The Remediation of Role Disorders through Focused Group Work

(role functions, group therapy, role transformation)

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Normally, a person performs a variety of roles in the family, at work, and in the community. Maintaining these roles intact is of critical importance for the well being and personal identity of the individual. Persons with a physical illness or disability may face a reduction or termination in the number of roles they can sustain. The use of role-focused groups as a treatment method is based on role acquisition and transformation concepts derived from theories of sociology, psychology, and occupational therapy.

This paper presents relevant concepts of role acquisition, describes the relationship between the disability and its impact on personal role functions, and examines the factors contributing to erosion of specific adult, occupational, family, and avocational roles. It offers guidelines for evaluation and explores the use of role-focused, interactive, experiential groups both in role maintenance and as a treatment method for role disorders. Finally, a variety of role-focused group models and themes for treatment are described.

Despite advances in medicine and rehabilitation, a high percentage of patients are discharged from the hospital unprepared to meet the demands of daily living and are not motivated to reach and maintain projected functional levels of performance. Their return to the community may be followed by social withdrawal, depression,
regression, and multiple readmissions.

Harber and Smith define disability as the inability to perform the usual role activities as a result of a physical or mental impairment of long-term duration (1). The idea central to this paper is that loss of or change in valued personal roles can result in role disorders. Role disorders may produce social, psychological, and behavioral problems more profound than the disabling condition (2, 3) and signal the need for occupational therapy intervention.

Role Theory
The therapist committed to restoring a patient’s physical function should also consider the patient’s need to continue to meet role responsibilities. An understanding of the developmental aspects of role acquisition and the tasks and social skills that support adult roles is indispensable both in the evaluation of role loss and disorder and in the design of treatment programming (4, 5).

Berger states that Man directs considerable energy and commitment to the development of a variety of role functions resulting in the formation of personal identity and a unique life style (6). This process is a continual life task and might be thought of as part of Man’s career.

Reilly and Moorehead have described the hierarchical development of a role through play, chores, and activities. This development is conceived of as a fluid process continuing through the life span and requiring continual adaptations and acquisitions of new skills and habits (7, 8).

Sociologists agree that the genesis of the adult role occurs in childhood through play, exploration, and relationships developed within the family and community. The child tests out or practices the role tasks and social interactional skills that allow adult roles to be successfully performed. These early maturation experiences of the child may be viewed as a learning laboratory or clinic where role models can be observed and role possibilities experienced, thus providing an indispensable process leading to adult role taking (6).

The resulting adult roles—such as sexual, occupational, family, avocational, and social—allow an individual to participate in his or her culture and to satisfy human needs. The mature, well adjusted person integrates all his or her roles into a balanced life style (7, 9).

Role Disorders
Physical illness and disability may adversely affect personal role functions on a continuum from minor changes to complete obliteration of all major roles. A hospitalized and disabled patient struggling to maintain role responsibilities may experience a reduction or fragmentation in functional role skills that undermines confidence and may lead to depression, formation of a poor self-image, and lack of motivation for the rehabilitation task. Functional role skills include maintenance tasks such as shopping and cooking, and work/occupational tasks such as driving, using the telephone, and caring for children. Patients may also temporarily have to shelve role tasks such as meeting financial obligations, maintaining personal standards, and meeting social commitments (10, 11).

Role disorders are often compounded by the patients’ fears that their customary life style will change irrevocably. Patients may deal with these anxieties by resorting to maladaptive behaviors such as dependency, denial, and regression (12, 13). For example, a cardiac event may precipitate fear, anxiety, and depression, which may result in unnecessary retirement, the termination of many adult roles, and entrenchment in a sick role (14).

The residual effects of disability may prevent the performance of those “physical” skills that make the execution of major roles possible and thereby result in the exacerbation of role disorders (3). For example, the loss of the physical skills that allow driving cancels the patient’s ability to drive a car. Driving can be a vocational necessity and also influence participation in recreation and social activities. The loss of these physical skills severely limits the patient’s ability to meet his or her human needs and prevents a balanced and rewarding life style.

Avocational experiences fill needs for creativity and physical action. The loss of physical functions required to dance or ski may not only lead to the termination of pleasurable recreation, but also affect the release of tension through activity. The inability to perform these physical skills means that the role or role tasks must be changed and human and occupational needs must be met in a different manner (15).

