Client-Oriented Role Evaluation (CORE): The Development of a Clinical Rehabilitation Instrument to Assess Role Change Associated With Disability

Darene Toal-Sullivan, Peter R. Henderson

KEY WORDS
• occupational performance
• role assessment
• role theory

This paper describes the development of an instrument, the Client-Oriented Role Evaluation (CORE), to help meet the needs of rehabilitation clients and clinicians in their joint efforts to define realistic and meaningful therapeutic goals. The CORE is based on a model that captures the relationship among identity, roles, constituent occupations, and personal and environmental determinants. The model encourages a comprehensive approach to examining role change and role loss that occurs with disability. The instrument consists of a series of steps in which role changes are identified, role values are assigned, and satisfaction with role performance is rated at different points in time across the rehabilitation process. A description of the CORE development is presented along with preliminary data from clients involved in a chronic pain rehabilitation program.


Health care providers from all disciplines face increasing pressure to measure the impact and effectiveness of their clinical interventions. At the same time, client-centered approaches are promoted as the means to engage individuals in their rehabilitation and thereby achieve better and more relevant outcomes in terms of function and client satisfaction. This paper introduces a client-centered instrument for measurement of treatment progress and outcome in rehabilitation settings. The instrument was based on the observation that clients and clinicians frequently tackle rehabilitation from different perspectives. Rehabilitation clients see themselves as unable to function as their preinjury or predisability selves whereas clinicians see clients as unable to perform daily activities. The instrument described in this article establishes a common perspective, based on the linkages between activity, roles, and self. Clients are involved in a self-appraisal in which roles are identified, their relative importance quantified and the impact of disability on role performance is derived. Selection of relevant activities to support identified roles can be used to guide goal-setting and facilitate the rehabilitation process. Because roles can provide an organizing principle around which lifestyle decisions and changes are made, we propose that role definition is fundamental to the rehabilitation process.

Role Theory

A role is defined as an expected pattern of behavior associated with a distinctive position in society (Sarbin & Allen, 1968). Role fulfillment is based on an individual’s expectations, the expectations of significant others, and finally, a client’s satisfaction with his or her performance (Heard, 1977; Super, 1980). Every individual...
has a variety of roles that are relatively stable over time, and that are compatible with and complementary to the other roles of the person and those of other individuals within the social environment (Tunks & Roy, 1982). Based on societal expectations and rules, roles establish identity and lifestyle (Versluys, 1980). A role defines social status and duties, creating opportunities for the development and application of skills. Roles provide structure for time use and establish norms for behavior and standards of competence, all of which provide a framework for satisfaction and quality of life (Hillman & Chapparo, 1995; Jackoway, Rogers, & Snow, 1987; Tunks & Roy). As Piel Cook (1994) commented, “to understand what gives an individual’s life structure and meaning, it is necessary to consider his or her involvement in a variety of life roles including but surpassing the paid work role” (p. 86).

Roles develop continuously across the lifespan through acquisition of new skills, habits, and the process of adaptation. The number of roles increases as an individual matures from childhood to adulthood as do role-related values, honors, and privileges (Elliott & Barris, 1987). Life transitions, such as aging and disability, can impose a progressive change and loss of roles as individuals retire and, either with or without change in health status, experience losses in physical capacity (Blair, 2000; Hillman & Chapparo, 1995).

Roles and Rehabilitation

Definitions of disability often refer to changes in roles. Disability has been defined as an inability to perform the usual role activities because of a physical or mental impairment of long-term duration (Versluys, 1980). Illness, injury, and disability can adversely affect role participation along a continuum ranging from a minor change in roles to an abandonment of all major roles (Jackoway, Rogers, & Snow, 1987; Versluys). The role loss may be temporary in response to an acute health problem or, in the case of chronic illness or disability, may be long-term or permanent (Blair, 2000; Golledge, 1998a). New roles and behaviors may be considered inherent to the experience of disability and life transitions (Blair). Mosey (1988) has proposed that a client’s occupational role performance is critical to the process of adaptation and therefore needs to be thoroughly explored in rehabilitation.

