Perceptions of Role Assessment Tools in the Physical Disability Setting

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Various role assessment tools in occupational therapy have been developed to help the clinician understand role performance and role adjustment and guide the structure of intervention. This study was designed to examine the clinician's perceptions of standardized role assessment tools in physical disability settings. A random sample of 450 occupational therapists was surveyed to learn about therapists' knowledge of four published role assessment tools. The study also examined the frequency of tool use in the acute care hospital, the rehabilitation center, and the long-term care facility.

The results from 236 questionnaires (a 52% response rate) indicated that more than half of the respondents reported that their current initial evaluation did not effectively address role performance. Additionally, most of the therapists surveyed had a poor understanding of the four standardized role assessment tools, and only 5% were using an assessment instrument in their practice. The respondents reported a desire to learn more about these instruments and how they affect treatment planning. Training implications, educational opportunities, and recommendations for future research are discussed.

Patients with physical dysfunction confront multiple problems in returning to valued roles or adapting to new ones. The occupational therapy literature indicates that role performance is a major focus in occupational therapy practice (Flory & Michelman, 1982; Kielhofner, 1985; Oakley, Kielhofner, Barris, & Reichler, 1986; Reilly, 1969). Occupational therapists are no longer interested only in the symptomatology of the disease or physical ailment; they are concerned with the assessment and treatment of daily role adjustment as well.

Various role assessment tools in occupational therapy have been developed to assist the clinician in understanding adaptive roles and guiding treatment intervention. The present paper examines four of the role assessment tools in the occupational therapy literature that identify strengths and weaknesses of daily role adjustments for the physically disabled population: (a) the Role Checklist (Oakley et al., 1986), (b) the Occupational Role History-Revised (Kielhofner, Harlan, Bauer, & Maurer, 1986), (c) the Occupational Therapy Functional Screening Tool (Kielhofner, 1985), and (d) the Role Change Assessment (Jackoway, Rogers, & Snow, 1987).

Although occupational therapists generally recognize the importance of using reliable and valid evaluation tools in clinical practice, they nevertheless tend either to develop their own assessment instruments or to adapt standard instruments to meet their specific setting (Kaplan, 1984; Rogers & Masagatani, 1982). Therapists sometimes develop their own tests, unaware of existing published instruments (Hempill, 1988). Many therapists working in physical rehabilitation clinics gather information on a patient's role function through informal interviews, similar to the medical history (Rogers & Masagatani, 1982; Smith & Tiffany, 1978). The use of an informal interview to understand role performance, however, does not provide systematic evaluation of this behavioral complex.

Study Purpose

Role assessment tools can contribute to the treatment and intervention process with the physically disabled population. The purpose of this study was to examine how clinicians who work with the physically disabled population perceive the use of role assessment tools. The following research questions were addressed:

1. What level of understanding do occupational therapists have of the four published role assessment tools?
2. Do occupational therapists in physical disability settings believe it is necessary to use standardized tools in this area?
3. What are the possible reasons why occupa-
tional therapists do not use role assessment tools?

An understanding of tool use provides the basis from which we can develop tools that reflect the needs of clinicians working in the physical disability setting. This study also provides information regarding the training needs of clinicians working with this population.

Background

The concept of role is complex, composed of many different components and behaviors. The term role is borrowed from the sociology literature and is defined as a position in society that contains a set of expected responsibilities and privileges (Sarbin & Allen, 1968). Roles serve as vehicles for social involvement and productive participation. Human adult roles are divided into three major groups—family roles, personal-sexual roles, and occupational roles (Thomas, 1966). As occupational therapists, we focus on occupational, or productive, roles, that is, those roles that constitute the bulk of daily functioning and routines (Kielhofner & Burke, 1985).

Occupational role refers to the performance of behavior components on a continuum from productive activities (e.g., homemaking, working, studying) to playful activities (e.g., hobbies, sports, social recreation) (Oakley et al., 1986). The loss or change in valued personal goals due to physical illness or disability can result in role dysfunction. The patient may experience a decrease in functional role skills that undermines confidence, which may lead to depression, poor self-image, and lack of motivation.

