with his physical and social limitations.

The social worker plays an important part in the team assessment of the patient, which serves as a basis for effective rehabilitative planning and treatment. The nature of this role has been described as follows:

Through a social study of the patient and his social situation, the medical social worker contributes to the physician and other members of the medical team an understanding of the social and emotional factors which are affecting or are affected by the patient's illness or his fullest use of available medical and social services.³

¹ Rice, Elizabeth, "Teamwork in Medical Social Work", Presented at the Southern Regional Institute, Atlanta, Georgia, June 1957. Reprint, National Association of Social Workers, Inc., pp. 2-5.
Therefore, the social worker's assessment contribution may be said to reflect a balanced analysis of the physical, psychological, social, economic and cultural factors which determine the patient's social functioning and rehabilitative potential. Harriett Bartlett has pointed out that there would appear to be three constant elements in the assessment of a medical social situation. (1) The patient's medical problem and its implications (environmental and psychosocial). (ii) The patient's motivation, adaptive pattern, adaptive capacity and his social roles. (iii) The environmental influences, such as family functioning as it is affected by and affecting the patient's functioning, other social relationships, and finally socio-economic-cultural aspects, including community resources.¹

Since this study is primarily concerned with the social assessment processes in rehabilitative practice, the planning and treatment provided by the team as a group, which includes the social worker, will not be discussed. It is to be understood, however, that the social assessment is part of the total rehabilitative process and it is not clearly distinguishable from the total planning and treatment which are integral parts of this process. It is primarily because the social assessment phase is an on-going process that this study is concerned with devising a research instrument which could be employed to assess the patient's social functioning. It would be of particular help to members of the treatment team, if they were provided with summary assessments of the patient's level of social functioning, before the onset of arthritis, at intake, and again before discharge. Further this periodic assessment could then be applied to future follow-up studies. Certain implications in the assessment of the patient's

social functioning will be the main topic of consideration in the following chapter. Before going on to this, a brief description will be given here of the particular rehabilitative setting of this study.

**The Rehabilitative Setting**

The patient sample studied for this thesis received in-patient treatment at the Vancouver Canadian Arthritis and Rheumatism Society medical centre during the 1962-1964 period.

The rehabilitative program in this medical centre began in 1949, a year after the inception of the B.C. Division of the Canadian Arthritis and Rheumatism Society. The Society's four objectives are related to: (a) furthering research, primarily in the form of grants to University medical schools, (b) education, through the dissemination of knowledge regarding the treatment of the rheumatism diseases, to doctors, to the general public and to arthritis patients, (c) fund-raising, to carry out programs supported by this Society, (d) rehabilitation programs, offered by the Canadian Arthritis and Rheumatism Society medical centres established in various cities across Canada.

Development of mobile physiotherapy units, the provincial program, the out-patient program for arthritic patients at the Vancouver General Hospital and at St. Paul's Hospital in Vancouver, has been outlined in detail elsewhere. In addition, the Canadian Arthritis and Rheumatism Society operates a medical centre in Vancouver to serve out-patients from the greater Vancouver area and it also provides residential treatment for the above patients and for patients referred from other parts of the province. The facilities of the Vancouver C.A.R.S. medical centre occupy a wing in

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the G.F. Strong Rehabilitation Centre. Separate medical, nursing, physio-
therapy, occupational therapy and social service departments are maintained
by the C.A.R.S. medical centre.

Arrangements with the G.F. Strong Rehabilitation Centre, have made
their hydrotherapy pool available to the C.A.R.S. medical centre patients.
The G.F. Strong Rehabilitation Centre also provides eight to ten beds for
intensive in-patient treatment to C.A.R.S. patients. Its other facilities,
such as dining area, library, recreational activities are also used by

Eligibility for out-patient rehabilitation care is dependent on
a referral of the patient by his private physician who retains medical
responsibility for the patient. The physician also specifies the type of
services to be given the patient. Similarly, in order to be eligible
for residential treatment, the patient must be referred by his private
physician. For in-patients the C.A.R.S. staff retain the responsibility
for the decision regarding admission and supervision of residential treat-
ment while the patient is in its care.

Cost of treatment is handled privately by the patient, if it is
within his means. If there is a balance over what the patient is able to
pay, this is underwritten by the Canadian Arthritis and Rheumatism Society.
Low-income patients are provided with rehabilitative care, underwritten
either by the Social Welfare Branch of the Province or by the Canadian
Arthritis and Rheumatism Society.

The Social Service Department's involvement in rehabilitation
services devoted to in-patients is not confined to merely handling the
financial arrangements for the patient's residential treatment. Pre-
admission social assessments of the patient are also submitted, whenever
possible. Active casework is carried on with all patients via regular weekly interviews, during their stay at the medical centre. Casework services are directed towards helping the patient and his family mobilize their inner resources to facilitate effective medical treatment. Community resources are also fully utilized to help in the resolution of the patient's problems. Some of the community resources, which may be instituted, when these services are appropriate to the needs of the particular patient are as follows: referral to social assistance resources, family service agencies, National Unemployment services and retraining programs.

This chapter has attempted to highlight the team approach in rehabilitative services employed on behalf of rheumatoid arthritis patients. In the following chapter attention will be given to the assessment phase of rehabilitative care, with particular emphasis being placed on the social worker's assessment of the patient's social functioning.
CHAPTER III

ASSESSING THE FUNCTIONING OF ARTHRITIS PATIENTS

It was noted in the last chapter that the facilities for residential treatment at the Vancouver C.A.R.S. centre are limited to eight to ten beds. Since all arthritis patients referred by their private physician cannot be accommodated, eligibility for the treatment program is based on a pre-admission team assessment, whenever this is possible. Criteria for acceptance of patients are not rigid.¹ Certain general conditions are used as guidelines in the selection of patients to ensure the best possible use of the treatment program. For example, one of the necessary conditions is that the patients must be able to feed and care for themselves since nursing beds are not available.

Whenever possible, the patient is examined and interviewed by the members of the C.A.R.S. staff, in order to formulate a pre-admission assessment of the patient's functioning. In the case of out-of-town patients or those in the process of recovering from an acute attack of the arthritis process, other means of assessment are utilized. Out-of-town patients may be assessed by the travelling medical consultant service or by the mobile physiotherapy units. Information on the patient's financial situation and social adjustment, which is used in assessing their suitability for residential care, is provided on request by the Social Welfare Branch of the Provincial Government Department of Health and Welfare.

Local patients unable to come to the centre are visited in their homes or in hospital, by various members of the C.A.R.S. staff in order to secure the necessary pre-admission information and to orient the patient to the residential program. In most cases, acceptance of the patient for residential treatment, aside from the general conditions explained above, (available space and self care) is primarily dependent on whether the pre-admission team assessment indicates that the patient has the potential to gain from the rehabilitation treatment program.

The pre-admission assessment of the patient consists of a study of the following primary areas: (a) a medical assessment of the patient's general physical condition and in particular, the stage of the arthritis process, (b) an assessment of the patient's physical functioning capacity, (c) an assessment of the patient's social functioning.

(a) Medical Assessment

It has been clinically observed that patients can make greater gain from the treatment program, if their arthritis is in a remission phase, whether "natural or induced by drug therapy". Therefore the patient is examined at the C.A.R.S. centre by one of the attending physicians who assesses the patient's general health, the phase (remission or exacerbation), and the stage of the disease process. A classification system based on the standards laid down by the American Rheumatism Association is used to indicate the stage of the disease process. Four stages of rheumatoid arthritis are defined in the classification system, namely, (i) minimal,

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3 Appendix I.
(ii) moderately advanced, (iii) advanced, (iv) far advanced. All the patients included in the sample for this study were classified as having Stage II or Stage III rheumatoid arthritis.

(b) **Assessment of the Patient's Physical Functioning Capacity**

It has already been noted that self-care, including mobility at least in a wheelchair, is a prerequisite in the acceptance of the patient for residential treatment. Therefore an assessment of the patient's ability to manage in the physical environment of the centre is carried out by a physiotherapist and an occupational therapist. This assessment determines not only the patient's functional capacity, but also whether special prosthetic appliances will need to be employed to facilitate the patient's ability to partake in the program. The physiotherapist and the occupational therapist also include the following information in their evaluation of the patient's functional capacity:

Some knowledge of the patient's motivation towards recovery will be gained during these examinations, as there is opportunity to observe his general reactions to the proposed treatments and to gauge to a certain extent his interest and enthusiasm.¹

A functional capacity code² is utilized to indicate the degree of physical disablement, namely: (i) unimpaired or slightly impaired, (ii) complete self-care, (iii) partial self-care, (iv) severely impaired. Patients included in this study had a functional capacity assessment of Class II or Class III.

(c) **Assessment of Social Functioning**

The social worker is generally informed about the patient's tentative medical assessment and physical functioning capacity, before the social

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² Appendix J.
assessment interview(s) take place. Thus the patient's physical suitability for residential treatment is known and the social worker's immediate task is to assess the psycho-social factors which may contribute or impede the patient's ability to gain from residential care.

The social worker's purpose in the assessment interview(s) is a dual one. (a) It must be determined whether the patient is psychologically well-motivated to accept and co-operate in the rehabilitative treatment program. Assessment of this is important, since the patient will not benefit from the treatment program unless his willingness to participate is optimal. (b) Facts are gathered regarding problems in the patient's social environment and social relationships which may represent a threat or create anxiety for the patient. It is important that the patients have as little anxiety as possible when they enter the centre for residential treatment. Pressing unresolved psycho-social problems may prevent the patient from making proper use of the treatment program or may cause the patient to withdraw prematurely from residential care. It has been pointed out in Chapter II, that one of the reasons the treatment team is interested in the patient's social functioning is the recognition that effective rehabilitative treatment is contingent on treating the whole or total patient. To reduce this statement to practical terms, an example will be cited. It would be totally ineffective for the medical practitioner to prescribe periods of complete rest while the patient is in residential care, if it is not within the patient's means to carry this out. A female in-patient anxious and concerned about the homemaking care of her husband and children would be unable to rest, if this anxiety is too pressing. An assessment by the social worker will not only indicate the obstacles in the home
situation which might impede the medical treatment program, but it will also point to the direct and indirect services which may need to be employed to help resolve these problems.

It has been recognized that the social assessment is important not only to determine patient suitability for residential care, it is also important in the medical management to prevent further disability. Dr. H. S. Robinson, Medical Director of the Vancouver C.A.R.S. Medical Centre, has noted the following:

At any time during the life of the rheumatoid patient, it may be of great importance to direct attention to social factors which may prevent the patient from co-operating in a management program or satisfactorily functioning in his community. Early measures which the social workers employ may have a distinct prophylactic value.

Discussion of what is inherent in social assessments will be the main consideration of this chapter. But before going on to this in detail, it should be noted that the team pre-admission assessment is important for various reasons other than the facilitation of the patient's total functioning. These assessments communicated in readily understood language, facilitate each team member's contribution, which in turn enhances the total effectiveness of the treatment program. Further, these assessments by the team members play a dominant role in the joint decision made by the treatment team, as to the suitability of the patient for residential care. Finally, the team members are ultimately responsible to the policy making body of the medical centre, the C.A.R.S. Board. It is the team assessment of the patient, before he is admitted to the medical centre, compared with a like assessment at discharge, that could help to indicate that the main purpose of the

institution, maintenance and enhancement of the arthritis patient's functioning has been achieved.

In summary, considering the assessment phase in rehabilitative service in the light of its import to the patient, his acceptance for residential care, its effect on each team member's contribution, its consequence on an effective treatment program and its value for the Board's policy-making decisions, it becomes quite evident that a reliable systematic method of assessing the patient's functioning is of paramount importance. Since the social worker is responsible for formulating and communicating an objective assessment of the patient's social functioning, consideration will now be given to what is inherent in making this assessment.

Implications in Social Functioning Assessment of the Physically Disabled

The assessment process whereby the social worker derives his (or her) professional opinion of the patient's social functioning has been described as:

A process of deriving meaning from the facts at hand. It is essentially a thought process. As the caseworker thinks about the objective and subjective facts elicited through the study process, he comes to some tentative conclusions concerning the nature of the need or problem, the personality of the client, the possible means of meeting the need, and the capacity of the client for using the helping services available.1

Since social functioning encompasses many facets and is enormously complex, there are no absolute guidelines which this thought process can follow to guarantee an objective assessment of social functioning. An absolute definition of social functioning is still lacking due to the limitation of present-day understanding of human behaviour. This limitation

in knowledge prevents preferential rating of the determinants which are the inter-related and interconnected components of social functioning.