Roles define the tasks, activities, and routines of relevance to the individual that must be learned or relearned over one’s lifetime. Skills represent the means by which these tasks are accomplished. Successful skill acquisition and belief in one’s ability to perform the skill are required for improvement in occupational performance. This perceived self-efficacy is believed to be a major determinant of behavior (Bandura, 1977; Gage, Noh, Polatajko, & Kaspar, 1994). In the occupational performance domain, behaviors define roles and support role attainment. With disability a person’s repertoire of behaviors is altered and the value derived or available from role performance may be altered. When this happens, role evaluation becomes critical to the planning and development of meaningful and attainable rehabilitation goals. Within this role framework, rehabilitation goals need to address maintenance and preservation of roles, and the skills necessary to fulfill these roles (Heard, 1977; Versluys, 1980).

Traditionally, rehabilitation has tended to focus on reduction of impairment and disability by enabling activity (Canadian Association of Occupational Therapists [CAOT], 1998; Heard, 1977). Both assessment and intervention have reflected this activity emphasis. Occupational therapy has attended to the performance components—physical, spiritual, mental, and psychosocial—that contribute to occupation (CAOT, 2002). Occupational science, the study of occupational beings, seeks to generate knowledge that will both explain occupation and advance the therapeutic application of occupation by practitioners (Lunt, 1997).

Despite the importance assigned to roles in occupational therapy theory and practice, a clear definition of the relationship between occupation, role, activity, and skill does not exist in the occupational therapy literature. For example, in a 1997 statement, the American Occupational Therapy Association attempted to clarify “occupation,” “purposeful activity,” and “function” but significantly omitted consideration of “roles.” Both Breines (1995) and Golledge (1998a) have noted that the same terminology is used with different intent and implication by various authors. Similarly, a review of the Canadian Model of Occupational Performance (CMOP) noted that definitions of “purposeful activity” and “occupational performance” were confusing, overlapping, and at times synonymous, making understanding of the relationship between these constructs extremely difficult (McColl & Pranger, 1994). Golledge (1998a) acknowledged the lack of consistency in the use of terminology in occupational therapy and proposed clarification of the terms “occupation,” “purposeful activity,” and “activity.” The Canadian Association of Occupational Therapists [CAOT] (2002) proposed that “occupations encompass more than one task, while tasks encompass more than one activity” (p. 34). Therefore, occupation is viewed as broader in scope than task or activity, and is identified by its personal or cultural meaning for people and its ability to fulfill a goal or purpose. Golledge (1998a) defined occupations as daily living tasks that are
part of an individual's lifestyle, supporting participation in roles and having purpose and meaning to the client. “Occupations and roles are inextricably intertwined” because individuals enact occupations to support their life roles (Golledge, 1998a, p. 102).

Although the core of occupational therapy practice is directed toward enabling clients to perform meaningful occupations in the areas of self-care, productivity, and leisure, the evaluation and remediation of roles is often overlooked. Whatever value roles may have in theoretical terms, the concept of roles and its implications may have been largely lost in clinical practice. Vause-Earland (1991) observed that few therapists use role assessment tools or systematically address or evaluate role status. Activities, not roles, have been the focus of intervention although it is the roles and their fulfillment that may have the most meaning to the client and therefore are “fundamental to occupational therapy” (Golledge, 1998b, p. 159). We have observed that too frequently it is assumed that activity resumption is equivalent to role resumption.

Occupations, Roles, and the Self

Our conceptualization of the relationships among occupations, roles, and identity is presented in Figure 1 as a hierarchy with self-identity at the apex, supported by a number of defined roles, each in turn, operationalized by the performance of a variety of occupations, either generic or specific to a role. This conceptualization though perhaps dated in terminology, is based on clinical observations and impressions gained in working with rehabilitation populations. The categories of occupation and the determinants are based on those identified in the CMOP (CAOT, 2002). In keeping with role theory, multiple roles may contribute to an individual's identity (Tunks & Roy, 1982). Thus the roles of worker (physician), family member (mother, daughter), household manager, partner, community member (Parent Teacher Association [PTA] chairperson), and athlete (cyclist, figure skater) can all be enacted concurrently by one person. The roles are complementary (e.g., mother and PTA chair) and have varying importance or weight (mother versus PTA chair) in the definition of self. Purposeful activities are encompassed within occupations and, either individually or in combination, contribute to the enactment and fulfillment of a role. Again, occupations may be specific to a role or as is more likely, may support multiple roles. For example, driving a car (self-care) may support both a person's worker role and family member role. The determinants of occupation form the base of the model. These can include the client’s physical, spiritual, cognitive, and affective attributes, as well as physical, social, cultural, and institutional environmental factors. In our model, the boundary between these determinants and occupations is depicted as permeable to convey the notion that many factors may contribute to successful occupational performance. Thus these variables provide the foundation upon which occupations, role and identity are maintained.