Patients vary in their ability to deal with role loss and to accept role substitutes. The loss of a valued role may present a barrier to role substitution for those patients who had invested time and effort in roles that increased status and self-esteem.

The time required for medical treatment, the stress of rehabilitation, the lack of mobility, and concern with changing personal appearance may precipitate a number of crises for the patient. The patient’s response to this stressful or traumatic situation may be the devel-
development of avoidance behaviors that protect him or her from fear of rejection and contribute to social isolation. A family role such as father and provider carries certain expectations and responsibilities. Discontinuation of these roles, even for a short time, may result in crisis for both the patient and the family (10, 13).

Although dedicated to rehabilitation, the hospital system has its own overt and covert rules for patients' conduct and behaviors that may contribute to role dysfunction. Patients are no longer in charge of their own destiny and may find that they are unable to exert control over the use of their own time (i.e., when to eat and when to go to bed, when to leave the hospital to visit their family). The patient is expected to adhere to decisions made by others, often without his knowledge or input. The patient's special skills prized in the community or at work are not useful in the hospital nor are they recognized by the hospital staff as significant. Personal initiative and problem solving are discouraged (10).

Goals of rehabilitation should include the preservation and maintenance of adult roles or the development of strategies to compensate for the loss of social, task, and performance skills that make major role performances possible.

Factors Influencing Role Transformation

Occupational therapy intervention into role disorders is first aimed at assisting the patient to adjust to and understand the hospital system, and thus be in a better psychological position to benefit from rehabilitation. The second strategy is to assist the patient in maintaining role responsibilities during the period of treatment. However, if the prognosis indicates permanent dysfunction, including the patient's inability to fill previous life roles, the goals of treatment are to rehabilitate by the transformation and reassignment of roles.

Based upon the premise that adult roles with their resulting identities are socially bestowed and sustained, it follows that role transformation or the re-assignment of roles is a social, interactive process. Perhaps the most important influence in role maintenance and transformation is the contribution of the family. The attitudes the family maintains toward the patient's roles, their willingness to re-establish or contribute to role maintenance, and their identification and assignment of roles useful to the family and within the patient's capabilities are essential in reaching rehabilitation goals (5, 10, 16).

Human roles influenced by cultural definition may be limited in the options for role change and reassignment (6). Patients and their families may assume that there is only one way to be a successful man or woman, a worker, or to fill family membership roles. The considerations of alternative life styles and concomitant adult roles may be difficult for the patient and resisted by the family.

The patient may accept the need to try new work options, devise a new life style, and work to experience and develop different leisure time interests. However, these choices must also be supported by family and reflect the reality of the patient's background experiences, interests, and real skills, both physical and intellectual. Failure to achieve in new endeavors may discourage the patient's progress in rehabilitation and his or her wish to become a viable part of the community upon discharge.

Role loss and lack of role acquisition should be assessed developmentally and chronologically before a problem list for treatment programming is identified. The occupational therapist should be aware that the patient's major life roles vary in priority at different times in the life cycle. Treatment goals should consider the patient's present and future role needs. After the degree of physical and role dysfunctions have been determined, treatment emphasis is placed upon guiding the patient in re-experiencing early developmental tasks through role-focused group experiences. Conditions for change within such groups include interpersonal transactions within a human group, opportunities for exploration, play, and the choosing and use of activities (6, 7, 17). The patient involved in such a treatment program must also identify the need and purpose for maintaining and/or acquiring new skills (18).

Focused Group Work

Occupational therapy believes that change occurs through action and involvement that reinforce the learned tasks or new skills. The patient, after the traumatic event or as a result of long illness and hospitalization, may not have the ego, strength, and energy to handle formal discussions concerning disability, role skills, and psychosocial needs. Didactic or vicarious teaching, independent of an experiential component, is not successful in increasing self-esteem or in helping the patient to explore new role possibilities (10).

Focused Group. A focused group experience provides a training ground where patients test their ability to deal with problems of living, decision making, and risk taking involved in the change process.
Patients are encouraged to continue responsibility for role tasks in the hospital, family, and community. The patient can be assisted in identifying and maintaining major role responsibilities through a problem-solving process. Graded social roles can be designed for and assigned to the patient for practice in the hospital and the community (10, 19).

