Issues in Assessment of Psychosocial Components of Function

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For occupational therapy to provide a holistic view of meaningful activity, we must understand the relationship between physical, psychological, and social variables, especially as they affect our psychosocial evaluations and treatment. Existing definitions of psychosocial variables are unclear and, for occupational therapy practice, must be linked to activity and occupational performance.

Occupational therapists need to become more educated about the uses and limitations of psychosocial instruments and to develop new instruments that address the central tenets of occupational therapy by focusing on whether or not a person is able to do what is necessary and fulfilling. Further, understanding what is meant by meaningful activity and what people need to accomplish it will advance our effectiveness in occupational therapy assessment and practice.

A colleague in a work-hardening clinic recently said that she had always thought of herself as a “physical dysfunction therapist,” yet most of her clients actually had performance deficits that characterized psychosocial problems rather than physical ones. She noted that motivation, self-esteem, values, and beliefs, rather than physical capacities, tended to dictate successful return to work.

Her comment seems to refute the concerns that many have expressed about the viability of occupational therapy in mental health (Bonder, 1987). It is, rather, a reflection of the increasing understanding of the mind-body relationship (Cousins, 1979; Sacks, 1987, Selye, 1979). Many theorists and researchers support the notion that the state of one’s psyche influences one’s physical health and the state of one’s physical health influences one’s psyche. In fact, it is increasingly difficult to make a distinction. Schizophrenia almost certainly has a biological etiology (Tsuang, Faraone, & Day, 1988), and many persons who have strokes will experience accompanying clinical depression.

Although the number of therapists identifying themselves specifically as mental health practitioners is diminishing, early theorists (Englehardt, 1977; Meyer, 1922) accurately noted that every effective occupational therapist must recognize the holistic nature of function. The distinction between the two primary occupational therapy specialty areas persists, but the realities of our improved understanding of human well-being demand better integration of these spheres of practice.

What Are Psychosocial Variables?

Our recognition of the holistic nature of function means that all therapists must assess psychosocial factors for every client. Thus, the key question is not “What is psychosocial occupational therapy?” but rather “What do we mean by psychosocial variables?” On this point, confusion is rampant. A recent chapter describing psychosocial evaluation included instruments that focus on motor performance, cognition, mental status, and sensory integration, along with self-care, roles, depression, and loneliness (Bruce & Borg, 1991). Although many or most of these instruments may be appropriate to include in assessing a client in a mental health setting, not all assess psychosocial variables.

Occupational therapists are not alone in their struggle to delineate this concept. Saunders Encyclopedia and Dictionary of Medicine, Nursing and Allied Health (4th ed.) (Miller & Keane, 1987) defined psychosocial as “pertaining to or involving both psychic and social contexts” (p. 1032). The Diagnostic and Statistical Manual of Mental Disorders (3rd ed. rev.) (DSM III-R) (American Psychological Association, 1987) does not define psychosocial at all, and gives this description of mental disorders:
Each ... is characterized as a clinically significant behavioral or psychological syndrome that occurs in a person and that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. (p. xxii)

Like many other definitions, this one is so vague that it provides little information to the clinician, despite the fact that DSM III-R is the primary guide to psychiatric diagnosis. Definitions in occupational therapy sources are equally vague. According to Kielhofner (1988), psychological means "the symbolic (i.e., temporal, meaningful, and purposeful) and affective experience of the self and the world" (p. 89). Christiansen and Baum (1991) defined psychosocial as follows: "Psychological constructs; psychological concepts; terms (without universal definitions) commonly used to describe mental states" (p. 857).

The Uniform Terminology Checklist developed by the American Occupational Therapy Association (AOTA, 1989) provides the following list of psychosocial variables: roles, values, interests, initiation and termination of activities, self-concept, and social skills. It is not clear what defining characteristics were applied to identify variables as psychosocial or how those variables contribute to a meaningful constellation of activities. For example, therapists are left uncertain about whether the client's values are deficient or adequate.