From a practice perspective, Figure 1 illustrates the different levels of analysis in occupational therapy intervention. Often, emphasis has been placed on activities and their determinants without ample consideration of the meaningfulness of these to roles to the person. This approach, referred to as “bottom-up” (Holm, Rogers, & Stone, 1998), presumes that mastery of generic task abilities will translate into performance of client self-care, work, and leisure roles. This view of performance discrepancy contributes to the confusion between activity and occupation noted by Golledge (1998a). Bottom-up implies that a sum of parts will approximate the whole person; activities, in and of themselves, will be meaningful to the person. An alternative perspective begins with the person, the whole, and then moves downward through the person's important and relevant roles, necessary and supporting occupations, and the personal and environmental conditions necessary to enable these occupations. This approach, labelled “top-down” by Holm et al. (1998) begins with what is valued by the person and guides the assessment and interventions that follow. It applies the notion of the whole person being greater than the sum of constituent parts—or, in Golledge's terms, greater than the "reductionist components of function" (1998a, p. 103). We conclude that this “top-down” approach is truly client-centered since it may be more likely to engage the client in meaningful rehabilitation planning and goal identification. In our experience it is a model to which clients can relate since it seems to describe their experience.

Client-Oriented Role Evaluation: A Work in Progress

Development of the Client-Oriented Role Evaluation (CORE) began in 1992 within the context of a chronic pain program in a Canadian rehabilitation center. This program is an interdisciplinary clinical service designed to address the multidimensional aspects of pain and the resultant social, psychological, physical, and lifestyle effects on the individual and the family. This inpatient pain program is based on cognitive behavioral principles and employs a group format in which clients attend education sessions, and participate in discussions and activities to promote independence in self-management of their pain-related dis-
ability. Historically pain management programs have promoted clients’ reactivation, pain adaptation, and lifestyle adjustment rather than elimination of pain (Loeser & Turk, 2001). A standard measure of progress has been activity level: Increased activity has been interpreted as positive outcome. This approach assumes that all activities have the same value or meaning to the client. It does not consider the many factors that enable performance of activity including personal factors such as physical tolerance, psychosocial factors such as motivation to engage in activity, and environmental factors such as family support. All of these areas, affected by a chronic pain condition, are referred to as determinants in Figure 1.

The CORE was developed in response to our observation that individuals with chronic pain were frequently “stuck,” holding onto roles that they were unable to perform. In our experience chronic pain clients tended to set goals in terms of their predisability levels of function rather than their existing functional capacities. Rather than such a focus on role resumption, a more realistic objective of chronic pain rehabilitation is adaptation of role performance. Clients would often speculate on their ability to perform activities in an effort to determine if they could fulfill various life roles. Clients therefore, identified a link between activity and role, however a measure to evaluate the relationship did not exist. An instrument was required that was sensitive to change in (a) role importance over time, (b) client satisfaction with identified roles, and (c) attained value from role participation. The CORE is a self-assessment instrument in the pilot stage that was designed to capture change across the rehabilitation process.

Development of the CORE Instrument
Role Identification

In our desire to incorporate the concept of roles into clinical practice, specifically in a pain rehabilitation program, we recognized that clients would have difficulty conceptualizing occupation and its relationship to roles. We initially used the Role Checklist (Oakley, Kielhofner, Barris, & Reichler, 1986); however, we found that it did not provide a means for the client to reflect on the component occupations that constitute various life roles, nor did it measure the relative importance of selected roles to the person. Role categories were developed from the Role Checklist (Oakley et al.) to provide a choice for client’s selection. A weekend checklist was also developed to provide examples of activities for each role category to assist clients in recognizing what was involved in role fulfilment. We also realized that some of the activities that clients were participating in were not captured in the existing role categories or were inconsistent with our program philosophy and objectives. Therefore, wellness and illness were identified as critical role categories for the chronic pain population because clients invested considerable time and energy in these roles. The illness role was defined as behaviors in response to pain (e.g., avoidance of activity, reliance on medication, dependency, and disability focus) while the wellness role referred to behaviors directed towards management and prevention of pain and suffering (e.g., pacing, nutrition, exercise, and relaxation techniques).