Cohesive Group. A cohesive group sustains patients while they experiment and master the skills necessary for physical and psychological survival in the community (16, 21). These necessary role skills are called "Weapons of Life," by Kutner (5). To maintain viable adult roles and personal independence, patients need an arsenal of social and interpersonal skills, the ability to deal with everyday problems of living, and to take social responsibility.

Yalom states that, in the intrinsic act of giving, patients receive a boost to their self-esteem and find that they can be altruistic and important to others (20). The physically disabled patient who encourages, responds, and becomes actively involved in supporting and sharing with other group members including family feels immediately more confident and useful, more in control and positive about his/her ability to handle change.

Role-focused Group. A role-focused group assists in the ventila­tion of feelings concerning the permanence of disability, allows the patient to see that others have struggled and succeeded, amplifies the motivation for change, encourages the patient to feel more socially acceptable and to plan more realistically toward transition into the community.

Through group interaction patients are exposed to a variety of social roles. Through activities and involvement in encouraging, planning, organizing, helping, and sharing, patients discover they are capable of being productive within their physical and medical limitations (17, 21, 22).

Also important in treatment for the atrophy or loss of adult roles and underlying role skills is the kind of stress inherent in society. The removal of all stress in therapy groups will impoverish role expectations and thus limit the available number and complexity of roles the patient can play (23). It becomes the responsibility of the therapist to estimate when the patient can handle stress and to program experiences to meet individual learning needs.

The design of role-focused groups includes the following six factors: a group of patients that have the potential to become cohesive; role-building experiences that allow the patient to explore and test new behaviors (5); the freedom to seek out and use activities to please the self and others and to feel competent (17); a clear communication system of supportive and realistic feedback that encourages adaptation and reinforces learning (24); social recognition of group members and their role functions; and opportunities for role experiences that are compatible with the patients' values, culture, and preferred life styles (5, 7).

Role Disorders. Certain responsibilities are specifically the therapist's task. The first is evaluation of role disorders. Guidelines include: 1. a diagnostic projection to identify the degree of permanent functional limitation; 2. patient and family interviews to identify the importance to the patient of each adult role and those role areas central to preservation of the patient's self-esteem and identity; 3. an analysis of the elements of each role most prized by the patient to determine whether these needs can be met through substitute role activities, or compensated for by adaptive equipment or acquisition of new task skills; 4. evaluation of the family commitment level and the skills available in the family to achieve role continuity; 5. recognition of cultural and religious influences; and 6. determination of the patient's interest, values, background, experience, and preferred life style.

In addition to evaluating the patient, the occupational therapist should also: 1. facilitate insight concerning coming changes in adult roles and role skills; 2. design strategies to circumvent those role tasks the patient can no longer perform; 3. develop and encourage realistic treatment goals with the patient; 4. counsel and investigate alternative ways of filling role requirements; 5. prevent role saturation by insisting that role acquisition proceed cautiously and progressively so that new role tasks and behaviors become well integrated within one major role; 6. stimulate development of follow-up programming within the community to strengthen and internalize new roles.

The patient's performance must be facilitated and monitored skillfully. Tasks need to be assigned, and dialogue and feedback that reinforce the direction and pace of new learning must be provided (5, 24).

Rehabilitation staff may feel that role disorders will remedy themselves when patients return to the community, or that the social and emotional needs of patients are not part of the total rehabilitation goals. Such concepts must be rejected since role disorders cannot be treated quickly, at the last minute, or post-discharge. The timing of treatment is important and should
occur concurrently with physical rehabilitation, beginning at the time a patient is admitted to the hospital. The inclusion of experienced handicapped role models as group leaders or group members provides evidence to patients that others have been successful in building satisfying lives.

**Role-Focused Group Models**

**Homemaker’s Group.** In this group, members consider alternative ways of home management with emphasis on such specialty areas as child care, cooking, architectural and interior design, and social entertaining. They also deal with feelings about change in living style and the loss incurred in relinquishing familiar ways of meeting personal and family needs at home. Techniques the therapist might use include education, problem solving for individual situations, role playing, direct experience at home, and handicapped role models as teachers and consultants. Families are invited to participate (15).