The occupational therapy literature emphasizes that the goals of the profession should be the preservation and maintenance of occupational roles (Heard, 1977; Matsutsuyu, 1971; Versluys, 1980). Assessment of role performance, therefore, is an important part of the evaluation process. Few studies have examined the process of role evaluation in occupational therapy, particularly in physical rehabilitation clinics. Rogers and Masagatani (1982) observed and interviewed 10 therapists who worked with patients in medical settings. The purpose of their study was to describe the reasoning process used to determine functional problems and treatment goals. The authors found that the therapists did not systematically address occupational role history or leisure skills. The therapists said they preferred the informal interview approach because of practicality.

Barris (1987) conducted a similar study that described the initial evaluation process in psychosocial occupational therapy. Nineteen therapists were observed as they interviewed patients. Most of the therapists appeared to use an interview developed at their own setting; only a few used existing interview formats. Similar to the previous study, few therapists (25%) used role assessment tools to evaluate role status.

Currently, four role assessment instruments provide the means to obtain, interpret, and document the role status of the individual. The Role Checklist (Oakley et al., 1986) is a written assessment tool aimed at acquiring reliable and valid information about several roles in which people engage in occupational behavior. The administration of the Role Checklist takes 15 min. It has test-retest reliability and content validity.

The Occupational History, originally developed by Moorhead (1969), was a lengthy history designed to assess the respondent's occupational life-style. Florey and Michelman (1982) abbreviated this tool and called it the Occupational Role History. Kielhofner et al. (1986) further revised this tool to suit a physically disabled population and devised a rating scale based on the history. The Occupational Role History yields qualitative and quantitative information about a person's occupational strengths, weaknesses, and life experiences. It takes a maximum of 90 min to administer. Kielhofner et al. (1986) established test-retest reliability in their study.

The Occupational Therapy Functional Screening Tool (Kielhofner, 1985) is used only for an acute care physically disabled population. This instrument is a modification of the Occupational Functioning Tool (Watts, Kielhofner, Bauer, Gregory, & Valentine, 1986). The tool identifies problem areas within the human system, and portions of the instrument specifically address roles. The Occupational Functioning Tool demonstrated concurrent validity and acceptable test-retest reliability, although the Occupational Therapy Functional Screening Tool has not been tested for validity and reliability.

The Role Change Assessment (Jackoway et al., 1987) systematically evaluates the change in past, present, and future participation in such life roles as family, leisure, and self-care. This tool was developed for a geriatric population, and it takes an average of 53 min to administer. The interview could be split into two half-hour sessions.

Although the use of assessment tools has become an expected part of practice, a review of the literature indicates a gap in actual clinical practice and the profession's position on evaluation and treatment. Currently, there is limited knowledge regarding therapists' use of standardized role assessment tools. The present study yields descriptive information regarding clinicians' perceived level of understanding of
four role instruments and possible reasons why these tools may or may not be used in clinical practice.

Method

Procedure and Sample

A total of 450 registered occupational therapists nationwide were selected randomly through the American Occupational Therapy Association's direct mail services. A stratified random sampling procedure was used to obtain the names of occupational therapists working in one of three settings: acute care hospitals, physical rehabilitation centers, and long-term care facilities. This procedure ensured representation of occupational therapists working with the physically disabled population in these three primary work settings. The sampling procedure yielded 200 therapists in acute care, 100 in physical rehabilitation, and 150 in long-term care. The number of therapists in each subset is proportional to the percentage of occupational therapists currently employed in each physical disability setting.

Instrument

Survey questions were developed based on a review of the literature regarding current role assessment tools and the occupational therapy evaluation process. A pilot study was conducted with 20 occupational therapists working in a physical disability setting prior to data collection. Based on written and verbal feedback, revisions in questionnaire items were made to improve the utility and clarity of the questions.

The final survey instrument contained 30 questions, which assessed (a) demographic background, (b) the degree to which the identified assessment tools were used, (c) the perceived limitations and advantages of the four role instruments, (d) the identified frame of reference used in assessment and treatment planning, and (e) the level of understanding of the four assessment tools.

Response Rate

Of the 450 questionnaires sent, 236 were returned, thus yielding a 52% response rate. Of the 200 occupational therapists working in acute care hospitals, 95 (47.5%) responded; of the 100 therapists working in physical rehabilitation, 60 (60%) responded; and of the 150 therapists working in long-term care, 81 (54%) responded.

Results

The demographic variables examined in this study were sex, occupational therapy work experience, highest degree held, work environment, and job position. Of the 236 respondents, 92% were women. Six percent of the respondents had less than 1 year of work experience as an occupational therapist; 34% had 1 to 5 years; 26% had 6 to 10 years; 18% had 10 to 15 years; and 16% had more than 15 years.