In the health field, where increasing recognition has been given to the inter-relation of emotional and social factors in the etiology and treatment of disease, answers are being sought to the complex problem of assessing and measuring the social functioning of disabled patients. Research efforts have been accelerated and research funds are becoming increasingly available in an attempt to resolve this problem. For example, a conference was initiated in 1963 at Palo Alto, California, which involved representations of the medical specialties, public health, psychiatry, physical-medicine, psychology, social work and sociology in an attempt to find a solution to the following research question:

Can a simple, valid measuring instrument be constructed and uniformly applied to individuals, who have been physically incapacitated, that will tell us in easily understood, useful terms what can be expected of this individual, based on his previous level of physical and psycho-social functioning and his improved physical capacities, in order to arrive at a method of full adaptation to the new life that medical skill has put within his reach?

The interchange of ideas at this conference illustrated the difficulties encountered in coalescing varied approaches into a generally accepted method of assessing human adaptive behaviour. Recognition was given to the importance for further research, so that a profile or measuring model could be developed which would assess and predict the disabled patient's pattern of social functioning. To the writer's knowledge, no universally applicable

2 Holstrom, L.L. and Hall, Wm., Research in Social Functioning in Health and Illness. (An annotated Bibliography), Social Research Program in Heart Disease Division of Clinical Social Work, Stanford University School of Medicine, 1963, p. 1.
research model has been devised, which assesses and measures the social functioning of the physically disabled person. Until there is a further break-through in knowledge explaining human behaviour, social work researchers will have to content themselves with continuing to make small inroads in defining the specificity of social functioning.

The criteria established in this study for assessing and measuring the social functioning of female married arthritis patients will be discussed in Chapter IV. First, consideration will be given to the two approaches, one broad, the other specific, which may be utilized by social workers for understanding and assessing social functioning. The broad theoretical approach for understanding human behaviour will be reviewed briefly. These considerations will then be linked to the specific approach of social role theory which is the conceptual frame of reference used for this study.

Broad Theoretical Approach for Understanding Social Functioning

Theories advanced by various disciplines in biology, medicine, anthropology, psychology, sociology have provided a reservoir of knowledge, which social workers utilize as a frame of reference for the study and understanding of their clients' patterns of behaviour. Basic to the numerous theories which propose conceptual explanations for man's behaviour is the vital assumption that man is essentially a social being. Dr. Beukenkemp, has offered the following succinct rationale for acceptance of this hypothesis: "Man is born a member of a group. He is raised in a group. His whole life is a group function. The one to one relationship can stand alone, but only for a limited time. The compound group is society. Society is men."¹

Acceptance of this assumption influences the social worker's assessment analysis. The client is not perceived as an island unto himself, functioning in a vacuum. Rather he is perceived in terms of his unique interactions with the dynamic milieu in which he lives. The "continual interdigitation of nature and nurture"\(^1\) is the broad abstract concept of social functioning. In order to perform the professional task of assessment effectively, social workers must synthesize the multiple determinants of the client's interactions with his fellow-man, which have brought about his unique balance in daily living. This synthesis of multi-causative factors is sought by many professional disciplines including social work because it is recognized that these multiple factors affect the person's total physical, psychological and social well being.

Increasing knowledge regarding the cause and effect relationship in human growth and behaviour has enabled social workers to overcome as much as possible their ethno-centrism and has influenced a more integrated understanding of the client, his problem(s) and his unique behaviour. This broad theoretical knowledge also helps the social worker to avoid the pitfall of over-simplification in casework assessments. The social worker is aware that one broad causal factor cannot explain the person's total unique behaviour. For example, in the case of the arthritis patient, *arthritis per se* is not the only contributing factor to his social dysfunctioning. The extent of his dysfunctioning will also depend on his level of social functioning before the onset of arthritis, plus his ability to use his potential to adapt and create a new equilibrium in his daily living.\(^2\) Thus in assessment

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formulation, attention is given to the numerous interacting factors which make up the essence of the client's unique social functioning. These interacting factors are: (i) his biological endowment, (ii) his culturally determined value system of basic and psychological needs, (iii) his family, (iv) his personality. The circular interaction of these main reacting systems determine the client's interpersonal relationships, his ego-functioning and his modes of adaptive behaviour.

Recognition and consideration of these reacting systems is important in assessment formulations of the arthritis patient's social functioning.

It has been pointed out that:

No matter how a 'common cause' may affect many clients, a particular client is always affected in a specific way, since the impact is felt differently in accordance with his unique vulnerabilities from his unique constitutional equipment and life experiences.¹

Understanding the many implications inherent in the concept of social functioning is becoming more difficult since there is a myriad of existing theories on man's biological endowment, culture, class, family and personality development. There is a tendency today to broaden this concept further, with the inclusion of new theories that have been advanced to explain human behaviour. For example, the General Behaviour System Theory² and theories advanced by cyberneticists have added other viewpoints for understanding man's social functioning.

The Specific Approach of Social Role Theory in Assessment of Social Functioning

In recent years, many of the leading authorities in social work, such as Helen Perlman and Werner Boehm have recommended that the sociological

concept of social role theory be integrated into social work theory. The raison d'être is that social role theory offers a framework for the assessment of interacting factors which have an effect on the individual's social functioning. Social role theory proposes that social functioning be understood in terms of the sum total of the individual's role performance.

Werner Boehm, reviewing the importance of social role theory for social work, came to this conclusion:

The indicators are many that the problem with which social workers deal are problems in social functioning. Therefore the caseworker's activities are concerned with helping clients to be more effective in their total role performance, because it is through the performance of assigned social roles, that social functioning is expressed.¹

A perusal of recent social work literature indicates that there is general agreement in the field that "social work is in one of its most crucial phases of reorganization and assimilation of new material".² Some social workers have been hesitant in accepting social role theory as a conceptual framework for assessment, because it cannot be applied to casework practice without adaptation; the terminology and many of its concepts are unfamiliar, and it requires much testing and research before its true value as a diagnostic tool can be assessed. On the other hand, Werner Boehm, Helen Perlman, Swithun Bowers and others, have championed the integration of social role theory into the social work problem-solving process. Swithun Bowers in assessing the future of social work has stated the following:

There is a change coming about in social work, a good and healthy change, a going back to social work's original emphasis on the family and on the crucial social roles that exist within this primary group and primary environment.³

Acceptance of social role theory in social work practice has been slow in coming. It remains for research workers to demonstrate that utilization of social role theory leads to a more scientific method for casework assessment than the older, more casual approach. It was mentioned previously that social role theory was used as the conceptual frame of reference for the construction of this study's research model. Before consideration is given to the criteria established for the study's research model, a brief resume of social role theory will be given.

Components of Social Role Theory

The concepts of role, status and stress are the inter-related components of social role theory. The first two concepts, (role and status) provide the means for viewing the client in terms of his social functioning, while the concept of stress helps to point out the client's problems, which are the cause(s) of dysfunctioning due to impairment of role performance. It is important that the characteristics of these main components be understood if social role theory is employed in assessment formulations. For the purpose of this present study the following definitions will be used:

Concept of Social Functioning

Social functioning was defined earlier, as the sum total of the social roles a person performs. Therefore, to view social roles in their theoretical perspective they are equated to units of social functioning.

Concept of Social Roles

Social role describes the activities and tasks which an individual is expected to perform by virtue of his membership in a given social
group or in his participation in a given social institution. It permits examination of the way in which these tasks are actually performed in terms of the social and individual factors which determine their performance.\(^1\) Social role is concerned with the function\(^2\) it has to perform, whether it is group-related or institution-oriented and therefore role performance is functional. For example, a person who is part of a group is performing a group-related role. Whether the person is a group leader or a participant, he is performing a group role, since he both influences the group and is influenced in his actions by group behaviour. Performing institution-oriented roles refers to the numerous roles in society, such as, husband, father, son, mother, wife, student, doctor. These roles are "prescribed behavioural patterns embodied in law, custom, tradition, convention and other norms, which tell how certain functions are to be performed."\(^3\) Jessie Bernard points out that although there are prescribed norms for performing social roles, a certain amount of improvisation or ad-libbing\(^4\) takes place.

**Role Reciprocity**

Refers to the fact that every social role has a counterpart, or complementary role, i.e. mother and child. To carry a role implies doing something in relation to one or more persons whether or not

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2 Function is the broad general term for the natural, required or expected activity of the person.
4 Bernard, Jessie, Ibid., p. 46.
the person performing the reciprocal role is physically present.

**Role Network**

Refers not only to the cluster of roles every person performs in his daily living, but also to the inter-relatedness of the roles performed by others, who are in interaction with the person.

**Role Expectations**

Implies that there are social norms or appropriate behaviour associated with particular roles, which persons anticipate from others and from themselves, e.g. the wife anticipates that her spouse will perform his husband role according to prescribed social norms of behaviour.

**Role Perceptions**

Refers to the way the role is viewed whether performed by the person himself or by others. Role perception refers to insight or awareness of what is involved in carrying the role. Role impairment can result from faulty role perception and expectations which are conditioned by culture and class membership.¹ For example, the patient may fail to co-operate in a treatment program because he did not correctly perceive what was expected of him in his role as patient.

**Role Playing**

Is a diagnostic technique used in socio-drama and it is useful in understanding how people will behave in similar reality situations.

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For example, role playing may be used in group therapy sessions for patients to be discharged from mental institutions to acclimate them to social situations outside the institution.

Role Taking

Refers to a person imagining himself in another person's position. It can be a valuable aid to the social worker in trying to understand the client's particular frame of reference.

Role Performance

Refers to how the person actually behaves when the role and his self coexist. The person's behaviour is natural and spontaneous, because the role has been internalized.

Role-Acting

Rather than internalize the role, the person does what he considers to be the norms of behaviour for a particular role. The person's actions therefore are pre-meditated and superficial.¹

Concept Regarding Relationship of Social Role and Status

The taking on of a social role involves the dynamic aspects of status. Status as an aspect of role refers to a secure position, in a group, however humble. It has the same connotation as "face". Its most important characteristic is that it confers security. In essence the person with status "belongs".² The individual is socially

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¹ An excellent example of the difference between role performance and role acting may be found in Goffman, Erving, Presentation of Self in Every Day Life, Anchor Books, 1959, p. 116.
assigned a status whether it be 'ascribed' or 'achieved' and he occupies it in relation to other statuses.

Roles are linked to status or positions in society and represent behaviour expected of persons occupying a particular position. Thus role behaviour is linked with position, rather than to the person occupying the position. The personality of the person in the position, however, influences the idiosyncratic pattern of his role performance.1

By specifying the demands made upon the client, the social worker is able to study the manner in which the client meets them and in so doing he develops insight into the personality make-up of the individual. It has been pointed out that the social workers must use these insights carefully and dynamically understand the particular cultural impact upon particular personality structures in each case.2 Another idea has been advanced that by extending the concept of social role to include the concept of status, a personality action system, and a social action system can be said in certain respects to be roughly homologous.3

Role Determinants

To discover the full meaning of a particular client's role performance, the social worker must take into consideration the consistently reacting systems of his physical endowment and functioning, culture, class, family, and finally, the person's unique personality. These determinants provide the person with their value system related to their

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basic and psychological needs\(^1\) and cause him to perform his roles in a unique way. Mary McCormick has summed this up in the following statement: "An individual's social functioning is his response to values and includes aspects of motivation or 'why', performance or 'how' and goals or 'what' and 'where',"\(^2\)

**Role Problems**

Although the value systems of society influence the individual's value system, they do not operate as a single unit; rather they shift and dynamically recombine. A person may be said to have a problem in his social functioning (or in his role performance) when his individual values are threatened and he is unable to adapt to the resulting stress. When a client is aware of a problem he usually perceives it as a problem in social adjustment, since it makes itself known to him as he performs his social roles. In essence, problem is related to the inability of the person to carry one (or more) vital social role(s). It has also been recognized that impairment of one role tends to have a chain-like reaction on other roles. For example, inability to carry the breadwinner role may have an effect on the husband and the father roles.

**Concept of Stress**

A stress situation may be defined as one involving threat. Jessie Bernard analytically breaks down stress into three major component parts. The stress factor which threatens is known as the stressor (i); the value which is being threatened (ii); and reactions or modes of

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behavioural adaptation to the threat (iii). 1

(i) The Stress Factors

Stress factors can arise in the person's body (i.e. illness), his external environment (e.g. poor housing), in the functioning of the social system itself (e.g. unemployment) or in the person's role network (i.e. social relationships). Although a certain amount of stress is inevitable, there is no universal list of stress factors. Firstly, because of the specificity of stress, what affects one person may not affect another person. Secondly, there is no formula to indicate who will be vulnerable to a specific stress.

