Group Work in Occupational Therapy: A Survey of Practice

(group dynamics, occupational therapy, research, treatment modality)

Linda W. Duncombe

This paper documents the extent to which occupational therapists use groups in practice. A questionnaire was mailed to 300 occupational therapists nationwide. Questions included the types of groups occupational therapists lead, the facilities in which the groups take place, the patients included, the activities presented, and individual and groups goals. Results were tabulated based on the responses of 120 therapists. We established that 60% of occupational therapists in all areas of practice lead groups in treatment. Of the 209 groups described by the respondents, there was a significantly greater number of activity groups than verbal groups. Also, there were significantly more groups with ten or less members than groups of more than ten. This paper describes the ten categories of groups that were identified in this study.

Margot C. Howe

A fundamental problem in professional education of occupational therapists is the establishment of a close accord between the actual practice of the profession and what is being taught in the academic setting. We are currently in an era when health care practices are increasingly subject to change from forces within legislative, financial, and administrative areas and where medical science and technology are rapidly developing. It is often difficult for the academic instructor to keep informed of current professional practice and to update the curriculum of the preprofessional student.

A case in point is the application and scope of group treatment in occupational therapy practice. The following question led us to this study. What is the nature of occupational therapy groups and to what extent are groups used in the practice of occupational therapy?

More than 60 years ago, Adolph Meyer (1) described the occupational therapy group as individual patients working on largely individual craft projects in a group setting. Since that time, groups have continued to be a common method of treatment in many areas of practice; however, the role of the occupational therapist in structuring the group as a treatment modality has changed. Meyer described occupational therapy groups in which the interaction of the patients was informal and largely peripheral to the activity; but, the group in the contemporary clinic is usually carefully planned to maximize the patients' interactions with other group members and to focus on specific treatment goals.

In 1955, the American Occupational Therapy Association received a grant from the National Institute of Mental Health to study occupational therapy with psychiatric patients. As part of this study grant, the Allenberry Conference was held in 1956 to study issues of practice. One of these issues was the use of groups and group activities in patient treatment. The recommendations of that conference ultimately led to a revision of the educational standards of occupa-

Linda W. Duncombe, MS, OTR, is Clinical Assistant Professor, Department of Occupational Therapy, Sargent College of Allied Health Professions, Boston University, Boston, MA 02215; Margot C. Howe, EdD, OTR, FAOTA, is an associate professor, Tufts University—Boston School of Occupational Therapy, Boston, MA 02154.
tional therapists (2). These revised Essentials of an Accredited Curriculum in Occupational Therapy (unpublished document prepared in 1965 by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association (AOTA); available from the Education Division, AOTA, 1383 Piccard Drive, Rockville, MD 20850) stipulated that the study of group process, group techniques, group dynamics, and the selection of group activities be included in the professional curriculum. However, follow-up study to evaluate the effect that this change has had on occupational therapy practice has not yet been made.

We made a search of the literature published in The American Journal of Occupational Therapy from 1972 to 1982 to review the information available on the scope and nature of group treatment in practice. We found two articles describing group treatment with young children (3, 4). Five articles described group work with elderly persons in the community (5–9), whereas another article reported on a group designed to assist individuals to plan for retirement (10). Another nine articles we found depicted occupational therapy groups in physical rehabilitation settings for patients with the following conditions: chronic back pain (11), Parkinson’s disease (12), stroke and hemiplegia (13, 14), spinal cord injury (15), lung disease (16), and general chronic disabilities (17).

The following are topics of articles that describe group treatment with psychiatric patients: schizophrenic patients (18–22), in-patient programs (23, 24), short-term hospitalization (25), community out-patient programs (26–33), adolescents (34, 35), and child abuse parents (36).

This enumeration of the literature did provide some information on the breadth and scope of occupational therapy treatment groups; however, we needed more specific data on the exact nature of these groups. What were the characteristics of occupational therapy groups? Did the leaders stress verbal interaction or were members asked to perform specific tasks together? Was membership in these groups open or closed? Then, we focused this study on obtaining direct information from practicing occupational therapists regarding the scope and nature of the groups that formed part of their treatment program.

Methodology

Questionnaires were mailed to 306 occupational therapists whose names were randomly selected from the 1980 Member Handbook of the AOTA. The sample was stratified around one variable: geographic distribution. To assure anonymity of the respondents, we asked for no identification. As a result, the degree of data bias due to nonresponse is unknown. Forty percent of the questionnaires were returned; this is considered a satisfactory return for a mailed questionnaire (37).

Research results were based on the responses of 120 currently employed occupational therapists. The distribution of respondents among work settings, geographical location, and number of years of certification approximated the distribution of practicing therapists in this country, as reported by the AOTA Member Data Survey of 1977 (38).