Fifty percent of the respondents worked in urban regions. Seventy-nine percent of the respondents worked full-time; 21%, part-time. Seventeen percent of the therapists worked alone. Forty-one percent of the respondents held staff therapist positions; the remainder held such positions as senior staff therapist, supervisor, administrator, and clinical specialist.

Seven percent of the respondents received a basic master's degree in occupational therapy; 5%, a postprofessional master's degree in occupational therapy. Only 1.3% of the respondents were currently enrolled in an occupational therapy master's degree program, and 5% were enrolled in other master's degree programs.

The questionnaire addressed issues directly related to patient care, specifically the evaluation process. Most of the respondents (67%) reported completing an initial evaluation for their patient population in 1 hr or less. More than half of the therapists (53%) specifically addressed the patient's occupational role performance most of the time. Twenty-nine of the respondents (12%) never addressed occupational role performance, and 127 respondents (61%) believed that their initial evaluation did not address occupational role performance effectively.

The respondents were asked which of the four role assessment tools listed were available in their work setting and to identify any other role assessment tools they used in practice (see Table 1). Twenty-two percent of the respondents (n = 51) used the role assessment tool developed by their own department, 81.4% (192) of the respondents indicated using an informal interview approach to obtain information on occupational role performance. This finding concurs with Rogers and Masagatani's (1982) study showing a preference for an informal interview to assess occupational roles. Fifty-five percent of the respondents (n = 12) used any of the published role assessment tools in physical disability settings. Interestingly, 88% of the respondents (n = 209) believed that identifying a patient's role function is an important focus in occupational therapy. Only 6% (n = 14), however, believed it was always necessary to use standardized tools when assessing occupational role performance. Conversely, 79% (n = 186) believed it was occasionally necessary to use standardized tools when assessing role function.
To understand why standardized role assessments were not widely used, I examined the clinicians' level of understanding of each of the four instruments. Sixty-four percent of the respondents (n = 151) felt they had a poor understanding of each standardized role assessment tool. Sixty-seven percent believed that if they had a better understanding of tool use (i.e., administration and interpretation), they would use role assessment tools more during the evaluation process.

Not surprisingly, 65% (n = 149) of the respondents learned about role assessment tools in occupational therapy school. More than half of the respondents (n = 121) learned about role instruments through readings. Twenty-seven percent (n = 64) learned about role assessment tools at their place of employment. Thirty-two clinicians (14%) had attended one or more workshops that introduced a specific role assessment tool. Eighty-four percent (n = 27) of the clinicians who attended workshops reported that the role instrument presented was directly linked to a particular theoretical model.

Due to the small representation of occupational therapists with basic and postprofessional master's degrees, associations between level of understanding (i.e., role assessment tools) and level of education could not be statistically examined. Of the 28 master's level therapists who responded, however, only 5% of the respondents occasionally use the identified role assessment tools in practice. The results of this study, however, suggest that occupational therapists are not satisfied with their current method of evaluating role function. Sixty-one percent of the respondents reported that their initial evaluation did not effectively address occupational role performance. Many therapists believed that if they had a greater understanding of role assessment tools, they would use them more during the evaluation process. This implies the need to inform and educate clinicians on role assessment procedures. We could make such information available by instituting such educational programs as graduate

### Table 1
Tool Availability and Use in the Work Setting (N = 236)

<table>
<thead>
<tr>
<th>Assessment</th>
<th>No. of Clinicians With Access to Role Instrument</th>
<th>No. of Clinicians Using Role Instrumenta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Role History-Revised</td>
<td>17 (7%)</td>
<td>4 (2%)</td>
</tr>
<tr>
<td>Role Change Assessment</td>
<td>4 (2%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Role Checklist</td>
<td>23 (10%)</td>
<td>8 (3%)</td>
</tr>
<tr>
<td>Occupational Therapy Functional Screening Tool</td>
<td>14 (6%)</td>
<td>4 (2%)</td>
</tr>
</tbody>
</table>

a Some clinicians used more than one instrument in their work setting. b(Kielhofner, Harlan, Bauer, & Aurel, 1986). c(Jackoway, Rogers, & Snow, 1987). d(Oakley, Kielhofner, Barris, & Reichler, 1980). e(Kielhofner, 1985).