(ii) The Values Threatened

The stress, be it internal or external to the individual, may threaten the following basic or psychological needs: "Life, health, property, privilege, freedom, security, status, "face", honor, self-respect, opportunity, future prospect - all as related either to one's own self, to one's loved ones or to one's group, or to all three." 2

Although these values may be said to cut across all classes of society and may be objectively perceived in the same way by many individuals, they are felt subjectively different due to culture, class or situational differences. For example, illness may subjectively represent a threat to loss of security for a laborer whereas it may be a threat to loss of opportunity and future prospects for a business executive. It has been noted 3 that a certain amount of anxiety

2 Bernard, Jessie, Ibid. p. 75.
is normal when persons perform their social roles, therefore stress does not automatically lead to social dysfunctioning. When the anxiety becomes prolonged or excessive because the individual has been unable to resolve it, and this in turn leads to role performance breakdown (role impairment), then one may say that the stress produced social dysfunction.

(iii) Reactions to Threat

A person's defensive and adaptive reactions to threat take place concomitantly on several levels, physiologically, emotionally and socially. These defensive and adaptive responses help the individual to cope with the stress in order that he may maintain his dynamic equilibrium or his balance in social functioning.

Helen Perlman has compiled a list of eight reasons related to this stress concept, as to why persons may have problems carrying one or more social roles. For example, a person may be hindered in carrying a vital role due to deficiency of financial resources, lack of physical capacity and so on. Henry Maas has proposed a list of eight modes of responses patterns in role terms, for viewing the mode of adaptive behaviour the individual may employ in order to cope with the stress and bring about a changing form of social equilibrium. For example, one person's mode of adaption may include the use of the defence mechanisms of denial and flight; he may abandon completely the performance of the role. An example of this related to arthritis patients,


2 Maas, Henry S., "Stressful Situations and the Concept of Role Expectations", Extracts from a paper by Henry S. Maas, University of California (Berkeley), pp. 5-6.
would be the woman patient who totally abandons her homemaker role, in spite of the fact that it has been medically indicated that she could continue to perform this role with the aid of prosthetic appliances.

One could summarize the importance of the concept of stress for casework assessments by pointing out that when it is used with social role theory, it provides a more scientific means for discovering and analyzing why a person has problems in his social functioning. Also it helps to determine what adaptive and maladaptive behaviour responses are being utilized by the client to bring about a state of equilibrium in his daily living.

Relevance of Social Role Theory and Concept of Stress to this Study

As it was pointed out in the first chapter, the main objective of this study is related to developing a research model which could facilitate a summary assessment of a person's social functioning. Of particular interest is the need to determine the level of the patient's social functioning at particular points in time in order to distinguish movement and changes in social functioning. Therefore the scope of this study was oriented and limited to how the patient is performing major social roles by assessing individual role performance. Analysis of the factors leading to the impairment in role performance was not an objective of this study. To have included the concept of stress directly would have broadened this study to unmanageable proportions. There are several reasons for this. Defining stress in role terms and modes of adaptive behavioural reactions requires
not only a separate set of criteria, but also certain detailed social service records and knowledge in depth about the patient. This could only be obtained during an extensive casework interviewing period. The social service records at C.A.R.S. are not sufficiently detailed to lend themselves to application of the concept of stress in role terms. Furthermore, the limitations of time made it unmanageable for the writer to engage in a number of interviews with each of the patients included in the sample.

A description of the methodology of the study will form the body of the following chapter.
CHAPTER IV

METHODOLOGY OF THE STUDY

This chapter describes the method devised for obtaining a summary assessment of the subject's level of social functioning at four particular points in time. It includes: (a) the criteria established for selecting the research sample, (b) the criteria established for assessing and rating the performance of the subject's nine major social roles, (c) the interviewing schedule developed for obtaining data from the C.A.R.S. social service records and the subjects.

(a) **Criteria for the Sample Selection**

The subjects for this study were to be drawn from the former patient population who received residential treatment at the Vancouver C.A.R.S. medical centre.

Two criteria suggested by the C.A.R.S. medical and social service administrators were included in the list of criteria for sample selection. All former patients to be selected should have a medical diagnosis of rheumatoid arthritis, classified as moderately advanced or advanced (Stage II or Stage III). The C.A.R.S. medical and social service administrators were particularly interested in securing information regarding how the former patients were functioning eighteen or more months after discharge from residential care. Therefore the selection of the subjects was confined to those patients who had discharge dates during the time period between

1 Appendix I.
January 1, 1962 and May 31, 1964. This allowed an interval of approximately eighteen months to four years between the date of discharge and the follow-up interview.

The following additional criteria for the sample selection were established by the writer. The sample selection was limited to female subjects, since inclusion of male subjects would have necessitated creating specific criteria for two separate profiles involving differences in social roles for men and women. Since C.A.R.S. provides residential treatment to both in-town and out-of-town patients, it was practical to include in the sample, only those subjects who at present are residents in the greater Vancouver area. Recognizing that single women do not have the same roles to perform as married women, i.e. no marital role, the sample excluded former patients who were single at the time of discharge. Since married women in a certain age group are more likely to have the same type of roles to perform, e.g. marital role, homemaker role, mother role, etc., the sample selection was confined to subjects within the age group of 30-60 years. The writer had intended originally to confine the sample to married women with children. This proved to be impractical, because there were not enough subjects who met all the criteria outlined above. Thus the criteria for sample selection were broadened to include married women who were childless.

Statistical accounting of the sample selection will be included with the findings of the study in the next chapter.

(b) Criteria Established for Summary Assessment of Social Functioning

It was mentioned in Chapter I that to the writer's knowledge, there have been few research projects reported which had as a primary objective,

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1 Appendix B
2 Appendix K
the development of a research model for assessing and measuring the social functioning of physically disabled adults.

Before criteria could be developed for the assessment of social functioning, the approach for breaking down social functioning into practical units of research had to be formulated. To the writer, an approach employing the conceptual formulations of social role theory seemed particularly relevant. By accepting the assumptions that social functioning is "the sum of the individual's activities in interaction with other individuals and situations in the environment"¹ and that "social role describes the activities and tasks which an individual is expected to perform by virtue of his membership in social groups and his participation in social institutions",² one could then define social functioning as the sum total of social roles performed by a person. Thus for the purposes of this study, social functioning was equated with the total role performance of the subject.

The thesis written by Constance Hawley was carefully reviewed and her suggestions regarding future utilization of social role theory in social work research, also influenced the writer's approach to this study. Constance Hawley recommended the following:-

In this study the approach was through the concept of stress to the concept of role. The client's inner self was examined first, to determine how and where it had affected the performance of his outer self. This was done because of the nature of the material used. The writer would suggest that a more fruitful and direct approach would be through the concept of role. The first step would be to examine social functioning in major social roles and move from this to an investigation of the source of stress which has caused impairment.³

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The direct approach for assessing the level of social functioning through the concept of role was employed in this study. Nine major roles were delineated to represent the total role performance of married women who have rheumatoid arthritis. These roles were as follows: (i) disability role, (ii) occupation role, (iii) economic-status role, (iv) marital role, (v) homemaker role, (vi) mother role, (vii) daughter role, (viii) sibling role, (ix) social role. The choice of these particular roles was influenced by several related articles and studies.

Because of the medical focus of this inquiry, it was necessary to include a disability role. It has been pointed out by Talcott Parsons and others that "illness is not merely a 'condition' but also a social role". Charlotte Babcock suggested that illness and disability create psychological strains in the person's adaptive capacity and she offered the following conclusions:

Within the specific reaction patterns of any character structure, whether the reaction is healthy or pathological, one may see shifts in the inner alignment as the ego attempts to cope with the stress of illness. These patterns must always be seen as dynamic interacting clusters of behavior.

Several other studies also influenced both the delineation of the roles and the criteria established in this study, for assessing role performance. For example, L. E. Pinchak and G. W. Rollins have identified and developed a social adequacy rating scale for the major areas of social adjustment. Their study influenced the inclusion of an occupation role to

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determine the vocational responsibility and adjustment of the subject (if the subject was performing an occupation role). The headings employed by the Pinchak and Rollins study also influenced the inclusion of the social role and the roles reflecting the subject's interpersonal relationships, i.e. mother role and so on.

Evelyn Cooper pointed out in her article that a large number of patient problems fall into four groups: (a) problems of anxiety, (b) problems for members of the family, (c) problems related to career and employment, (d) problems in marital relationships. This article influenced the inclusion of the economic status, marital, daughter, sibling roles in the research profile.

For the purpose of this study, the nine roles delineated in the research profile were all assigned equal value and were not considered as either primary or secondary roles. This was done because it was felt that vital roles tend to have a chain-like reaction on each other and impairment in performing any of the above roles would most likely influence the level of the subject's social functioning.

Although a single criterion was devised for rating the performance of each role, a guide for the assessment of total role performance was developed first, to ascertain which criterion would be chosen for the summary rating of each role. Of particular relevance for devising the criteria used in this study was the thesis written by DeWolf and Mansfield and the pertinent study on social functioning carried out by the Family Centres Project in St. Paul.

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2 Appendix D.
3 Appendix C.
1) **The Disability Role**

Criteria developed by DeWolf and Mansfield to measure physical factors were adapted for use in the study guide, which suggested criteria for determining the performance of the disability role. Three criteria were included, which subsequently led to the choice of one, for rating the subject's disability role. These were: (a) the limitations imposed on physical functioning by the disability, (b) health apart from the disability, and (c) attitudes expressed overt or covert in performing the disability role. Since the first two criteria would be part of the physical functional capacity and the medical assessment, the last criterion was established for rating the disability role. Thus the rating was devised to indicate the degree of independence and self sufficiency, partial dependency, total dependency, in the subject's performance of her disability role.

2) **Occupation Role**

In recent years, many married women have continued to carry their occupation role or they have assumed it again when the youngest child begins school. Performance of the occupation role before the subject developed arthritis and how this role was affected after the onset of arthritis, could affect the subject's level of social functioning. The occupation role was also included because it was anticipated that some subjects might depend on the performance of their occupation role, for the economic support of their family. This did indeed prove to be the case with one subject. Two criteria were established for the guide, but for the actual study, the occupation role was assessed in terms of how much the subject works now, in comparison with the three earlier points in time. The rating therefore was established as: works full-time, works half-time, works quarter-time or none.
Economic-Status Role

In Western society, the role that economic status plays not only determines the person's position in the economic class structure of the community, it also affects her behaviour and attitudes towards others. Loss of financial independence deeply affects a person's role perceptions and expectations, since it affects her sense of self-worth, economic security and social associations. Further, impairment of this role may cause a chain-like reaction on the performance of the person's other major roles. For example, loss of financial independence may cause severe marital conflict, affect the person's relationship with her extended family or cause her to change her social friendships and contacts. Since impairment of this role could easily contribute to the subject's level of social dysfunctioning, this role was included in the research profile. Several criteria were suggested in the guide for determining how this role was being performed. The rating subsequently established for this study was based solely on whether the performance of this role was affected by the person being financially independent, partially or totally financially dependent.

Marital Role

The criteria established by the St. Paul study and likewise the criteria established by Constance Hawley, mentioned previously, were adapted for assessing the performance of the marital role. Four criteria were suggested in the guide for assessing the performance of this role. These were as follows: (a) source of companionship, (b) sociability, (c) communication system, and (d) strength of the positive emotional ties existing between the marital partners. The above criteria were used as leads for rating the performance of the marital role, as good, fair or poor marital relationship.
5) and 6) **Homemaker and Mother Roles**

It has been noted that "housekeeping and the care of the children is still the primary functional content of the adult feminine role".\(^1\)

In establishing criteria for these two roles, it was found that there is a great deal of overlapping between the homemaker role and the performance of the mother role. Separate criteria were devised for these two roles, since it was anticipated that some of the subjects in the sample might be childless. However, it should be noted that the ability to perform household tasks used as the criterion for rating the homemaker role, was also used as a criterion in the guide for assessing the mother role. The summary criteria established for assessing the homemaker role were, able to perform without help, partially and unable to perform without help. Summary criteria of the mother role placed more emphasis on the mother's ability to provide maternal warmth, love, emotional support, and her ability to put the children's interest before self-interest.\(^2\) This was translated into the rating scale as, good, fair or poor relationship with children.

7) and 8) **Daughter and Sibling Roles**

The strong positive emotional ties a person maintains with the members of the immediate extended family will affect: (a) the performance of her reciprocal roles and (b) the degree of realistic support the family will be able to offer the person in times of stress, i.e. illness. Ability to maintain strong positive relationships with parents, brothers, or sisters,

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also affects the psychological security of the subject. Likewise, it may affect the psychological security of the members of her nuclear family. The reaction of the extended family to the person's disability may range widely. The extended family may rally around the disabled person and lend a hand in caring for the subject and her family. On the other hand, the extended family may tend to be over-protective, so that the subject may give up performing roles that are within her physical ability to perform. Some subjects may even be rejected by the extended family.