We designed a three-part questionnaire for the mail survey. The first section asked for information to identify attributes of the respondents, such as whether or not they had taken courses in group process, the length of time of their certifications, the kind of facility in which they worked, and what types of patients they treated. The second section established whether or not the respondents used groups as a treatment modality and if not, why not. The third section was divided into two parts and was to be answered only by those respondents using groups as a method of treatment. The first part requested open-ended information; respondents were asked to describe up to four treatment groups that they led. In the second part, a checklist was provided to obtain specific information on group characteristics and goals. A group was defined as “an aggregate of people who share a common purpose which can be attained only by group members interacting and working together” (39).

The material from the first part of the third section of the questionnaire required an additional procedure because no conceptual parameters had been given for respondents to follow. We identified group types by a) what respondents called the groups they were leading and b) the activities listed for the groups. We independently placed the groups into 12 previously identified categories. An interrater reliability of .94 was established. Because 2 of the 12 group types, games and community field trips, had such small numbers, they were reevaluated and placed into other group types based on activities described. Although the groups seemed to cluster in the final ten categories, there were clearly some areas of overlap in the activities used. This characteristic of overlap
Table 1
Respondents' use of Groups by Facility

<table>
<thead>
<tr>
<th>Type of Facility</th>
<th>Therapists Leading Groups</th>
<th>Therapists Not Leading Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Large general hospitals</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>2. Small general hospitals</td>
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<td>3. Rehabilitation centers</td>
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<td>7. Community programs</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>8. Schools</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td>9. Developmental disabilities programs</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>10. Miscellaneous</td>
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<td>3</td>
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<tr>
<td><strong>Totals</strong></td>
<td><strong>72 (60%)</strong></td>
<td><strong>48 (40%)</strong></td>
</tr>
</tbody>
</table>

is also seen as a reflection of practice.

Results

All respondents indicated on a checklist that they worked in one of the following ten types of health facilities: a) the large general hospital, including military and Veterans Administration hospitals; (the major diagnoses of the patient population involved in occupational therapy included schizophrenia, drug dependency, manic-depression, alcoholism, cerebral vascular accident, burns, traumatic injuries, arthritis, and various orthopedic and neurological problems, and patients were predominantly adults and elderly) b) the small general hospital, serving much the same population as the large general hospital; c) the rehabilitation center, which provided treatment for a wide range of physical dysfunctions and developmental disabilities in adults and in some cases children; d) psychiatric hospitals, which care for adults with psychosocial problems; e) the community mental health center, which serves both adults and children; f) nursing homes for adults and elderly persons with multiple problems; g) community programs that are largely day programs for patients with psychosocial, developmental, and aging problems; h) schools representing preschool and public school programs for children with special needs; i) centers for developmental disabilities; and j) miscellaneous facilities’ category of highly specialized programs.

The following results were obtained. Of the 120 responding therapists, 72 used groups in treatment and 48 did not (see Table 1). The major reasons given for not using groups in treatment were either that occupational therapy services were provided only on a one-to-one basis in their facility (42%) or that patient populations were not suitable for group treatment (36%). A percentage comparison of the use of groups by facility showed that all the respondents working in psychiatric hospitals and community mental health centers used groups. To some extent, the use of groups was reported in all ten types of treatment facilities (see Figure 1).

The third section of the questionnaire provided descriptive data on 209 groups, which were led by the 72 occupational therapists who reported using groups in practice. The data on nine of these groups were only partially complete and therefore could not be included in the characteristics data base. Data from the group characteristics checklist were tabulated for each group category (see Tables 2 and 3).

Two group characteristics that are frequently important determinants of group process are group size and group activity. Both of these characteristics were studied in greater detail. Of all the groups, 54%, or 109 groups, were labeled activity groups and 24%, or 48 groups, were labeled verbal groups. A chi-square analysis showed that there was a significantly greater number of activity

Figure 1
Percentage comparison of the use of groups by facility

![Figure 1](http://ajot.aota.org/pdfaccess.ashx?url=/data/journals/ajot/930453/)
**Table 2**
Group Characteristics

<table>
<thead>
<tr>
<th>Type of Group</th>
<th>Exercise</th>
<th>Cooking</th>
<th>ADL</th>
<th>Task</th>
<th>Arts and Crafts</th>
<th>Self-Expression</th>
<th>F-O Dis</th>
<th>R-O Dis</th>
<th>Education</th>
<th>Total</th>
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ADL, activities of daily living; F-O Dis, feeling-oriented discussion; R-O Dis, reality-oriented discussion; SI, sensory integration.

confirmed that there were significantly more groups with ten or less members than groups of more than ten members (31.9, df 1, p < .01). Ten categories of groups were established. The first category was the exercise group. This was followed by a series of four types of groups engaged in a concrete group task. These included the cooking groups, the activities of daily living (other than cooking) groups, task groups, and the arts and crafts groups. The sixth cate-
The members also played games involving ball play, such as catch, volleyball, pingpong, and bowling. The members also played short-term groups (meeting for less than 3 mo) and had specific goals of facilitating communication and socialization, increasing task skills, and sharing information. The participants were most commonly found in psychiatric facilities and in large general hospitals.