The role categories were not presented as absolute in terms of their individual definition. Clients were encouraged to define each role according to their personal contexts or experiences. Roles were described as fluid, not fixed traits, but dependent on circumstance, opportunity, and ability. The client completed the self-assessment with the assistance of a therapist. Often it required a considerable...
amount of effort to orient the client to the concept of roles because the concept of activities was more familiar when considering occupational performance. We chose to use a fixed list of role categories to facilitate clients’ orientation to and selection of roles whereas others (Hillman & Chapparo, 1995) have employed a free choice of role definition.

Role
We decided to ask clients to define their roles and assign role importance at two points in time: prepain or injury and postpain or injury. We recognized that role change occurred with disability and a reevaluation of role importance and the required skills and abilities was required to reflect this. However in our experience we found that clients tended to focus on their preinjury status and ability—they were not aware of the prerequisite skills or abilities needed to fulfill their preinjury roles. A present versus preinjury distinction was critical because it focussed the client on the rehabilitation process, promoting identification of realistic goals required for attainable role fulfillment. Moreover it promoted an awareness of the evolving nature of roles in accordance with ability.

Using a weighted multivoting technique (Brassard & Ritter, 1994), we developed a method to assist in identifying the importance of roles to the self-identity of the clients in our chronic pain program. The multivoting technique requires a person to distribute points (commonly a base 10) among various items on a list according to their perceived importance or priority. We opted to use 100 points because persons are familiar with percentages and a greater percentage commonly represents greater significance. Clients were asked to define themselves by selecting from the CORE list of role categories. The only stipulation was that a total of 100 points had to be distributed across the selected roles. The number of roles chosen was the client’s decision. Clients assigned a weight to each role with the number of points reflecting the importance of each role to their definition of self. Points assigned reflected the importance of the role not necessarily the time devoted to it. This was based on the premise that it is not the time spent participating in a role but the value attached to the role that contributes to identity.

Role Appraisal
After the individual identified the relevant roles, the next step was to examine what the person received from these roles. Clients rated their satisfaction with their ability to carry out the activities that fulfilled each role category. A scale of 0–10 was used to measure satisfaction, with 0 indicating no satisfaction and 10 indicating complete satisfaction. Satisfaction ratings represent the client’s degree of satisfaction with occupational performance and role fulfillment. The client was asked to rate Satisfaction based on their present level of function rather than their preinjury level of function. The product of the client’s satisfaction rating and the assigned Importance to a role was defined as Role Return and represents what the client receives from investment in each role relative to the Importance assigned to it. We reasoned that individuals access situations or activities to support roles that they identify as meaningful or important to them. Therefore only those roles that the individual identified as being important to his or her identity had the potential for Role Return. Finally, the total of all role categories was calculated from a potential maximum of 100 points. We postulated that personal fulfillment could be conceptualized as an aggregate of all the role return values. Since we began with a base of 100 points in defining identity, personal fulfillment could approach but not exceed 100.

Using the CORE
The initial CORE instrument was piloted with team members in the chronic pain management program. No major revisions were recommended, however concern was expressed that the process might be too complex for clients. In response to this feedback a psychoeducational session was developed based on the CORE as a means to discuss role change, rehabilitation, and adaptation to disability. Clients were walked through the steps of the instrument, with guidance in evaluating their progress and completing the forms as required. The CORE instrument was used routinely with clients throughout the pain management program. In practice, the CORE can be completed initially to assess the client’s Role Return from role performance and periodically thereafter to evaluate rehabilitation progress.

Table 1 summarizes the CORE process for a client, Robert, at three intervals: prepain, pain program entry week, and pain program exit week. Importance, Satisfaction, and Role Return were completed within the program, whereas the prepain rating was used to acknowledge the difference between preinjury and present functional capacity in valued life roles. When Robert was admitted to the program he was invested in the worker role (50 points) and derived minimal Satisfaction (0/10) and Role Return (0). Other role categories such as family member, caregiver, and hobbyist, where he may have been more capable of obtaining Satisfaction, were assigned little Importance, and delivered poor Role Return. The chronic pain management program encouraged a more balanced distribution of Importance across roles, furnished knowledge and skills to
Robert, a 35-year-old construction worker, sustained a low-back injury 2 years ago. He had two unsuccessful returns to work trials during the first-year postinjury. He is married with three young sons. He has gradually withdrawn from family and leisure activities including attending his sons’ soccer and hockey games, and fishing, baseball, and family camping. Prior to his injury he was highly invested in the worker role as noted by the assigned Importance = 70. Two years later, he maintained this perspective on admission to the chronic pain management program, with assigned Importance (A) = 50, despite reporting no Satisfaction (0/10) in role performance. Significant discrepancies were noted between assigned Importance (A) and Role Return (A), in all identified roles. Robert reconsidered his family, caregiver, and wellness roles, and assigned more Importance (B) to each role. The roles of friend and hobbyist were unchanged. With knowledge and application of pain management techniques, Satisfaction (B) scores generally increased across all selected roles. He identified the new role of student and he began exploring retraining efforts were then directed to increasing Satisfaction in the realigned role categories.