**Role Maintenance Group.** This group would assist the patient in maintaining role responsibilities while hospitalized. Emphasis is on identification and realistic appraisal of those roles that can be maintained during rehabilitation and separation from work and family. The occupational therapist and group members are responsible for facilitation of negotiations with community and family in problem solving as well as in continual feedback and monitoring of the maintenance process. For example, the salesman who can handle some of his accounts at the hospital through meetings with clients who visit him requires cooperation of the hospital administration and the employer. The group helps him negotiate with these authorities. Also, a mother is encouraged to give input to child care, children’s activities, and home management via the telephone and family visits. Meeting the family at the hospital to establish role responsibilities may be helpful. A patient’s social obligations and committee tasks can be handled via the telephone. Community, work, and family responsibilities can be re-designed to allow patients continued participation. Family, friends, and business associates are encouraged to attend some of these group sessions.

**Social Skill Development.** In this group, the emphasis is on maintaining social and communication skills by providing structured learning experiences within a patient group. Mature social skills may have atrophied because of isolation and lack of opportunity to practice, or may be developmentally delayed. Treatment is focused on the development of age-appropriate social and communication skills through interactive exercises, social club activities, and expressive media—for example, poetry and literature. The end goals of community participation are stressed. For example, to illustrate this role-focused group, a patient may learn new social games within his or her physical capacities and then join a community group; for example, chess, bowling, musical club.

**Sensitivity Training.** This group is designed to assist patients in coping with feelings about community re-entry, being visible in the community, and dealing with rejection. Techniques include sequenced social experiences, planned tasks within the community such as shopping, luncheon, or parties, and dialogue with handicapped role models (17, 19). There is an emphasis on group design of experiential community assignments. The patients assigned to community tasks report back to the group on their personal experiences and feelings. The group provides feedback and support, and assists in solving problems encountered in mobility, access to public buildings, and poise in public or social situations.

**Family Task-oriented Groups:** These are interhospital groups formed to strengthen and maintain family relationships and encourage the maintenance of the patient’s roles within the family constellation. Patients and family are involved in dialogue concerning the adjustments to disability, the treatment process, planning for discharge, and in social and recreational activities. Emphasis is on programming that provides opportunities for families to interact with the handicapped member (16, 25). Participation in task-oriented activity groups helps to reduce the tension a family feels toward relating to the patient who is physically ill or disabled. Activities include dinners prepared by patients and families, trips, game nights, parties, and expressive media experiences. Handicapped role models allow the family to observe the potential for good functioning after rehabilitation. Activities involving the patient and family allow the family to observe how the staff relates to the patient and what independent behavior is possible; for example, the patient’s ability to eat independently, organize activities, or to research and present information used for group planning.

**Transitional Group.** This group offers transitional or bridging activities designed to provide linkage between the hospital and the community. The patients consider ways to participate in family activities and work/social relationships. They prepare to meet their future social
and emotional needs by participation in community groups while still hospitalized, and practice the social role skills necessary upon discharge. Group techniques include dialogue and activities with family, friends, community volunteers, and anticipatory guidance by handicapped consultants. Group design of transitional or bridging activities includes both interhospital and community activities such as patient organization. For example, patients make and carry out plans to go to church, arrange job interviews or preliminary visits to the old work area, participate in volunteer experiences to teach skills to hospital staff or community groups, and find ways to maintain old friendships and to make new ones (5, 21, 22).

Summary

Patients with a physical illness or a disability may find that their usual adult roles must be modified or permanently changed. Role disorders occur when patients are no longer able to meet their usual role responsibilities. The resulting social and psychological disturbances may be a permanent response to the physical trauma and more profound than the residual limitation warrants.

Treatment goals for such patients should include not only the mastery of physical and compensatory skills required for activities of daily living and mobility, but also parallel programming to treat the psychological and social effects of role disorders, hospitalization, and isolation from the family and community.

Remediation of role disorders can occur through an involvement in experience-based activity groups focused on maintaining and/or transforming major adult role functions. Group goals include re-mastery of social and communication skills, role building, the development of new and satisfying role experiences, and the enhancement of family cohesiveness.

Within the transitional programming between the hospital and community, the patient learns that intergroup roles are also relevant to family, work, and the social community.

Role-focused groups are specialized, flexible, and designed to meet the individual and changing needs of a patient population with role disorders secondary to physical disability.

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