The Exercise Groups

Patients in these groups did physical exercise to increase coordination, mobility, and strength. Members were adults with psychosocial or physical dysfunctions or developmental disabilities. They played games involving ball play, such as catch, volleyball, pingpong, and bowling. The members also performed movement and dance, "new games," and various recreational sports activities. Participation in the activities was often from a chair or wheelchair. Group size varied from 6 to 20 participants. Exercise groups were most frequently found in rehabilitation centers and schools. Group members were usually adults (65%), and group goals were primarily therapeutic, this to facilitate communication and increase physical abilities.

Cooking Groups

The cooking groups usually combined the tasks of meal planning, shopping, cooking, and eating. This group consisted of adults and adolescent psychiatric patients and had schizophrenia as the most common diagnosis. Also included were two groups for patients with learning disabilities. One therapist, employed in a rehabilitation center, conducted a cooking group with patients who had arthritis, spinal cord injury, and neurological diseases. The cooking activity gave them practice in using adaptive equipment. Cooking groups were small (with 5–8 members), short-term groups (meeting for less than 3 mo) and had specific goals of facilitating communication and socialization, increasing task skills, and sharing information. The participants were most commonly found in psychiatric facilities and in large general hospitals.

Activities of Daily Living Groups

This was the largest category and represented 17% of all groups. Two-thirds of these groups were conducted for adults with psychosocial dysfunctions. The remainder were adults found in rehabilitation centers having spinal cord injuries, head and neurological injuries, and stroke and cardiovascular accidents. In both settings, some groups worked on predischARGE living skills and on the development of a readiness for independent living in the community. The participants were concerned with issues like transportation, grooming, time and money management, and the use of leisure time. Other groups focused on the development of skills for greater independence in self-care within the institution; activities included self-feeding, dressing, learning grooming and hygiene, performing kitchen tasks, and using adaptive equipment. The living skills groups were small, short-term activity groups (3–8 members). Group goals were primarily to increase task skills and share information.

Task Groups

These were product-oriented groups. Although they took place in a variety of facilities, patients were being treated for a range of psychosocial disorders. Most groups were for adults. These groups had both a verbal and an activity component because a group discussion frequently preceded the activity for planning and an evaluation discussion followed. Activities included work tasks, planning leisure time and special events, reality orientation, drama, games, tournaments, and producing newspapers. One therapist ran a group of 10 to 16 year olds with psychosocial dysfunction who carried out all the activities necessary to produce a school paper. Another therapist ran a photography club with cerebral palsyed and mentally retarded patients in which scrapbooks were created. Still another therapist, working with developmentally disabled adults, did prevocational activities such as packaging, sorting, and collating. Most task groups were closed, and although they were both short- and long-term, they were frequently time-limited.

Arts and Crafts Groups

These groups used arts and crafts activities for treatment of
psychosocial disorders. Patients usually worked on individual projects within the group setting. Goals included skill development, most often of leisure skills, and provision of information for the evaluation of existing skills. Some of the groups, particularly those where evaluation of skills was the goal, were small (less than 5 members).

In other groups, where the goals were the development of leisure skills, the groups were larger (as many as 15 members). The specific arts and crafts media reported were ceramics, leather, copper tooling, woodworking, macrame, rug hooking, needlework, weaving, and art.

Self-Expression Groups

This group category was reported primarily by occupational therapists working with adult psychiatric patients. The self-expression groups used art, group collages, role-playing, or self-awareness exercises as their media. These groups were small, short-term, and largely found in psychiatric and general hospitals.

Feeling-Oriented Discussion Groups

The feeling-oriented discussion groups were found in psychiatric settings with schizophrenic and manic-depressive adult patients who were not psychotic. Some of the groups were actually designated as group psychotherapy. Many used role-playing, poetry, and fantasy as the medium to promote discussion. Other groups relied on a description of a current life situation to start the discussion, which then focused on the feelings involved in life events. These were verbal groups of six to ten adults. The goals were to provide support, to increase communication and socialization, and to achieve insight.