In the chronic pain management program, clients met with a team member to identify weekly goals and plans for their attainment, with the goals directly linked to role categories. Discussion focussed on strategies and actions for clients to improve their level of satisfaction in a role category, and identification of barriers to a higher level of satisfaction. This information was translated into specific goal statements applying knowledge, skills, or resources, or all three. A goal for Robert to fulfil the family member role, was taking his son to a community hockey game. The required skills included activity tolerance, pacing, planning, communication, seating ergonomics, and positive coping statements. Within a chronic pain management program, different members of the team assisted Robert in developing his plan, including psychology, occupational therapy, and physiotherapy. Treatment was directed towards enabling Robert to achieve his identified activities which in turn supported his important roles. Throughout this process consideration was given to Robert's standards for satisfaction and consequently resulted in significant improvement in Role Return on exit relative to the entry week, both within categories and overall (62/100 vs. 12/100).

### Planning for Client Improvement

The CORE provided the client and clinician with a means to explore avenues to optimize role function. Within each role category the discrepancy between the assigned Importance and Role Return was used as a basis for discussion with the client to explore barriers to role performance. This discrepancy reflected the difference between the client’s actual and ideal view of self. In our example of Robert, in order to achieve a higher Role Return from the role of family member, he changed the criteria for family. With rehabilitation and adaptation to disability, optimizing Satisfaction within roles required assessment of the role performance barriers (e.g., limited tolerance, poor physical fitness, depression) and development of strategies to circumvent these barriers. Strategies included education, skill acquisition (e.g., planning, pacing, energy conservation), activity modification, and, finally, reevaluation of the standards for satisfaction within the context of current ability (e.g., preinjury performance, self-efficacy beliefs). Recognizing the low potential for return from both the worker (50) and illness (25) roles, Robert reassigned the total of 75 points in Importance to the new roles of student (40) and wellness (20), or augmented the identified roles (family, 10 to 20; caregiver, 5 to 10). His rehabilitation
Preliminary Findings

The CORE is an instrument in development. Although no formal validity studies have been completed, some preliminary data have been collected and impressions based on client and therapist experience have been derived from routine use of the instrument within our chronic pain management program. Initial data from 23 clients who completed the 6-week inpatient pain management program revealed a shift from week 1 to week 6 in the mean Importance assigned to the worker role from 26.11/100 to 15.0/100. This decrease reflected a shift in Importance assignment to alternative role categories, notably wellness. Total Returned Value from roles increased over the 6 weeks, from a group mean of 46.38 to 60.56, indicating a sensitivity of the CORE to client progress in rehabilitation. Unfortunately, parallel measures of rehabilitation progress were not available to allow correlational analysis of the observed changes in the CORE.

Analysis of a second sample of 62 clients from the same inpatient program, 31 male and 31 female with a mean pain duration of 6 years, again reflected a shift in Importance from work to other roles and, as in the first sample, from illness to wellness roles. A between (Gender) and within (Time) analysis of variance performed on the total Returned Value data revealed a significant increase \( (F(2, 58) = 47.18, p < .0001) \) across time in the program \((41.82, 56.46, \text{and } 66.59 \text{ at entry, mid, and exit week, respectively})\). There was no difference in the mean Returned Value between males and females overall, \( (F(1, 59) = .89, p = .348) \) or as a function of gender over time, \( (F(2, 58) = .06, p = .941) \). Analysis of mean Satisfaction ratings also revealed an increase over time \( (F(2, 58) = 35.13, p = .0001) \). The actual number of roles weighted by clients increased only slightly across their program involvement suggesting that clients altered where and how much Importance they assigned to existing roles apparently in order to optimize Satisfaction and Returned Value. These preliminary findings suggest gender consistency in client response to role change and, more generally, the sensitivity of the CORE to rehabilitation process and outcome.