Several similar criteria were suggested in the guide for assessing the performance of these two roles. They were as follows: (a) the strength of the emotional ties, (b) source of mutual support, (c) dependency of the subject on the members of the extended family for emotional or financial support, (d) reliance on the extended family for social companionship. The criteria suggested in the guide were intended to influence the three-point rating of these roles which was described as strong, weak, little or no emotional ties with parents or siblings.

9) **Social Role**

The criteria established by Constance Hawley for measuring the performance of "the member of the community role" was relevant and adapted for use in assessing the performance of the subject's social role. Three criteria were suggested in the guide for assessing the performance of the social role, namely, (a) relationship with friends and neighbours, (b) participation in community organizational groups, and (c) ability to partake in social activities with friends. For the study's rating scale

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of the social role the following three-point rating was used: numerous, limited, little or no social contacts.

**Graphic Symbols Established to Indicate Level of Social Functioning**

Of considerable relevance to this study was the model for problem-solving process outlined by Werner Boehm. Adaptation of this model provided the writer with a means for describing and comparing the levels of social functioning in graphic symbols.

The Boehm model depicted the person's level of social functioning by utilizing graphic symbols to represent assessed role performance. For example, (a) □ = unaffected role performance, (b) ■ ■ = threatened role performance and (c) ■□ = lowered role performance. This method of using graphic symbols was adapted for use in this study the following way: (a) □ = unimpaired role performance, (b) ■■ = moderately impaired role performance and (c) ■□ = severely impaired role performance. The writer devised two additional graphic symbols to indicate the following: □ = insufficient information in the C.A.R.S. social service records to rate the performance of a particular role, □ □ = the role is not applicable in a given case. A role was defined as "not applicable" if it occurred under one of the following conditions: (a) not performing occupation role since marriage, (b) desertion, divorce or death of the reciprocate, (c) childless, (d) no other siblings, (e) absent homemaker role because the subject was single at the time of onset of arthritis.

Werner Boehm used graphic symbols to depict the client's level of social functioning before the onset of stress. The same graphic ratings

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2 Appendix E.
were then applied to discern the changes in the levels of social functioning as a result of stress, personal reactions to stress, as a result of intervention outside the client and the new level of social functioning. Perceiving changes in the level of social functioning in this manner, facilitates not only the identification of role performance changes, but also the assessment of the stability of these changes.

The concept of determining the client's level of social functioning at specific points in time also had relevance for this study. As it was mentioned in Chapter III, illness per se is not the only contributing factor determining a person's social functioning or dysfunctioning. Therefore, the assessment of the person's performance of roles before the onset of arthritis might help to predict her social functioning level after the onset of arthritis. It might also be helpful to the C.A.R.S. treatment team for their evaluation of the effectiveness of residential care, if its members could compare the patient's level of social functioning at admission with that observed at discharge. This method of comparison might help them to discern more readily whether the treatment objective had been achieved. Further, an assessment of the patient's level of social functioning made eighteen months or more after discharge, might help to indicate the stability of the changes in the level of social functioning noted before discharge. Likewise the follow-up interview assessment might help to indicate whether the patient continued to make further progress or whether she retrogressed in her social functioning after discharge. For the above reasons, four specific points in time were defined for assessing the levels of the subject's

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social functioning. They were as follows: (a) the time interval just before the onset of arthritis, (b) at the time of admission or intake, (c) at the time of discharge and (d) at the time of the follow-up interview.

Three Sets of Ratings

Whenever it was possible, several observers' ratings were compared, at the same four specific periods in time. It was felt that this procedure of using three sets of ratings would serve as a built-in test of objectivity and reliability of the research instrument. The three sets of ratings were formulated in the following manner. The summary role criteria were utilized to rate the subject's role performance, as recorded in the C.A.R.S. social service files. Likewise, ratings were established from the subjective estimates given by the particular subject at the follow-up interview and the writer's rating based on her assessment of the subject's role performance for the time period of the follow-up interview.

Mathematical Measurement of the Level of Social Functioning

In order to devise an experimental percentage figure which could represent the subject's level of social functioning, certain arbitrary scores were assigned to three ratings. A figure of 10 was used to represent unimpaired role performance; a figure of 5 to represent moderately impaired role performance; and a figure of 2 was assigned to represent severely impaired role performance. Thus if the subject's summary role performance for a given period in time was graphically portrayed as $6 \square, 2 \square, 1 \times$ it could also be represented by a percentage figure arrived at in the following manner: $6 \times 10, 2 \times 5, 1 \times 2 = 72$. This total score was then placed

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1 Details given in Chapter I, page 6.
over the optimum score of 90 (9 roles), i.e. \( \frac{72}{90} \times 100 = 80 \) percent level of social functioning.

This percentage figure was meant to connote differences in levels of social functioning. It was not assumed that it represented hundred percent social functioning of the subject, even in the absence of moderately or severely impaired role performance.

c) Construction of the Interviewing Schedule

An interviewing schedule\(^1\) was drawn up as an aid for securing the information needed, in order to test the validity of the rating systems used in the research model.

It was found that Part II of the interviewing schedule devised by Joan Boon et al\(^2\) was relevant for procuring concise identifying information regarding the subject and her immediate family. This material was adapted for use in Part I of this study's interviewing schedule.

Part II - Part IX were constructed to obtain information required for rating the subject's performance of her nine roles. In many instances the questions were directly related to the criteria established in the guide or the summary criteria established for rating individual role performance. In the past two years, C.A.R.S. has utilized two follow-up questionnaires\(^3\) which are mailed to former patients. The questionnaire constructed specifically for females was relevant and was adapted for use in the various parts of the interviewing schedule.

During the construction of the schedule, the order in which the questions should be elicited was carefully considered. Since the research

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1 Appendix H.
3 Devised by the late Miss Margaret MacInnes, C.A.R.S. Social Service Administrator.
was introduced to the subject, as sponsored by C.A.R.S., it was felt that physical factors would be uppermost in her mind and therefore this type of information should be dealt with first. Dr. H. S. Robinson, the C.A.R.S. medical administrator, suggested that the questions on physical factors be asked in terms of an average week, rather than for the specific day of the interview. Due to the unpredictable nature of the disease, the subject may feel physically well one day and perhaps fair or poor the next day. Therefore a sounder answer would be secured if the subjects were asked how they are able to manage physically in terms of an average week, rather than, in terms of a specific day. This suggestion was incorporated into the physical and home care factors of the interviewing schedule.

The questions related to sensitive areas of interpersonal relationships were arranged to follow the section on physical factors. The last part of the interviewing schedule was devoted to questions related to less sensitive areas of interpersonal relationships, so that the interview would end in a lighter vein for the respondent.

The writer gave thought to the matter of testing the interviewing schedule prior to initiating the interviews with the subjects in the research sample. It would have been preferable to test the interviewing schedule with several subjects first, in order that the writer could become more familiar with using the schedule and preparing herself for unexpected responses. In keeping with the suggestion made by H. Maas and N. Polansky that role-playing the interviewing schedule can be most helpful, the writer

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role-played the interviewing schedule with two elderly physically-disabled members of her own family. This device proved to be very useful. Role-playing the interviewing schedule pointed out ambiguities in the questions which required clarification or corrections. It also gave valuable information regarding the approximate time the interview would require. Length of interviewing time was important, since too lengthy a questionnaire might prove to be tiring to a physically-disabled person. Role-playing the schedule was completed in approximately one hour and this duration proved to be the same subsequently when the subjects were interviewed.

In the next chapter the material obtained in the interviews will be examined.
CHAPTER V

ANALYSIS OF THE FINDINGS AND CONCLUSIONS

In this chapter the following material will be presented and analyzed. (a) The statistical accounting of the sample selection. 
(b) Ratings established from the C.A.R.S. social service records. 
(c) Ratings established from the follow-up interview with the subjects. 
The last part of the chapter will be devoted to the conclusions drawn from this study.

(a) The Statistical Accounting of the Sample Selection

A total of 99 patients, who received residential treatment at C.A.R.S., were discharged during the January 1962 - May 1964 period. The average number of patients receiving residential care in a given year was 42. It should be noted that the reason C.A.R.S. is able to provide residential treatment to an average of only 42 patients yearly, is related to its limited facilities (8-10 beds) and the fact that some patients require residential treatment for one to five months.

During the 28-month period outlined above, 41 male and 58 female patients received residential care. Application of the criteria for sample selection\(^1\) to the records of the 58 female patients revealed the following findings: (a) 3 females had other forms of arthritis, (b) 29 females did not reside in the greater Vancouver area, (c) 5 females were single, (d) 1 female was duplicated on the discharge list, because she

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\(^1\) Appendix B.
received residential treatment in both 1962 and 1963, (e) 1 female died, (f) 9 females did not qualify within the 30-60 year age group; 3 females were younger than 30 years and 6 females were over the age of 60.

However, 10 women did meet the criteria outlined in Chapter IV. One woman was found to be out of town for an indefinite period of time. The 9 remaining subjects were contacted and fortunately all agreed to participate in the research. These 9 subjects made up the total research sample.

The ages of the nine subjects at the time of the follow-up interview (January 1966) were as follows: 1 was 31 years of age, 5 were in the 45-49 age group, and 3 were in the 52-58 year age group.

The collected data on the sample revealed other differences. One-third of the subjects were childless. For the other 6 subjects, the number of children per family varied from one to three. One of the subjects was caring for an 8 year old grandchild and for a teenage foster child, as well as her own teenage daughter. In the majority of cases the subject’s children were 16 years of age or older. All the children of one subject were married and living away from home.

The findings also indicated that at the time of discharge 6 subjects had medical classifications of rheumatoid arthritis Stage II (moderately advanced) and 3 subjects were classified as having rheumatoid arthritis Stage III (advanced).

Further analysis of this sample is unappropriate, since it is too small to make cogent comparisons based on the above collected data or to draw valid statistical conclusions. It is quite obvious that another group of
9 subjects would not necessarily produce similar findings. But later in this chapter, an attempt will be made to show that the sample does have value, as a means for demonstrating the usefulness of the research model.

(b) **Ratings Established from the C.A.R.S. Social Service Records**

As it was noted in Chapter IV, the summary criteria devised to assess the subject's role performance, were utilized as the rating scale to determine the subject's level of social functioning. This rating scale was applied three times to the C.A.R.S. social service records in order to secure individual ratings of the subject's performance of her 9 roles at specific points in time. The resulting ratings were graphically tabulated in the following manner. The ratings scored from the social worker's assessment of the subject's level of social functioning before the onset of arthritis was consigned to Column I. Likewise, the rated level at the time of admission for residential care was represented in Column II and the level at discharge in Column III.

The following summary ratings indicate the changes in levels of social functioning at 3 specific points in time. These summary estimates were secured by totalling the individual ratings of the 9 roles performed by each subject.

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1 Appendix D.
Table I. Changes in Level of Social Functioning at 3 Points in Time
(based on information from the C.A.R.S social service records)

<table>
<thead>
<tr>
<th>Subjects</th>
<th>I - Before Arthritis</th>
<th>II - At Admission</th>
<th>III - At Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs. A</td>
<td>5 □ 4 □</td>
<td>2 □ 2 □ 1 X 4 □</td>
<td>9 □</td>
</tr>
<tr>
<td>Mrs. B</td>
<td>4 □ 1 NA 4 □</td>
<td>1 □ 3 □ 1 NA 4 □</td>
<td>9 □</td>
</tr>
<tr>
<td>Mrs. C</td>
<td>5 □ 1 NA 3 □</td>
<td>3 □ 2 □ 1 NA 3 □</td>
<td>9 □</td>
</tr>
<tr>
<td>Mrs. D</td>
<td>5 □ 2 □ 2 □</td>
<td>3 □ 1 □ 2 X 3 □</td>
<td>9 □</td>
</tr>
<tr>
<td>Mrs. E</td>
<td>3 □ 1 □ 1 X 4 □</td>
<td>2 □ 3 □ 1 X 3 □</td>
<td>9 □</td>
</tr>
<tr>
<td>Mrs. F</td>
<td>4 □ 1 X 2 NA 2 □</td>
<td>3 □ 1 □ 3 X 2 NA</td>
<td>2 □ 7 □</td>
</tr>
<tr>
<td>Mrs. G</td>
<td>4 □ 2 □ 1 NA 2 □</td>
<td>2 □ 2 □ 2 X 1 NA 2 □</td>
<td>9 □</td>
</tr>
<tr>
<td>Mrs. H</td>
<td>6 □ 3 □</td>
<td>4 □ 2 □ 1 NA 2 □</td>
<td>9 □</td>
</tr>
<tr>
<td>Mrs. I</td>
<td>4 □ 3 NA 2 □</td>
<td>4 □ 1 □ 2 X 1 NA 1 □</td>
<td>9 □</td>
</tr>
</tbody>
</table>

Legend: Summary ratings of role performance are indicated by the following symbols:

□ = unimpaired, □ = moderately impaired, X = severely impaired,
NA = role not applicable, ? = insufficient information to rate the role.