Reality-Oriented Discussion Groups

This type of group was used primarily in psychiatric hospitals and large general hospitals with psychiatric patients. The topics for discussion were current events in the daily news or events that occurred within the program, such as program planning, goals for treatment, use of time, discharge planning, and daily patient concerns. Some groups used a specific group technique, such as Transactional Analysis, Assertiveness Training, and Role-Playing. One therapist described a group of burn patients where discharge plans were discussed. While these groups were largely verbal, they did include both a verbal and an activity component; they were small, short-term groups.

Sensori-motor and Sensory Integration Groups

Children were the largest group of patients in this category. The children were receiving treatment in groups within school programs from preschool through high school. They were being treated for learning disabilities, hearing and vision problems, developmental disabilities, cerebral palsy, and sensory integration disorders. These groups included gross motor and fine motor activities and tactile, taste, and vestibular stimulation. The groups were small in size (under 5 members) and were planned for long-term treatment.

The following three groups in this category did not fit the description given above: the sensory integration group, for adult chronic psychiatric patients, and the groups in rehabilitation centers, one for head-injured patients and one for patients recovering from a cerebrovascular accident.

Education Groups

The majority of educational groups were led for parents of families of individuals who were receiving treatment. Frequently, they were for parents of children having developmental disabilities, emotional problems, or cerebral palsy. Also included here were groups organized to provide information to patients about medications, joint protection for arthritis, and family planning. These were verbal, short-term groups that varied in size from 4 to 20 members.

Discussion

Twenty-five years after group theory courses were added to accredited occupational therapy curricula, our results indicate that more than half of all occupational therapists use groups. In our survey, occupational therapists, who worked in all types of facilities, with all age groups, and with patients having 27 different diagnoses, reported using groups to some extent. However, group treatment is still not included as a method in most occupational therapy texts.

It is important to note just how extensive we found the use of groups, not only in mental health but also in a broad variety of programs. We expected that all therapists in psychiatric facilities used groups because the existing occupational therapy literature reflects the use of groups with psychiatric patients.

In occupational therapy, there are two overriding themes: a) function and b) purposeful activity. Within the definition of occupational therapy, the following phrases are found: "... to restore, reinforce and enhance performance, facilitate learning of those skills and functions essential for adaptation and productivity ..."
perform with satisfaction to self and others those tasks and roles essential to productive living and to the mastery of self and the environment" (40, p 27). Hence, it is not surprising that in this study the activities of daily living groups were the most frequently reported and when added to cooking groups, comprised one-fourth of the total number of all groups. Furthermore, more than one-half of the groups and more than one-half of the group goals were geared toward increasing skills, including those in tasks, cognition, and physical abilities.

The philosophical base of occupational therapy includes the phrase "purposeful activity" throughout, and one sentence of the philosophy statement states, "Occupational therapy is based on the belief that purposeful activity (occupation), including its interpersonal and environmental components, may be used to prevent and mediate dysfunction, and to elicit maximum adaptation" (40, p 27). To verify the use of activity in treatment, more than three-fourths of all groups mentioned in our survey had an activity component. Even some of those that were primarily discussion groups were "talking about" activity or occupation, as the philosophy statement suggests.

In addition, in contrast to Meyer's (1) description of an occupational therapy group as "individual patients working on individual projects," the groups represented in this survey have as their most common goal to increase socialization and communication. All therapists listed more than one goal per group, but it is clear that occupational therapists see the importance of the interpersonal component to purposeful activity, as mentioned in the philosophy statement. In addition, socialization, the learning and practicing of roles in a social context (41) is equally important to occupational therapists. Jones (42), father of the therapeutic community, documented that recovery was accelerated in a therapeutic community setting because of the value of communicating and socializing with others who have similar problems. This was true both with patients having physical handicaps and with psychiatric patients. It behooves us to attempt to document and research the value of combining socialization with purposeful activity.

Conclusions

One of the major conclusions from this research is that groups are used in many areas of occupational therapy practice, not just in psychiatry. Therefore, it is important for occupational therapists to learn group process theories and become skillful at leading groups.

All therapists in our study indicated that their groups had more than one goal. Because the group dynamics literature (43, 44) indicates that a group working on multiple group goals is also meeting individual needs and goals, it is our feeling that the occupational therapy groups described in this study were working toward individual patient’s treatment goals.

One of the criticisms of group treatment has been the difficulty in obtaining reimbursement because of a lack of documentation of individual treatment goals. Once occupational therapists become accustomed to documenting an individual's treatment goals within a group, it may become increasingly important to use groups in treatment, given rising health care costs and manpower shortages.

In the future, we recommend that each group type mentioned in this survey should be analyzed in reference to each characteristic described and to previously unidentified characteristics. Cross tabulation between diagnoses and treatment groups could indicate models of practice identifying which diagnoses are most commonly treated in which type of group.

Finally, our research initiates the provision of data in the area of occupational therapy group treatment. We hope that it will be useful to both educators and clinicians.

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