Informal feedback from clients and therapists supported the value of the CORE instrument and process. Specifically, clients expressed appreciation for being asked what was important to them rather than being “inventoried” as to their activities. Although they found it challenging to allocate 100 points to various roles, they responded favorably to the CORE because it allowed them to describe themselves in terms of meaningful life roles. The role identification process required active consideration of the connection between what clients do (occupations) and who they are (roles). On introduction to the CORE, clients required assistance in understanding roles, component occupations, and their relationship to identity. Group sessions and individual consultation were necessary to orient clients to these concepts and to complete the CORE. In itself this education process contributed to their understanding of disability, role adaptation, and rehabilitation.

The total Role Return appeared to provide insight into current function and hopes for the future. The observed attitudes and beliefs of clients regarding the worker role were especially noteworthy. The CORE provided a framework for clients to consider the determinants for successful role fulfilment (Figure 1). For a worker, this may have included physical tolerances, concentration, belief in work feasibility in terms of productivity and safety, and receptiveness of the employer to accommodate the client, as well as a myriad of social workplace factors. Goal planning consisted of addressing each of these issues within the rehabilitation context. If the client was unable to develop or realistically attain these goals, the importance of the worker role was reevaluated and goals modified accordingly. For example, short-term goals focused clients’ efforts on wellness activities and community roles to improve tolerances and skills as a transition step, towards the long-term goal of return to work. Clients were encouraged to focus on present functional ability and shift from a perception of self based on past abilities and performance. Attainment of short-term goals provided the reinforcement of new skills and behaviors and the mastery necessary to extend gains. Clients who concluded that imminent return to work was not a realistic goal seemed to develop a clearer appreciation of their rehabilitation needs. Specifically, they recognized the need to accept the loss of the worker role and develop alternative and immediate sources of satisfaction congruent with their present abilities. Often, there was a shift in importance of roles from worker to alternatives: family, leisure, and wellness roles. For some this was a temporary shift, for others it concretized the losses related to their disability and the necessity to grieve these losses as a prerequisite to consideration of substitute occupations and vocational opportunities.

The CORE also seemed to sensitize clients to the notion of a balanced lifestyle and multiple roles. The common understanding of the worker role was expanded to legitimate alternative roles and occupations with their potential for satisfaction and value. Prior to injury or illness, leisure had often been undervalued, but during the rehabilitation process clients were encouraged to engage in activities to fulfill this role. Through experience, clients seemed able to appreciate the value of alternate roles especially when it became evident that these were a viable source of
satisfaction and had substantial potential for improved quality of life.

Discussion
Prior to the development of the CORE, roles, their importance, and the feasibility of their resumption were not evaluated for persons with chronic pain. Clients believed that participation in rehabilitation or pain management would enable them to resume prepain occupations and roles. Too often, the result was a perpetuation of unrealistic expectations. The eventual realization that they could not achieve previous levels of function often resulted in frustration, anger, and sadness. This distress impeded the process of adaptation and undermined clients’ willingness to, first, experiment with pain management techniques, and second, apply these on a day-to-day basis and maintain their use. In our experience clients required assistance in learning how they might adapt their performance to fulfill their important roles. If fulfillment of those roles was not feasible then a means to examine alternative roles and the skills required for their performance could be explored. With chronic pain, expectations of others and expectations of self may be redefined or modified to fit occupational performance abilities. The CORE provides an opportunity for clients to understand occupational roles, their value, and how these contribute to self-identity.

The CORE joins a family of role instruments. It extends the work of Oakley et al. (1986) to not only identify roles and their value, but also add a rating of satisfaction with role performance based on participation in occupations and the overall contribution of this participation to self-identity. In rating satisfaction with performance, the CORE shares some features with the Canadian Occupational Performance Measure (COPM), a well-recognized measure in occupational therapy practice (Law et al., 1990). However, some important differences exist. The COPM is problem-focused, encouraging clients to identify problems in daily activities and rate each problem on performance and satisfaction with performance. Averages of performance and satisfaction are then employed as an outcome measure. COPM validity studies have identified the need for further research on the distinction between satisfaction and performance and its relevance to function (McColl, Paterson, Davies, Doubt, & Law, 2000). Based on an assumption that the difference between satisfaction and performance cannot reliably be discriminated by either clinicians or clients, the CORE requires rating of satisfaction with performance.