Conceptual models derived through identification of a theory or frame of reference may better delineate psychosocial constructs. For years, occupational therapists borrowed liberally from other theories (e.g., analytic, behavioral, cognitive). More recently, theories have emerged in occupational therapy that have attempted to identify psychosocial variables in a way more consistent with the profession's beliefs. Among these are the Model of Human Occupation (Kielhoiner & Burke, 1980), role acquisition theory (Mosey, 1986), Allen's (1985) cognitive theory, and others. In general, these theories are more likely to provide laundry lists of psychosocial variables rather than a definition of the construct itself. As an example, in the Model of Human Occupation, Kielhofner (1985) listed valued goals, roles, beliefs, and attitudes, but provided no insight as to why these particular variables were chosen. This failure to explain why they fall into this category or how they contribute to meaningful activity is a problem for both borrowed and discipline-specific theories.

Clearly, psychosocial constructs are more difficult to conceptualize than physical or cognitive ones. This may explain the popularity of cognitive theory (Allen, 1985) as a sort of psychosocial theory. Its constructs are concrete, because cognitive levels can be described in terms of observed performance. However, a cognitive theory does not equate with a psychosocial theory, nor a psychosocial variable with a cognitive variable.

Thus, a definition of psychosocial variables must be developed that can explain (a) what persons need and want to do; (b) what they can and cannot do; and (c) for those activities they cannot do, what limits performance (Yerxa, 1967); these explanations must be framed from the perspective of psychosocial factors. The questions are not specific to psychosocial occupational therapy, but each question has a psychosocial component that must be defined. For example, a person (a) may not want to do anything, (b) may be unable to engage in meaningful social relationships, and (c) may have this deficit as a result of poor self-esteem. An alternative, physical dysfunction example would be the person who (a) needs to work, but (b) cannot because of (c) paralysis. Note that in the first example, the client may well have physical limitations, and in the second, the client may also have psychosocial deficits.

**Psychological Variables**

To adequately define the concept *psychosocial variable*, it is helpful to split the term into its two constituents, and then to identify the criteria by which these variables will be defined. *Psychological variables* address internal, unobservable processes that provide the person's drive toward activity. In other words, when occupational therapists discuss the therapeutic process as the method by which persons are enabled to accomplish activities they need or want to do, psychological variables create the perceived need or desire, the ongoing internal press to undertake a set of activities, and the internal evaluative process that results in satisfaction, dissatisfaction, and alteration or continuation of behavior. Additionally, psychological variables include those internal, unobservable processes that prevent activity. Thus, psychological variables would encompass motivation, interest, and self-evaluation (self-concept and self-esteem), and also depression, anxiety, and perceived stress. In every case, the defining characteristics, for the purposes of occupational therapy, are that the construct (a) is an internal process that must be inferred from observed action or self-report, and (b) relates to activity.

To meet these two criteria, psychological variables must be renamed to be relevant to occupational therapy. For example, anxiety itself is not significant to the occupational therapy process. If anxiety blocks a client's participation in activity or makes activity unpleasant for the person, however, it becomes a focus of assessment and intervention. It may be that a label such as activity-
related anxiety must be coined to adequately convey the import of the variable to the occupational therapy process. Similarly, only those aspects of self-concept or self-esteem that relate to activity are important in occupational therapy, so the emphasis for the therapist should be on activity-related self-evaluation.

Social Variables

Social variables exist at two levels. At the level of component skills (i.e., the person's social skills), social variables include the knowledge and ability required to relate to others (i.e., to make conversation, to approach other persons, and to maintain relationships). Social variables also exist at the occupational performance level, where a person's constellation of social activities (club memberships, family interactions, etc.) is at issue.

Psychological and social variables are distinct from each other. Social variables, at both the skill and performance levels, may be observed; by definition, psychological variables cannot. They must be inferred from behavior or from the person's descriptions of his or her internal processes and experiences. Psychological variables refer only to the person, whereas social variables reflect both the person and the environment, in particular the human environment. The two variables are closely related, however. For example, desire for companionship (a psychological variable), along with the ability to approach new persons (a social skill variable) combine to lead a person to go to a club meeting to make new friends (a social performance variable).