In the above table, it may be noted, for example, that before the onset of arthritis (Column I) Mrs. A. shows 5 unimpaired roles and insufficient information in the records to assign ratings to 4 roles. At the time of admission for residential treatment (Column II) the ratings show 2 unimpaired roles, 2 moderately impaired roles, 1 severely impaired role and insufficient
information on 4 roles to assign ratings. There was no information in the
social service records to give basis for ratings of Mrs. A's social function­
ing at the time she was discharged from residential care (Column III).

An analysis of the above tabulations shows that summary ratings
could not be completed on the 9 subjects' social functioning levels, before
the onset of arthritis. There was no information in the records to rate a
minimum of 2 roles and as many as 4 roles. It was found that 8 recordings
lacked information on the subjects' sibling role. Likewise, 5 records had
no information on the subjects' social role and 3 records contained no
information on the subjects' marital role. In all cases, an arbitrary
decision was made to score the economic status role as unimpaired, since no
record mentioned that the subject was partially or totally financially dependent.

Likewise, an analysis of the tabulations in Column II indicates that
summary ratings could not be completed regarding the subject's level of
social functioning at the time of admission for residential treatment.
Failure to establish complete summary ratings was due to insufficient infor­
mation in the social service recordings.

Similarly, the tabulations in Column III indicate that no summary
ratings were secured regarding the subjects' level of social functioning,
at the time of discharge from residential care.

A careful study of Table I indicates that the 9 social service
recordings could not meet the demands of the research rating scale. There
are valid explanations why this proved to be the case. The following
explanations are the ones which occur to the writer. (1) The reader should
be reminded that these recordings were made according to agency procedure
and were not intended to be utilized for this research study. Therefore
role theory and role terms were not used as a basis for social assessments and recordings. (2) The majority of these recordings were very brief, for example, 6 records contained only 2–4½ pages of recording, if one excludes the face sheet information. Although the majority of the subjects were seen weekly for an average of 3½ months, most of these interviews were not recorded. (3) In some records, there was too much emphasis placed on recording medical rather than social information concerning the subject and members of the family. This was found to be redundant, since it overlapped with the information contained in the subject's medical history recorded by the C.A.R.S. attending physician. (4) Finally, another explanation why the recordings could not meet the demands of the research rating scale lies in the fact that except for one case, no closing recordings were made, when the subjects were discharged from residential care.

In Chapter I, it was noted that one of the research objectives was to attempt a systematic comparison of the subject's social functioning levels at 4 specific points in time. Failure to establish the 3 summary assessment ratings from the social service files, makes it impossible to compare these with the summary assessment ratings established by the writer from the follow-up interviews. This is most unfortunate, since it also prevented the translation of the 4 summary ratings into percentage figures, and therefore the continuity in the changing levels of social functioning could not be compared.

The only inference to be drawn from Table I is that it indicates that some roles changed from unimpaired to moderately and severely impaired role performance. But there is insufficient information to compare these
changes with the subject's role performance at the time of admission or discharge.

c) **Ratings Established from the Follow-up Interview**

A tally was kept of the subject's reactions to being telephoned for an appointment with the writer. Eight subjects accepted interviewing appointments and did not request further information regarding the research, when it was offered. These subjects gave similar explanations for their willingness to participate in the research. They all expressed their gratitude to C.A.R.S. for the help extended to them in the past, and therefore they wished to be of help to C.A.R.S. by participating in the research. The one exception was Mrs. E, who was rather hesitant, but agreed to be interviewed after further information regarding the research was outlined. At the time of the follow-up interview all subjects but one were most co-operative in giving the information required for this study.

The rating scale was applied to the information given by the subjects at the structured follow-up interview. Three sets of ratings were established based on the subject's retrospective estimate of the roles performed at 3 specific time periods, namely, before the onset of arthritis (Column I), at admission (Column II), and discharge (Column III). The fourth set of ratings was obtained from the subject's estimate of how she was performing her roles in an average week, at the time of the follow-up interview (Column IV).

The following tabulations indicate that the graphic ratings of individual role performance, summary ratings and percentage figures of the

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1 Appendix H.
subject's social functioning levels could be established. These tabulations are based on the information given by Mrs. F.

Table 2. **Changes in Levels of Social Functioning at Four Points in Time**
(based on estimates given by Mrs. F).

<table>
<thead>
<tr>
<th>Roles</th>
<th>I Before Arthritis</th>
<th>II At Admission</th>
<th>III At Discharge</th>
<th>IV At Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Occupation</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Economic Status</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Marital</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Homemaker</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Mother</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Daughter</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sibling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summary Level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of Social Functioning</td>
<td>3, 1, X, 2NA</td>
<td>3, 1, X, 4X, 2NA</td>
<td>3, 3X, 2NA, 1X</td>
<td>3, 3, 1X, 2NA</td>
</tr>
<tr>
<td></td>
<td>88%</td>
<td>58%</td>
<td>58%</td>
<td>67%</td>
</tr>
</tbody>
</table>

Legend: Summary ratings of role performance are indicated by the following symbols:

- □ = unimpaired, ☐ = moderately impaired, X = severely impaired,
- NA = role not applicable, ? = insufficient information to rate the role.

In the above table it can be noted that before the onset of arthritis (Column I) Mrs. F. had 6 unimpaired roles, a severely impaired marital role,
no occupation role and she was childless. At the time Mrs. F. was admitted for residential treatment (Column II) the ratings of Mrs. F's disability role shows that she was almost totally dependent on others. The other ratings indicate that Mrs. F. was unable to perform her homemaker role, her social role was limited, and 6 roles remained unchanged. At the time Mrs. F. was discharged (Column III), the rating of her marital role had changed from severely to moderately impaired, the rating of her social role indicates a change to little or no social contacts and 7 roles remained unchanged.

Three and a half years later, at the time of the follow-up interview (Column IV), the ratings show changes from severely impaired to moderately impaired in Mrs. F's disability and homemaker roles and the remaining 7 roles were unchanged since discharge.

Before analyzing the percentage figures shown in Table 2, the reader should be reminded¹ that the figures representing the subject's levels of social functioning are experimental approximations. It is not assumed that the above percentage figures are precise measurements of the subject's social functioning. The percentage figures were secured by assigning scores to the summary ratings (□ = 10, △ = 5, X = 2) as described earlier,² in order to make mathematical measurements of levels of social functioning.

The experimental percentage figures in Table 2 indicate that Mrs. F's summary level of social functioning was 86% before the onset of arthritis. This level dropped to 58% at the time of her admission for residential treatment and it remained the same at the time she was discharged. Three and a half years later, at the time of the follow-up interview Mrs. F's social functioning level had risen to 67%.

¹ See Chapter IV, p.60.
² Ibid
The above ratings and percentage figures, although based on subjective estimates, indicate that the research model can demonstrate changes in role performance and in social functioning levels.

Similar demonstrations were secured of changes in social functioning levels based on information given by the remaining 8 subjects. The following table illustrates the summary changes in social functioning levels at 4 specific points in time established for the other 8 subjects.

Table 3. Changes in Levels of Social Functioning at Four Specific Points in Time.
(based on information provided by the listed subjects at the follow-up interview).

<table>
<thead>
<tr>
<th>Subject Name</th>
<th>Age (years)</th>
<th>Ratings Established from the Subjects' Estimate of Social Functioning Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Column I (percent)</td>
</tr>
<tr>
<td>Mrs. A</td>
<td>45</td>
<td>100</td>
</tr>
<tr>
<td>*Mrs. B</td>
<td>58</td>
<td>100</td>
</tr>
<tr>
<td>Mrs. C</td>
<td>44</td>
<td>94</td>
</tr>
<tr>
<td>Mrs. D</td>
<td>48</td>
<td>86</td>
</tr>
<tr>
<td>*Mrs. E</td>
<td>55</td>
<td>67</td>
</tr>
<tr>
<td>Mrs. G</td>
<td>52</td>
<td>87</td>
</tr>
<tr>
<td>Mrs. H</td>
<td>45</td>
<td>100</td>
</tr>
<tr>
<td>*Mrs. I</td>
<td>31</td>
<td>91</td>
</tr>
</tbody>
</table>

Legend: Columns I-IV represent the same periods of time as Table 2.

* Connotes subjects who had medical classifications of rheumatoid arthritis Stage III (advanced) at discharge.
The age figure represents the subject's age as of January 1966.
An analysis of the above tabulations indicates that all of the 8 subjects showed lowered social functioning levels at the time of admission compared to their level before the onset of arthritis. A comparison of Column II and III indicates that 5 subjects had an improved level at the time of discharge, one subject's level remained unchanged and the level of 2 subjects was lower than at the time of admission. A comparison of Column III and IV shows that the level of social functioning improved after discharge for 6 subjects. Two subjects, Mrs. B. and Mrs. E, show continued lowering of social functioning levels in Column II, III and IV. The table indicates that these 2 subjects had advanced rheumatoid arthritis and were 58 and 55 years of age respectively. It may be noted that Mrs. I, who also had advanced rheumatoid arthritis and who was 31 years of age did not show continued lowering of social functioning.

This sample is too small to conclude that the stage of the disease process and that the age of the patient were the determining factors for the continued lowering of social functioning levels established for Mrs. B. and Mrs. E. Although the two preceding tables have been based on subjective estimates given by the subjects at the follow-up interview, they do indicate that the research model can demonstrate changes in levels of functioning for one or more subjects. An inference can be drawn that for clinical purposes this research model has value in demonstrating changes in social functioning levels for a given person. The research model also has value for accumulating material to demonstrate changes in social functioning levels for groups of patients.

In order to establish more conclusively the value of the research model, the above estimates were compared with data from two other sources. One comparison was made with the incomplete summary ratings based on the C.A.R.S. social service records. The other comparison was made with the summary ratings
established by the present writer from the information and the observations she made at the follow-up interview.

The first check which compared the subject's estimates with the incomplete ratings established from the social service records, showed almost total agreement for Column I (before the onset of arthritis). In Column II (at admission) most subjective estimates and ratings established from the social service records were identical. The main difference was found in the rating of the disability role. Three subjects rated their disability role at admission as severely impaired, while the social service ratings showed only moderate impairment. No comparisons of ratings could be made for Column III (at discharge).

The only inference to be drawn from the first check was that the majority of the subjective estimates appeared to be valid.

The second check was made by comparing the subject's estimates with the ratings established by the writer for the time period of the follow-up interview (January 1966). The following table indicates the percentage figures secured of the subjects' social functioning levels for an average week as of January 1966. These percentage figures were based on the subjects' and writers' estimates, respectively.
Table 4. Comparison of Estimates of Social Functioning Level as of January 1966.*
(based on the subjects' and writer's estimate).

<table>
<thead>
<tr>
<th>Subject</th>
<th>Subject's Level of Social Functioning</th>
<th>Writer's estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Subject's estimate (percent)</td>
<td>Writer's estimate (percent)</td>
</tr>
<tr>
<td>Mrs. A</td>
<td>93</td>
<td>93</td>
</tr>
<tr>
<td>Mrs. B</td>
<td>65</td>
<td>60</td>
</tr>
<tr>
<td>Mrs. C</td>
<td>86</td>
<td>86</td>
</tr>
<tr>
<td>Mrs. D</td>
<td>93</td>
<td>93</td>
</tr>
<tr>
<td>Mrs. E</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>Mrs. F</td>
<td>67</td>
<td>58</td>
</tr>
<tr>
<td>Mrs. G</td>
<td>93</td>
<td>93</td>
</tr>
<tr>
<td>Mrs. H</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Mrs. I</td>
<td>86</td>
<td>86</td>
</tr>
</tbody>
</table>

* January 1966 = connotes an average week preceding the follow-up interview.

An analysis of the above tabulations shows that in 7 cases there was agreement between the subjects' and the writer's estimates. For the 2 cases where the estimates of social functioning lacked agreement, there are valid explanations. In the case of Mrs. B, all ratings agreed but one. Mrs. B rated her disability role as partially dependent on others, while the writer's assessment was that Mrs. B is almost totally dependent on others. This difference in the two assessments made up the 5% variation in the score. In the case of Mrs. F, the two estimates were the same for 7 roles.
In the estimates of the other 2 roles, Mrs. F. rated her disability role as partially dependent on others and that she was partially able to perform her homemaker role. From the information Mrs. F. gave at the time of the follow-up interview, the writer scored this woman's disability and homemaker roles as severely impaired. These differences in the scoring of these 2 roles caused the variation in the percentage summary estimates.