Of the 13 respondents who were currently using role assessment tools in practice, 6 worked in acute care settings, 6 in long-term care facilities, and 1 in a physical rehabilitation setting. Furthermore, 99% of these respondents (n = 9) were senior staff therapists or higher (e.g., supervisors, directors). Ninety-two percent (n = 12) believed that standardized role assessment tools helped them develop treatment plans and establish priorities. Again, with such a small percentage of respondents using role assessment tools, the relationship between tool use and type of setting remains undetermined.

### Discussion
This research represents an initial effort to evaluate the use of role assessment tools in physical disability settings. The results of this study indicate that most clinicians working with the physically disabled population believe that occupational role assessment is an important focus of occupational therapy. This finding is consistent with statements made in the occupational therapy literature (Florey & Michelman, 1982; Jackoway et al., 1987; Oakley et al., 1986). The clinicians in this survey supported the position that the maintenance of occupational roles is of critical importance to the well-being and personal identity of the individual (Versluys, 1980). Despite the commitment to occupational role assessment, however, the present study indicates that there is limited knowledge and understanding of the four standardized instruments developed by occupational therapists and that only 5% of the respondents occasionally use the identified role assessment tools in practice.

In theory, most clinicians base their treatment plan on results of formal tests and informal interviews (Smith & Tiffany, 1978). It appears that in the physical disability setting, therapists rely more on observing and interviewing patients and reviewing medical charts than on interpreting data from a standardized role instrument. The results of this study, however, suggest that occupational therapists are not satisfied with their current method of evaluating role function. Sixty-one percent of the respondents reported that their initial evaluation did not effectively address occupational role performance. Many therapists believed that if they had a greater understanding of role assessment tools, they would use them more during the evaluation process. This implies the need to inform and educate clinicians on role assessment procedures. We could make such information available by instituting such educational programs as graduate-
level courses on occupational therapy evaluation tools, clinical workshops, and publications of case studies reflecting the benefits of the use of standardized role assessment tools. Access to these instruments, knowledge of how to use them properly, and knowledge of the use of an organizing framework to guide instrument selection and to help interpret findings are all important issues for occupational therapists (Barris, Kielhofner, & Watts, 1983).

Study Limitations
Due to its exploratory nature, the survey questionnaire did not sufficiently address all of the relevant reasons for the lack of tool use in the physical disability setting. Many respondents could not comment on tool usefulness because they were unfamiliar with the tools in question. Because the respondents had limited insight regarding the four instruments, it is difficult to determine whether the assessment tools are too complex for this patient population, too time consuming, or too difficult for clinicians to administer and interpret.

Therapists from three different physical disability settings were surveyed. I was unable to correlate tool use and type of setting, primarily because of extremely low frequencies in each cross-tabulated cell. A chi-square test would not be valid under these circumstances.

Further research might focus on clinicians who have adequate knowledge of role assessment tools. A qualitative method may be more suitable for the exploration of reasons why role assessment tools are not used in physical rehabilitation.

Conclusion
The development and use of standardized assessment tools in occupational therapy is a topic of great concern and is considered a priority for the profession (Kaplan, 1984; Oakley et al., 1986). Over the last two decades, several authors have contributed to instrument development regarding role assessment. Traditionally, these instruments were developed for psychiatric settings. Occupational therapists working with persons with physical disabilities, however, are interested in learning more about role assessment instruments and finding effective methods with which to assess role status. Instead of duplicating previous efforts, clinicians could first examine the current standardized instruments available to them and determine their usefulness in the evaluation process. Attending workshops on occupational therapy assessments can increase the clinician’s knowledge base. Other resources include the American Occupational Therapy Association’s self-study series on functional assessments (Royeen, 1989), in which two lessons are devoted to the selection of evaluation tools, including role assessments, and Asher’s (1989) An Annotated Index of Occupational Therapy Evaluation Tools. One chapter in this book contains profiles of instruments for various roles and habits evaluations. The index contains basic information about each test’s purpose, method, reliability and validity, publishing address, and price.

Identification, confirmation, and remediation of valued occupational roles has become a key concept for the occupational therapist treating persons with physical disabilities. To facilitate adaptation and recovery of life roles, the occupational therapist should take a systematic approach to evaluate the patient. This contributes to the development of a unified database from which patients can be studied over a period of time. Use of role assessment tools would not only systematize the evaluation of role adaptation, but would also contribute to instrument validation for the physically disabled population.

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References


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