Discussions as to the meaning of client-focused practice have highlighted factors such as client context, enablement versus deficit models of intervention, and therapist as facilitator versus director (Law, Baptiste, & Mills, 1995). The CORE addresses context by encouraging clients to identify meaningful roles, component occupations, and the necessary changes in performance skills and the environment for goal attainment. The therapist is a facilitator who works with the client to identify goals and the relevant determinants of occupational performance (Figure 1). The primary focus of the CORE is not on the identification of problem areas, but is, rather, on opportunities for improvement in role performance.

The occupational science literature has criticized the use of preselected roles in assessment. For example, Jackson states that role theory assumes “one concrete reality” (1998, p. 51). Preselected roles are criticized as being exclusionary and not accommodating to cultural diversity, differences in abilities, gender, and lifestyle. The CORE does employ a forced choice format for its role categories. As an alternative, Hillman and Chapparo (1995) allowed clients to describe any number of roles and then rate their perceptions of role performance. A similar nonpredetermined role identification process could be incorporated into the CORE encouraging a truly client-centered approach to role choice, role performance, and role satisfaction. Future studies for the CORE could explore the impact of forced choice versus self-defined role categories and client response. The influence of the environment on role demands also needs to be examined further.

The CORE is a new instrument in the pilot stage of development, and we continue to examine data collected from clients involved in both inpatient and day hospital versions of the chronic pain program. Our interest is to determine the extent to which role change and role balance are correlated with improved outcome and longer-term adjustment following rehabilitation. The CORE is based on the premise that fulfillment of roles is personally meaningful and contributes to self-identity more than participation in activities. Fulfillment of roles is a vehicle to enhance satisfaction and quality of life. Accordingly, validity studies would seek to demonstrate the linkages between role fulfillment as evidenced by the CORE and standardized measures of mood and quality of life. A comparison of the CORE and the COPM in facilitating rehabilitation outcome in terms of quality of life, mood and participation in self-care, productivity and leisure occupations, may clarify the differences and commonalities between occupational performance and role fulfillment. At present, little is known about the average number of roles occupied, balance of roles, and typical value assigned to roles by persons with or without disabilities. Similarly, typical satisfactions of occupational performance within role categories and role return
are unexplored. Studies are needed to determine typical role patterns with different population subgroups in terms of, age, gender, disability, and culture. For example, North American culture may dictate stereotypical patterns of role occupancy for women, distinct from that for men. On the other hand, it may be that this instrument is idiographic allowing a comparison of the individual with the self over time, and a normative approach may be neither feasible nor meaningful. As such the value of the CORE may lie in "within individual" measure of change. If this is the case then studies are required to determine the reliability of the CORE in measuring real role fulfilment and role return, as opposed to spontaneous variability that occurs over time. We recognize that the CORE presents some challenges to administration in terms of complexity and time. However, we feel that it is comparable to other measures within the occupational performance area, for example the COPM, in terms of these demands.

This paper has presented the development of the CORE, the conceptual framework for this role instrument and preliminary data. It is hoped that further research and use of the CORE with a variety of rehabilitation clients in community-based and hospital settings, will help us understand the meaning of roles to clients, and the link between occupation, roles and self-identity.

Summary

The conceptual framework we have proposed organizes the terms activities, occupations, roles, and identity in a distinct, specific structure. Roles can be viewed as the integration of activities and occupations culminating in self-identity. The CORE links occupational performance directly to roles. The CORE is a tool to assist clients in the process of role change, a realistic objective not only for chronic pain disability but with promising relevance to many disability and aging populations where role change occurs. ▲

Acknowledgment

The authors would like to thank Dr. Joyce D’Eon for her insightful comments on an earlier version of this article. Portions of this article were presented at the American Occupational Therapy Association and The Canadian Association of Occupational Therapists, CAN-AM Conference, Boston, 1994.

References

Correction

To Figure 2 in Susan Rappolt’s article “Evidence-Based Practice Forum—The Role of Professional Expertise in Evidence-based Occupational Therapy” (September/October 2003, Volume 57[5], p. 591). The correct figure is published here.

![Figure 2. Professional Expertise in the Evidence-Based Occupational Therapy Process.](http://ajot.aota.org/)