Limitations of the Study

The following limitations were found which affected the results of this study.

The C.A.R.S. social service records could not meet the demands of the rating scale of this study, mainly because the social assessments and recordings were not organized on the basis of social role theory. The second limitation was that the median rating (moderately impaired) at times proved to be too crude for representing the actual estimate of the role performance. Sometimes a subject's estimate would be closer to one of the extremes (unimpaired or severely impaired) than the median rating and an arbitrary decision would have to be made whether to assign the rating to one of the extremes or the median rating. This resulted in some estimates being assigned to the median rating or extremes, which did not closely reflect how the role was actually being performed. The crudeness of the median rating also affected the scoring. It was found that although the median rating was scored with the figure 5, in actuality the subject's estimates sometimes were closer to 3 or 9. Once again the subject's level of social functioning would have been more accurately portrayed if the median rating could be scored as 8, 6 or 4. The final disadvantage was that there was no way of showing differential scoring, based on major and minor roles.
Obviously a severely impaired marital role would affect the subject's level of social functioning more seriously than a severely impaired sibling role.

**Recommendation for Further Study**

The following recommendations should be considered if this research model is used for further sequential research.

1. Repetition of a similar study should be limited to social service recordings which utilize social role theory in the formulation of social assessments.

2. It is suggested that the study's three-point rating scale be refined further by expanding it into a five-point rating scale, which would facilitate more precise assessments of social functioning.

3. Similarly, changes in the experimental percentage scoring should be made, in order that they may reflect more closely role impairment and changes in levels of social functioning.

4. Further study and research is required to determine the ordering and the differentiation of primary and secondary roles.

5. Further research might also prove fruitful, if the concepts of social role theory and stress were combined in the same experimental study.

**Conclusions**

The formulation of definite conclusions from this study is limited by the small number of sample cases and by the arbitrary decisions made due to the crudeness of the median rating in this study's three-point rating scale. An additional impediment to this research study is that the recordings were not organized for research purposes and therefore complete summary
assessment ratings could not be established.

These limitations must be kept in mind in considering the results of this study. The following conclusions were reached after careful consideration was given to the analysis of the findings in terms of the study's objectives noted in Chapter I.

The reliability of the specific criteria developed to assess social functioning of married female arthritis patients was not conclusively established. This resulted because one of the built-in checks for reliability failed to produce complete summary assessments.

However, tentative conclusions can be made based on the ratings established from the subjects' and the writer's estimates. This study has demonstrated that a research instrument has been devised which produces a systematic means for assessing the major roles performed by a person at a given time and therefore provides a basis for a summary assessment of social functioning. The research instrument also demonstrated changes in social functioning levels.

It can be concluded that this research model exposed gaps in social work information, and it also suggests a more useful method for securing and recording a complete summary assessment of the patient's social functioning.

Analysis of the findings indicates that by utilizing more clearly defined criteria to ascertain social functioning levels, certain movement and changes in levels of social functioning are more readily discernible.

It would appear that a systematic plan for recording social casework data, based on the specific criteria for assessing social functioning could be more amenable for use in the objective evaluation of the patient's total functioning. A corollary to this is that a more systematic approach
by the social worker could facilitate better communication between the rehabilitation team members.

The study has demonstrated that the present research instrument has the potential to offer a more meaningful and uniform method for collecting social assessment information. Information collected in this manner would be more amenable to medical and social work research which might be undertaken in the future.

It would appear that systematic summary assessments at intake and at discharge, based on this research model, could facilitate continuity of service given by social workers, when the patients are seen at a later date.

The subjects' estimates together with the writer's estimates have demonstrated that systematic comparisons can be made, of the performance of roles, and of levels of social functioning for a given individual or for groups of individuals.

This study has been applied to one group of individuals with a particular physical disability. It would appear that the research rating system has potential for its application in other medical centers dealing with different physical disabilities.

Social role theory has been tested in this study, and it may be possible that it offers a more systematic method for assessing and recording the social functioning of given persons. It is hoped that this study will blaze the trail for future sequential research which will facilitate the incorporation of more social work theory in day-to-day practice of social work.
Mr. W.G. Dixon,
Professor and Director,
The University of British Columbia,
School of Social Work,
Vancouver 8, B. C.

Dear Professor Dixon:

Thank you for your letter asking permission for Mrs. Walters to have access to the social and medical records of the Medical Centre in connection with research work. This has been discussed in some detail with Mrs. Walters.

We are happy to attach her as a student to the Arthritis Unit for the time required.

We hope it will be possible to develop more specific criteria for assessment of social functioning, particularly as it relates to the arthritis patient.

Yours sincerely,

H.S. Robinson, M.D.
Medical Director.
APPENDIX B

Criteria for Sample Selection

Disease Classification - Rheumatoid Arthritis - #2 or #3
Functional Capacity - #2 or #3

Discharged within last - 18 months - 4 years, using
patients discharge date

Duration of illness - 18 months or more

Classification limited to one sex - female

Confined to married women

Living in the Greater Vancouver Area

Age restricted to 30-60 year age group.
Guide for the Assessment of Social Functioning of Married Female Arthritis Patients - Based on Rating Scales for Assessment of Individual Role Performance.

I. Rating Scale for Assessing Performance of Disability Role

<table>
<thead>
<tr>
<th>Guide for Assessment of Role Performance</th>
<th>SOCIAL FUNCTIONING</th>
<th>EXPLANATION OF RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limitation imposed by the disability on physical functioning.</td>
<td>□ = Unimpaired role performance</td>
<td>□ = Moderately impaired role performance</td>
</tr>
<tr>
<td>Physical disability is expected to have little or no effect on daily activities.</td>
<td>Should be able to perform some but not all daily activities.</td>
<td>Expected to be physically unable to perform most daily activities.</td>
</tr>
<tr>
<td>Health apart from disability.</td>
<td>Good physical health apart from specific disability.</td>
<td>Suffers from minor disabling illness.</td>
</tr>
<tr>
<td>Attitudes expressed overt or covert in performing disability role.</td>
<td>Independent, self-sufficient and cooperative. Wishes to function at maximum capacity within limitations imposed by physical disability.</td>
<td>Some effort to co-operate and be self-sufficient, but partially dependent. Some motivation to function within physical limitations.</td>
</tr>
<tr>
<td>Summary Criteria of Disability Role.</td>
<td>Independent and self-sufficient.</td>
<td>Partially dependent on others.</td>
</tr>
</tbody>
</table>
II. Rating Scale for Assessing Performance of Occupation Role

<table>
<thead>
<tr>
<th>Guide for Assessment of Role Performance</th>
<th>SOCIAL FUNCTIONING - EXPLANATION OF RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ = Unimpaired role performance</td>
</tr>
<tr>
<td></td>
<td>□ = Unimpaired role performance</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Time gainfully employed.</td>
<td>Worked full time.</td>
</tr>
<tr>
<td></td>
<td>Worked full time.</td>
</tr>
<tr>
<td></td>
<td>Worked quarter time or less.</td>
</tr>
<tr>
<td>Attitude toward occupation.</td>
<td>Finds job satisfying and interesting.</td>
</tr>
<tr>
<td></td>
<td>Finds job satisfying and interesting.</td>
</tr>
<tr>
<td>Summary Criteria of Occupation Role.</td>
<td>Works full time.</td>
</tr>
<tr>
<td></td>
<td>Works full time.</td>
</tr>
<tr>
<td></td>
<td>Works quarter time or less.</td>
</tr>
</tbody>
</table>

III. Rating Scale for Assessing Performance of Economic Status Role

<table>
<thead>
<tr>
<th>Guide for Assessment of Role Performance</th>
<th>SOCIAL FUNCTIONING - EXPLANATION OF RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ = Unimpaired role performance</td>
</tr>
<tr>
<td></td>
<td>□ = Unimpaired role performance</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequacy of financial income.</td>
<td>Income provides well for the family's economic needs beyond the subsistence level.</td>
</tr>
<tr>
<td></td>
<td>Income provides well for the family's economic needs beyond the subsistence level.</td>
</tr>
<tr>
<td>Level of financial functioning.</td>
<td>Total financial independence.</td>
</tr>
<tr>
<td></td>
<td>Total financial independence.</td>
</tr>
<tr>
<td></td>
<td>Financially independent.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX C (iii)

**IV. Rating Scale for Assessing Performance of Marital Role**

<table>
<thead>
<tr>
<th>Guide for Assessment of Role Performance</th>
<th>Social Functioning - Explanation of Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ = Unimpaired role performance</td>
</tr>
<tr>
<td></td>
<td>□ = Moderately impaired role performance</td>
</tr>
<tr>
<td></td>
<td>□ = Severely impaired role performance</td>
</tr>
<tr>
<td>Source of companionship.</td>
<td>Spouse working in town and living at home.</td>
</tr>
<tr>
<td></td>
<td>Spouse frequently absent from home engaged in out of town work but commutes home when possible.</td>
</tr>
<tr>
<td></td>
<td>Spouse works out of town and rarely visits home.</td>
</tr>
<tr>
<td>Sociability.</td>
<td>Frequently goes out socially with spouse.</td>
</tr>
<tr>
<td></td>
<td>Seldom goes out socially with spouse.</td>
</tr>
<tr>
<td></td>
<td>Does not go out socially with spouse.</td>
</tr>
<tr>
<td>Communication system.</td>
<td>Communicates easily with spouse, no gross marital discord.</td>
</tr>
<tr>
<td></td>
<td>Does not communicate easily. Some marital conflicts.</td>
</tr>
<tr>
<td></td>
<td>Little or no communication, severe conflicts with spouse.</td>
</tr>
<tr>
<td>Emotional support.</td>
<td>Positive emotional ties with balance ability for dependence and independence.</td>
</tr>
<tr>
<td></td>
<td>Ambivalent emotional ties increasing dependency.</td>
</tr>
<tr>
<td></td>
<td>Weak emotional ties totally dependent.</td>
</tr>
<tr>
<td>Summary Criteria of Marital Role.</td>
<td>Good marital relationship.</td>
</tr>
<tr>
<td></td>
<td>Fair marital relationship.</td>
</tr>
<tr>
<td></td>
<td>Poor marital relationship.</td>
</tr>
</tbody>
</table>
V. Rating Scale for Assessing Performance of Homemaker Role

<table>
<thead>
<tr>
<th>Guide for Assessment of Role Performance</th>
<th>SOCIAL FUNCTIONING - EXPLANATION OF RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐  = Unimpaired role performance</td>
<td>☐  = Moderately impaired role performance</td>
</tr>
<tr>
<td>☐  = Severely impaired role performance</td>
<td>☐  = Severely impaired role performance</td>
</tr>
<tr>
<td>Ability to perform household tasks.</td>
<td>Able without help to keep home moderately clean and attractive. Able to prepare meals, wash, iron, etc. without help.</td>
</tr>
<tr>
<td></td>
<td>Requires considerable help from others to manage household tasks.</td>
</tr>
<tr>
<td></td>
<td>Unable to perform most household tasks, Totally dependent on others to care for household needs.</td>
</tr>
<tr>
<td>Ability to share in management of household budget</td>
<td>Shares management of household budget.</td>
</tr>
<tr>
<td></td>
<td>Some responsibility for management of household budget.</td>
</tr>
<tr>
<td></td>
<td>Assumes no part in management of household budget.</td>
</tr>
<tr>
<td>Summary Criteria of Homemaker Role</td>
<td>Able to perform without help.</td>
</tr>
<tr>
<td></td>
<td>Partially able to perform.</td>
</tr>
<tr>
<td></td>
<td>Unable to perform.</td>
</tr>
</tbody>
</table>
# APPENDIX C (v)

## VI. Rating Scale for Assessing Performance of Mother Role

<table>
<thead>
<tr>
<th>Guide for Assessment of Role Performance</th>
<th>SOCIAL FUNCTIONING</th>
<th>EXPLANATION OF RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider of children's physical care.</td>
<td>□ = Unimpaired role performance</td>
<td>■ = Moderately impaired role performance</td>
</tr>
<tr>
<td></td>
<td>Provides well-cared for home, able to secure and prepare meals unattended, shares responsibility for children's health needs, cares for their clothing.</td>
<td>Partially able to care for physical needs of the family with some help.</td>
</tr>
<tr>
<td>Source of emotional support.</td>
<td>Provides maternal warmth, love and emotional support. Able to put children's interest before self.</td>
<td>Provides some emotional support. Children's interests and own interests are often in conflict.</td>
</tr>
</tbody>
</table>
APPENDIX C (vi)