Psychosocial Instruments

Use of these definitions for guidance in terms of assessment does not solve all the dilemmas the therapist must confront. There are numerous psychosocial instruments, but their content and interpretation may not be helpful in evaluating psychosocial status. Lists of instruments developed for use with persons with psychiatric disorders are legion (Asher, 1989; Christiansen & Baum, 1991; Hemphill, 1988), and fall into roughly three categories:

1. Standardized instruments that assess self-care (activities of daily living [ADL] and instrumental activities of daily living [IADL]). These include such instruments as the Milwaukee Evaluation of Daily Living Skills (MEDLS) (Leonardelli, 1988), the Kohlman Evaluation of Living Skills (KELS) (McGourty, 1979), and the Scoreable Self-Care Evaluation (SCORE) (Clark & Peters, 1984). Each requires observation of the client performing actual or simulated tasks that presumably relate to ability to accomplish self-care activities such as grooming, dressing, budgeting, cooking, and so on.

2. Nonstandardized assessments of roles, interests, use of time. These include the Role Change Assessment (RCA) (Jackoway, Rogers, & Snow, 1987), Interest Check List (Matsutsuyu, 1969), and Activity Configuration (Mosey, 1973). These instruments require the person to respond, either on paper or by interview, to questions about what they do, and, perhaps, how they feel about activities.

3. Instruments borrowed from other fields that assess various presumed psychosocial factors. These include such instruments as the California Personality Inventory (CPI) (Jackson & Paine, 1961) and the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961).

Existing self-care instruments serve useful purposes, but fail to answer the key clinical questions of what psychological factors contribute to performance deficits and strengths and how remediation should be provided. Difficulties are apparent in the selection and interpretation of these instruments. These instruments provide useful information, but they are not measures of psychosocial variables. For example, self-care instruments yield numerical scores that presumably provide some information about level of ability. In some instances, the meaning of that score has been defined by the test developer. The MEDLS was developed specifically for use with regressed clients in inpatient mental health facilities to predict ability to function in less restrictive environments (Leonardelli, 1988). It does not explain, however, why performance is impaired. Is it because of limited range of motion or limited motivation? This is an essential question if assessment is to provide information about psychological deficits.

Role and interest inventories do measure psychological and social variables. Although they may well explain what people do or how they feel about their activities, they fail to provide information about why people choose those activities or what constitutes an acceptable range or configuration of activities. To be helpful, interpretation should be criterion-referenced, but there is no known criterion. We have little information about what constitutes a satisfying pattern of activity or what creates a meaningful life. These instruments identify a person's interests but not whether those interests provide maximal (or even adequate) life satisfaction.

The same set of criticisms applies to instruments borrowed from other disciplines. What sort of information relevant to occupation is obtained from the CPI or the Beck Depression Inventory? These instruments may have some value if they are found to measure component skills that support performance, but this relationship has yet to be tested. Given the current state of theory and research, presumed links remain largely speculative. These instruments have promise as measures of psycho-
social variables, but they remain untested in the context of occupational therapy.

Content of the assessment is one consideration. Method is another. Instruments that focus on normative data are particularly problematic. Definitions of normal or average are hard to come by in the psychosocial arena and are largely irrelevant. Is it normal to have three friends? Ten friends? Twenty? How much self-esteem is enough? How much is too much? The issue is what will permit survival and, it is hoped, self-actualization. For this, criteria are unknown, and almost certainly vary widely among persons. This suggests the need for additional criterion-referenced tests, with criteria related to desired individual performance outcomes. As others have pointed out (e.g., Mathiowetz, 1993; Trombly, 1993; Velozo, 1993), there is a need for research that clarifies the relationship between component variables and occupational performance.

Further, assessments that are strictly numerical have limited use. Assessments that yield rich descriptions of values, attitudes, and beliefs may be far more helpful guides to intervention, provided they can be interpreted in some meaningful way. Although it would be unwise and perhaps impossible, in the current health care system, to eliminate numbers entirely, neither should we buy into an overreliance on reductionistic instruments (Yerxa, 1991).

Methods of Improving Psychosocial Instruments

Three steps must be taken. First, therapists must be better educated about the uses and limitations of existing instruments. Administration of an interest checklist may be helpful, but therapists must be cautious about overreliance on instruments that provide data that have no established relationship to performance, and for which interpretive information is missing.