VII. Rating Scale for Assessing Performance of Daughter Role

<table>
<thead>
<tr>
<th>Guide for Assessment of Role Performance</th>
<th>SOCIAL FUNCTIONING - EXPLANATION OF RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□  = Unimpaired role performance</td>
</tr>
<tr>
<td></td>
<td>■  = Moderately impaired role performance</td>
</tr>
<tr>
<td></td>
<td>X  = Severely impaired role performance</td>
</tr>
<tr>
<td>Ties to parents</td>
<td>Strong emotional ties with parents.</td>
</tr>
<tr>
<td></td>
<td>Weak ties with parents.</td>
</tr>
<tr>
<td></td>
<td>Little or no ties with parents.</td>
</tr>
<tr>
<td>Source of emotional or financial support.</td>
<td>Mutual emotional security, totally financially independent.</td>
</tr>
<tr>
<td></td>
<td>Partial emotional security and/or partial financial dependency.</td>
</tr>
<tr>
<td></td>
<td>No emotional security and/or total financial dependency.</td>
</tr>
<tr>
<td>Summary Criteria of Daughter Role</td>
<td>Strong emotional ties with parents.</td>
</tr>
<tr>
<td></td>
<td>Weak emotional ties with parents.</td>
</tr>
<tr>
<td></td>
<td>Little or no emotional ties with parents.</td>
</tr>
</tbody>
</table>

VIII. Rating Scale for Assessing Performance of Sibling Role

<table>
<thead>
<tr>
<th>Guide for Assessment of Role Performance</th>
<th>SOCIAL FUNCTIONING - EXPLANATION OF RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□  = Unimpaired role performance</td>
</tr>
<tr>
<td></td>
<td>■  = Moderately impaired role performance</td>
</tr>
<tr>
<td></td>
<td>X  = Severely impaired role performance</td>
</tr>
<tr>
<td>Ability to maintain contact with siblings.</td>
<td>Strong contact with siblings.</td>
</tr>
<tr>
<td></td>
<td>Tenuous contact with siblings.</td>
</tr>
<tr>
<td></td>
<td>Little or no contact with siblings.</td>
</tr>
<tr>
<td>Source of emotional security.</td>
<td>Strong emotional ties offering a sense of security to one another. Not dependent on siblings for financial assistance.</td>
</tr>
<tr>
<td></td>
<td>Marginal sense of emotional security. Partially dependent on siblings for help with family care or financial assistance.</td>
</tr>
<tr>
<td></td>
<td>No emotional security, lack of communication and no interest.</td>
</tr>
<tr>
<td>Social activities.</td>
<td>Social companionship interdependent.</td>
</tr>
<tr>
<td></td>
<td>Little social contact.</td>
</tr>
<tr>
<td></td>
<td>No social contacts with siblings.</td>
</tr>
<tr>
<td>Summary Criteria of Sibling Role</td>
<td>Strong ties with siblings.</td>
</tr>
<tr>
<td></td>
<td>Weak ties with siblings.</td>
</tr>
<tr>
<td></td>
<td>Little or no ties with siblings.</td>
</tr>
</tbody>
</table>
IX. Rating Scale for Assessing Performance of Social Role

<table>
<thead>
<tr>
<th>Guide for Assessment of Role Performance</th>
<th>SOCIAL FUNCTIONING - EXPLANATION OF RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends and neighbours.</td>
<td>Has good relationship and communication with friends and neighbours.</td>
</tr>
<tr>
<td>Participation in community organizational groups.</td>
<td>Active in at least one community organization.</td>
</tr>
<tr>
<td>Social activities</td>
<td>Numerous social activities with friends.</td>
</tr>
<tr>
<td>Summary Criteria of Social Role.</td>
<td>Numerous social contacts.</td>
</tr>
</tbody>
</table>
APPENDIX D

Summary Criteria for Rating Role Performance

1. **Disability Role**
   - [ ] independent and self-sufficient
   - [ ] partially dependent on others
   - [x] totally or very dependent on others

2. **Occupation Role**
   - [ ] works full time
   - [ ] works half time
   - [x] works quarter time or less

3. **Economic Status Role**
   - [ ] financially independent
   - [ ] partial financial dependence
   - [x] total financial dependence

4. **Marital Role**
   - [ ] good marital relationship
   - [ ] fair marital relationship
   - [x] poor marital relationship

5. **Homemaker Role**
   - [ ] able to perform without help
   - [ ] partially able to perform
   - [x] unable to perform

6. **Mother Role**
   - [ ] good relationship with children
   - [ ] fair relationship with children
   - [x] poor relationship with children

7. **Daughter Role**
   - [ ] strong emotional ties with parents
   - [ ] weak emotional ties with parents
   - [x] little or no emotional ties with parents

8. **Sibling Role**
   - [ ] strong ties with siblings
   - [ ] weak ties with siblings
   - [x] little or no ties with siblings

9. **Social Role**
   - [ ] numerous social contacts
   - [ ] limited social contacts
   - [x] little or no social contacts
APPENDIX E

Legend - Graphic Symbols Representing Assessed Role Performance

☐ = Unimpaired role performance
■ = Moderately impaired role performance
□ = Severely impaired role performance
? = Insufficient information for rating role performance
NA = Role not applicable, i.e.

(a) Not performing occupation role since marriage.
(b) Death, divorce or desertion of the reciprocate.
(c) Childless.
(d) No other siblings.
(e) Homemaker role did not exist, as the subject was single at onset of arthritis.
Mrs. X - Sample Table Demonstrating Changes in Levels of Social Functioning

<table>
<thead>
<tr>
<th>Roles</th>
<th>Social Functioning Level Before Onset of Arthritis</th>
<th>Social Functioning Level at Admission</th>
<th>Social Functioning Level at Discharge</th>
<th>Social Functioning Level at Follow-up Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Role</td>
<td>□ independent and self sufficient</td>
<td>X very dependent on others</td>
<td>□ partially dependent on others</td>
<td>□ partially dependent on others</td>
</tr>
<tr>
<td>Occupation Role</td>
<td>NA no role since marriage</td>
<td>NA no role since marriage</td>
<td>NA no role since marriage</td>
<td>NA no role since marriage</td>
</tr>
<tr>
<td>Economic Status Role</td>
<td>□ financially independent</td>
<td>□ partial financial dependence</td>
<td>□ partial financial dependence</td>
<td>□ financially independent</td>
</tr>
<tr>
<td>Marital Role</td>
<td>X poor marital relationship</td>
<td>X poor marital relationship</td>
<td>□ fair marital relationship</td>
<td>□ fair marital relationship</td>
</tr>
<tr>
<td>Homemaker Role</td>
<td>□ able to perform without help</td>
<td>X unable to perform</td>
<td>□ partially able to perform</td>
<td>□ partially able to perform</td>
</tr>
<tr>
<td>Mother Role</td>
<td>□ good relationship with children</td>
<td>□ good relationship with children</td>
<td>□ good relationship with children</td>
<td>□ good relationship with children</td>
</tr>
<tr>
<td>Daughter Role</td>
<td>□ strong ties with parents</td>
<td>NA parents deceased</td>
<td>NA parents deceased</td>
<td>NA parents deceased</td>
</tr>
<tr>
<td>Sibling Role</td>
<td>□ weak ties with siblings</td>
<td>□ weak ties with siblings</td>
<td>□ weak ties with siblings</td>
<td>□ weak ties with siblings</td>
</tr>
<tr>
<td>Social Role</td>
<td>□ numerous social contacts</td>
<td>□ limited social contacts</td>
<td>□ limited social contacts</td>
<td>□ numerous social contacts</td>
</tr>
<tr>
<td>Graphic Summary</td>
<td>6 □, 1□, 1X, 1NA</td>
<td>1□, 3□, 3X, 2NA</td>
<td>1□, 6□, 2NA</td>
<td>3□, 4□, 2NA</td>
</tr>
<tr>
<td>Social Functioning Level</td>
<td>6 □, 1□, 1X, 1NA</td>
<td>1□, 3□, 3X, 2NA</td>
<td>1□, 6□, 2NA</td>
<td>3 □, 4□, 2NA</td>
</tr>
</tbody>
</table>
Dear Mrs.

The Canadian Arthritis and Rheumatism Society (C.A.R.S.) is interested in research which may help to improve services to its patients. A survey has been undertaken by the U.B.C. School of Social Work in cooperation with C.A.R.S. The purpose of this survey is to determine how former patients have fared since discharge from the C.A.R.S. Arthritis Unit. Knowledge of your present way of life and degree of activity will enable us to study the results of our services and to improve them where we can.

An important part of this survey is the information you can give us in a follow-up interview which will be brought to you for discussion by a social worker, Mrs. Walters. We would like to assure you that all personal information will be treated in the strictest confidence and that your name will not be included in the research findings.

I would be most grateful if you could cooperate in this research by making yourself available for an interview which will be arranged at your convenience when Mrs. Walters contacts you within the next 10 days.

Yours sincerely,

H.S. Robinson, M.D.
Medical Director

HSR;jm
APPENDIX H.1
SURVEY INTERVIEW SCHEDULE

Date of Interview __________________________ Name of Social Worker ________________

Interviewee: ☐ Former patient ☐ Former patient's husband
☐ Others (specify)

Date of Discharge __________________________

PART I - IDENTIFYING INFORMATION

Family Name:

(a) Husband's Name __________________________ Date of Birth __________
    Address __________________________ Phone No. __________

(b) Former patient's Name __________________________ Date of Birth __________
    Address __________________________ Phone No. __________

Children:

<table>
<thead>
<tr>
<th>NAME</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>School Grade</th>
<th>In Home</th>
<th>Out of Home - Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Day</td>
<td>Mnth</td>
<td>Yr.</td>
<td>Age</td>
</tr>
</tbody>
</table>

Other Household Members:

<table>
<thead>
<tr>
<th>NAME</th>
<th>Sex</th>
<th>Status in Home</th>
<th>Relationship</th>
<th>Age</th>
<th>Entered - Left</th>
</tr>
</thead>
</table>

Do you live in: ☐ Own Home ☐ Boarding or Nursing Home
☐ Hotel ☐ Apartment ☐ Other
PART II - PHYSICAL FACTORS

1. In terms of your arthritis, is this a good, fair or a bad day?
   ( ) Good ( ) Fair ( ) Bad

2. Can you do as much now as you expected to be able to do: ( ) Yes ( ) No

3. Do you require help from another person in dressing: ( ) Yes
   ( ) Partly ( ) No

4. How is your health apart from the R.A.: ( ) Good ( ) Fair ( ) Poor

5. Have you been readmitted to any hospital since discharge from CARS?:

6. Do you use equipment such as wheelchair, chair on wheels, canes, dressing sticks, crutches, day splints, kitchen gadgets, others (specify):

7. Are you able to leave the house unassisted: _______ to walk a block _______

8. Can you use public transportation (bus, etc.) _______ can you drive a car now _______

9. Interviewee's Retrospective Estimate of Physical Performance:
   How were you able to manage physically, in terms of an average week -
   a) Before you had arthritis: ( ) Good ( ) Fair ( ) Poor
   b) When you first came to the CARS unit: ( ) Good ( ) Fair ( ) Poor
   c) At the time of discharge from the unit: ( ) Good ( ) Fair ( ) Poor
   d) Two years later: ( ) Good ( ) Fair ( ) Poor
   e) At the present time: ( ) Good ( ) Fair ( ) Poor

Summary Assessment Disability Role - From Interviewee's retrospective estimate and follow-up interview:

   [ ] Before Onset [ ] At Intake [ ] At Discharge [ ] At follow-up

   - From Case recording material and follow-up interview:

   [ ] Before Onset [ ] At Intake [ ] At Discharge [ ] At follow-up

10. Duration of Chronic Illness.
    How long have you had arthritis? _______ Date _______
    When did you first seek medical attention for arthritis? _______ Date _______
APPENDIX H.3.

PART III - SOCIO-ECONOMIC FACTORS

1. Husband's Occupation:

Grade completed at school:

Any changes of occupation or employment 1960-65:

<table>
<thead>
<tr>
<th>Date</th>
<th>Occupation</th>
<th>Date</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Interviewee's Occupation:

Grade completed at School:

(a) before marriage ________ How long employed ________ number of job changes____

(b) are you employed now: ( ) Yes ( ) No If yes, indicate if you started since discharge: ( ) Yes ( ) No

Any changes of occupation or employment 1950-65:

<table>
<thead>
<tr>
<th>Date</th>
<th>Occupation</th>
<th>Date</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(c) are you employed: ( ) fulltime; ( ) part-time; ( ) others

(d) is this different from the work you did before your hospitalization?