Second, existing instruments must be subjected to more extensive examination of validity and reliability. Validity is a critical issue, one that must be examined in the context of definitions of psychological and social variables. This is not to say that therapists in mental health settings should not be concerned with ADL, but, rather, that instruments labeled psychosocial measures should measure psychosocial variables, and, in occupational therapy, we should measure only psychosocial variables that relate to functional performance.

Finally, new assessments must be developed to meet several criteria. Most important, they should address the central tenets of occupational therapy. It is the role of the occupational therapist to emphasize whether a person can do what is necessary and fulfilling, not whether a person is depressed. If depression is characterized by low energy and motivation that impair occupational performance, our diagnosis should start from the direction of impaired occupational performance rather than from the depression (Rogers, 1982; Trombly, 1993).

In all occupational therapy assessment, we must recognize the "blind persons and the elephant" syndrome. Assessment that ignores the physical or cognitive components of function puts us in jeopardy of treating the trunk, rather than the elephant, just as physical or cognitive assessments that ignore the psychosocial components leads us to treat only the tail.

Psychosocial variables that contribute to performance must be better defined and incorporated into theories that provide a more integrated understanding of function. Instruments that permit evaluation of the many facets of performance must be developed and refined. To develop them, we cannot rely on paradigms that have been used by other disciplines, but must choose measurement methodologies that enable us to address the concerns of occupational therapy. We must be prepared to defend the need for more than one kind of assessment and to explain our purpose to others.

An example that identifies issues in current assessment strategies for psychosocial variables and some directions for the future can be found in the description of the Options Program in California (Jackson, Rankin, Siefken, & Clark, 1989). In examining a transition program for adolescents with developmental disabilities, the investigators examined four ability areas: (a) skills and interests in independent living, work, and leisure; (b) self-concept; (c) future aspirations; and (d) "self-direction skills," which the authors defined as risk taking, flexibility, persistence, self-initiation, constancy of behavior, decision making, problem solving, judgment, and social interaction skills.

Many of these are psychosocial variables, but others are not. Independent living skills, for instance, are not by themselves psychosocial. It is entirely appropriate that a comprehensive assessment would include both types of variables, but it is also helpful to be clear about what kinds of factors are being measured, and whether they are components or occupational performance.

Assessments used in the study reflected the diversity of the variables examined and included a number of methods. The Piers-Harris Self-Concept Scale (Piers, 1985), a standardized self-concept scale, was included. The Interest Check List (Matsutsuyu, 1969) was also administered, as were several investigator-developed questionnaires for the subjects and their parents. Finally, naturalistic assessment, in this case direct observation of performance in a natural setting, was included.

Much is positive about the assessments selected. They represent a constellation of instruments designed to obtain a wide variety of information through a number of methods. However, the assessments selected also demonstrate the current dilemmas in assessing psychosocial variables. Most notably, interpretation of all the selected instruments is complicated by the absence of a clear un-
understanding of the ways in which psychosocial variables contribute to activity. For example, what sort of self-concept is consistent with accomplishment of needed and desired self-care activities? How do interests identified on the Interest Check List relate to existence of a constellation of meaningful activities? In the absence of answers to such questions, making clinical sense out of test scores or out of qualitative observations is difficult in the extreme.

Underlying all discussion of evaluation in the psychosocial sphere is a vital, missing piece of information: What constitutes meaningful activity, and what do people need to accomplish it? Existing theories such as the Model of Human Occupation (Kielhofner & Burke, 1980) address parts of that question, but the key question is still unanswered.

Conclusion

Occupational therapy is a highly complex, sophisticated discipline (Yerxa, 1988). For too long, we have attempted to avoid this reality by oversimplifying the nature of occupation (Yerxa, 1991). Development of relevant instruments in occupational therapy is a daunting but exciting challenge, and it is encouraging to see the profession maturing to the point where it is willing to grapple with these issues. In the psychosocial arena, the crucial challenges relate to definition of the terms psychological and social as they relate to occupation, better understanding of the contribution of psychological and social components to performance, and more effective evaluation mechanisms. Addressing these issues will ensure that occupational therapy adheres to its core beliefs and provides a holistic view of meaningful activity. 

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