3. Interviewee's Retrospective Estimate of Occupational Role

Would you please estimate changes in your occupation:

a) Before you had arthritis: ( ) Worked fulltime ( ) ½ time ( ) ¼ or none

b) When you first came to Cars: ( ) Worked fulltime ( ) ½ time ( ) ¼ or none

c) At the time of discharge from the Unit: ( ) Worked fulltime ( ) ½ time ( ) ¼ or none

d) Two years later: ( ) Worked fulltime ( ) ½ time ( ) ¼ or none

e) At the present time: ( ) Worked fulltime ( ) ½ time ( ) ¼ or none
APPENDIX H.4

PART III - SOCIO-ECONOMIC (continued)

Summary Assessment Occupational Role - From Interviewee's retrospective estimate and follow-up interview:

- Before Onset  At Intake  At Discharge  At follow-up

- From Case recording material and follow-up interview:

- Before Onset  At Intake  At Discharge  At follow-up

4. Economic Status of the Family - from 1960-65

( ) Above $5000  ( ) $3000-$5000  ( ) Less than $3000

5. Source of Income self or spouse (No need to state amount)

( ) Salary  ( ) Unemployment Insurance  ( ) Social Assistance

( ) Private Income  ( ) Old Age Assist.  ( ) Disability P.A.

( ) Retirement pension  ( ) Workmen's Compensation

( ) Others (specify):

( ) Independent  ( ) Dependent on others  ( ) On S.W.  (S.W. estimate)

6. Do you find that your income is sufficient to provide for your everyday needs?:

Sufficient  Marginal  Insufficient

Adequate Food  
Housing  
Clothing  
Medical care  
Recreation  
Other services needed

7. Interviewee's Retrospective Estimate of changes in Economic Status:
Would you please estimate changes in your economic situation
a) Before you had arthritis: ( ) No change  ( ) Upward  ( ) Downward  ( ) Fluctuating
b) When you first came to CARS: ( ) No change  ( ) Upward  ( ) Downward  ( ) Fluct.
c) At time of discharge from unit: ( ) No change  ( ) Upward  ( ) Downward  ( ) Fluctuating
d) Two years later: ( ) No change  ( ) Upward  ( ) Downward  ( ) Fluctuating
e) At present time: ( ) No change  ( ) Upward  ( ) Downward  ( ) Fluctuating

Summary Assessment Economic Status Role - From Interviewee's retrospective estimate and follow-up interview:

- Before Onset  At Intake  At Discharge  At follow-up

- From Case recording material and follow-up interview:

- Before Onset  At Intake  At Discharge  At follow-up
PART IV - MARITAL FACTORS

1. Husband's presence in Home Indicated Part I: ( )Present ( )Absent
2. If absent, indicate reason:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Date</th>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desertion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorce</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remarriage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Works out of town</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Omit Questions 3 to 7 if husband absent from home:

3. Are you able to communicate with your husband: ( )Easily
   ( )With difficulty ( )Little or no communication
4. Do you go out with your husband socially: ( )Yes ( )Seldom ( )No
5. Do you agree on disciplinary measure for the children: ( )Yes
   ( )Partially ( )No
6. Do you share responsibility for managing the family household budget:
   ( )Yes ( )Partially ( )No
7. Would you please estimate your relationship with your husband -
   a) Before you had arthritis: ( )Good ( )Fair ( )Poor
   b) When you first came to the CARS unit: ( )Good ( )Fair ( )Poor
   c) At the time of discharge from the unit: ( )Good ( )Fair ( )Poor
   d) Two years later: ( )Good ( )Fair ( )Poor
   e) At the present time: ( )Good ( )Fair ( )Poor

Summary Assessment Marital Role - From Interviewee's retrospective estimate and follow-up interview:

[ ] Before Onset [ ] At Intake [ ] At Discharge [ ] At follow-up

- From Case recording material and follow-up interview:

[ ] Before Onset [ ] At Intake [ ] At Discharge [ ] At follow-up
PART V - HOME CARE AND MATERNAL FACTORS

1. Do you have help with housekeeping?:  
   - Weekly  
   - Daily  
   - From family daily

2. If family helps daily with housekeeping, indicate who:  
   - Husband  
   - Children  
   - Both

3. What household activities do you ordinarily do at present:  
   - Cooking  
   - Dishes  
   - Ironing  
   - Bed making  
   - Dusting  
   - Gardening  
   - Shopping  
   - All Housework

4. How were you able to perform your household tasks in terms of an average week:  
   a) Before you had arthritis:  
      - Good  
      - Fair  
      - Poor
   b) When you first came to the CARS unit:  
      - Good  
      - Fair  
      - Poor
   c) At the time of discharge from the unit:  
      - Good  
      - Fair  
      - Poor
   d) Two years later:  
      - Good  
      - Fair  
      - Poor
   e) At the present time:  
      - Good  
      - Fair  
      - Poor

5. If interviewee indicated children living at home, -  
   Were you able to provide for children's physical care as well as meals, clothing, etc.:  
   a) Before you had arthritis:  
      - Yes  
      - Partially  
      - No
   b) When you first came to the CARS unit:  
      - Yes  
      - Partially  
      - No
   c) At the time of discharge from the unit:  
      - Yes  
      - Partially  
      - No
   d) Two years later:  
      - Yes  
      - Partially  
      - No
   e) At the present time:  
      - Yes  
      - Partially  
      - No

6. Has your illness affected your relationship with your children, (re. how you get along, arguments, love for each other, help with their problems). Indicate if this relationship was:  
   a) Before you had arthritis:  
      - Better  
      - Same  
      - Worse
   b) When you first came to the CARS unit:  
      - Better  
      - Same  
      - Worse
   c) At the time of discharge from the unit:  
      - Better  
      - Same  
      - Worse
   d) Two years later:  
      - Better  
      - Same  
      - Worse
   e) At the present time:  
      - Better  
      - Same  
      - Worse

7. Do you feel that because of your arthritis, you now have to increasingly depend on your children:  
   - Yes  
   - No  
   Comment: ___________________________________
PART VI - FILIAL FACTORS

1. Are your parents living: ( )Yes ( )No
   If yes:

2. What is your estimate of your parents and yourself in regard to:
   (a) mutual help: ( )Strong ( )Weak ( )No ties
   (b) are your parents financially independent: ( )Yes ( )No
   (c) do they depend on you for some financial help: ( )Yes ( )No
   (d) do you depend on your parents for financial help: ( )Yes ( )Sometimes ( )No
   (e) do you depend on your parents for other types of help (i.e. care of children, home, etc.): ( )Yes ( )No If so, in what way? __________

   (f) do you spend time socially with your parents: ( )Frequently
       ( )Partially ( )None

3. Estimate your relationship with your parents:
   a) Before you had arthritis: ( )Strong ( )Weak ( )No ties
   b) When you first came to the CARS unit: ( )Strong ( )Weak ( )No ties
   c) At the time of discharge from the unit: ( )Strong ( )Weak ( )No ties
   d) Two years later: ( )Strong ( )Weak ( )No ties
   e) At the present time: ( )Strong ( )Weak ( )No ties
APPENDIX H.8.

Summary Assessment of Daughter Role - From Interviewee's retrospective estimate and follow-up interview:

- Before Onset  At Intake  At Discharge  At follow-up

- From Case recording material and follow-up interview:

- Before Onset  At Intake  At Discharge  At follow-up

PART VII - SIBLING FACTORS

1. Do you have brothers:  Sisters:  

Indicate number

If so:-

What is your estimate of your brother(s) - sister(s) and yourself in regard to:

(a) mutual help:  Strong ties  Weak ties  Little or no ties

(b) do you visit back and forth with your brother(s) and sister(s):

Frequently  Little contact  No

(c) Do you help them out financially:  Yes  No

(d) Do they help your family financially:  Frequently  Rarely  Never

2. Estimate of your relationship with your brother(s) and sister(s):

a) Before you had arthritis:  Strong  Weak  No ties

b) When you first came to the CARS unit:  Strong  Weak  No ties

c) At the time of discharge from the unit:  Strong  Weak  No ties

d) Two years later:  Strong  Weak  No ties

e) At the present time:  Strong  Weak  No ties

Summary Assessment of Sibling Role - From Interviewee's retrospective estimate and follow-up interview:

Before Onset  At Intake  At Discharge  At follow-up

- From Case recording material and follow-up interview:

Before Onset  At Intake  At Discharge  At follow-up
PART VIII - SOCIABILITY FACTORS

1. Do you entertain friends in your home: ( ) Frequently ( ) Very seldom ( ) Never

2. Do you rely mainly on your family for social contacts: ( ) Yes ( ) No

3. Has your circle of friends changed because of your illness:

4. Are you friendly with your neighbours: ( ) Good relationship ( ) Limited relationship ( ) No relationship

5. Do you participate in activities outside the home: ( ) Club meetings ( ) Church ( ) Recreating Groups ( ) Volunteer Work ( ) Others (specify:)

6. What pastimes or hobbies do you take part in at home:

What pastimes or hobbies do you take part in elsewhere:

7. Would you please estimate in terms of an average week, your social contact with friends:
   a) Before you had arthritis: ( ) Frequent contact ( ) Some contact ( ) Few contacts
   b) When you first came to the CARS unit: ( ) Frequent contact ( ) Some contact ( ) Few contacts
   c) At the time of discharge from the unit: ( ) Frequent contact ( ) Some contact ( ) Few contacts
   d) Two years later: ( ) Frequent contact ( ) Some contact ( ) Few contacts
   e) At the present time: ( ) Frequent contact ( ) Some contact ( ) Few contacts

Summary Assessment of Social Role - From Interviewee's retrospective estimate and follow-up interview:

[ ] Before Onset [ ] At Intake [ ] At Discharge [ ] At follow-up

- From case recording material and follow-up interview:

[ ] Before Onset [ ] At Intake [ ] At Discharge [ ] At follow-up
APPENDIX I

Medical Assessment - Stage Code

Note: The following stages are reported only with respect to Rheumatoid Arthritis.

1. Minimal
   i) No muscle atrophy.
   ii) No extra-articular lesions (nodules, tenosynovitis, etc.).
   iii) No joint deformity.
   iv) No ankylosis.

2. Moderately Advanced
   i) Muscle atrophy adjacent to affected joints.
   ii) Extra-articular lesions (nodules, tenosynovitis etc.) may be present.
   iii) No joint deformity.
   iv) No ankylosis.

3. Advanced
   i) Widespread muscle atrophy.
   ii) Extra-articular lesions (nodules, tenosynovitis, etc.) may be present.
   iii) Joint deformity subluxation, ulnar deviation and/or hyperextension.
   iv) No ankylosis.

4. Far Advanced
   i) Widespread muscle atrophy.
   ii) Extra-articular lesions (nodules, tenosynovitis, etc.) may be present.
   iii) Joint deformity subluxation, ulnar deviation and/or hyperextension.
   iv) Fibrous or bony ankylosis.
Functional Capacity Code

1. **Unimpaired or Slightly Impaired:**
   Functional capacity adequate to perform all normal activities of daily living without the use of prosthetic or other appliances, and despite slight intermittent discomfort or limited mobility of one or more joints.

2. **Complete Self-Care:**
   Functional capacity adequate to perform the majority of normal activities of daily living with or without the use of prosthetic or other appliances; able to feed, dress, use toilet facilities, and leave house without assistance from a second person.

3. **Partial Self-Care:**
   Functional capacity adequate to perform the majority of normal activities of daily living with or without the use of prosthetic or other appliances; able to feed, dress and use toilet facilities, may require occasional assistance from a second person, unable to prepare meals or unable to leave house without assistance from a second person.

4. **Severely Impaired:**
   Functional capacity insufficient to perform the majority of normal activities of daily living with or without the use of prosthetic or other appliances; requires regular assistance from a second person in performing one or more of the following activities: feeding, dressing, using toilet facilities, or getting about indoors in wheel-chair or otherwise.
**APPENDIX K**

**Statistical Accounting of Sample Selection**

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients discharged from January 1962-May 1964</td>
<td>99</td>
</tr>
<tr>
<td>Males</td>
<td>41</td>
</tr>
<tr>
<td>Females</td>
<td>58</td>
</tr>
<tr>
<td>Not in disease classification</td>
<td>3</td>
</tr>
<tr>
<td>Residing outside Greater Vancouver Area</td>
<td>29</td>
</tr>
<tr>
<td>Single female</td>
<td>5</td>
</tr>
<tr>
<td>Duplicate on discharge list 1962-1963</td>
<td>1</td>
</tr>
<tr>
<td>Deceased</td>
<td>1</td>
</tr>
<tr>
<td>Not in age group</td>
<td>9</td>
</tr>
<tr>
<td>Out of town at time of study</td>
<td>1</td>
</tr>
<tr>
<td>Available for study</td>
<td>9</td>
</tr>
<tr>
<td>Declined</td>
<td>0</td>
</tr>
<tr>
<td>Total sample</td>
<td>9</td>
</tr>
</tbody>
</table>
APPENDIX L

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