Occupational Role History: A Screening Tool for Psychiatric Occupational Therapy

(occupational behavior, role functions, role balance)

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Shirley M. Michelman

Psychiatric hospitalization has become telescoped, thus focusing on short-term acute care. Since discharge plans are needed on admission, occupational therapists must evaluate the patient quickly and succinctly. A screening tool was developed as a preliminary device to identify critical information in two major areas: patterns of skills and achievement or patterns of dysfunction in past and current occupational role; and the degree of balance or imbalance between leisure activities and those activities associated with occupational role. The screening tool, the Occupational Role History, was used in a pilot study on 20 adult inpatients at the UCLA Neuropsychiatric Institute. The results of the pilot study suggest that this tool is useful in establishing treatment priorities from an occupational therapy perspective.

History taking as a clinical tool is of paramount importance among professionals working with psychiatric patients. It is the cornerstone of diagnosis and treatment and is based on the assumption that past events have tremendous importance for understanding the present. Fundamental to understanding an individual’s present behavior is a careful history of the individual’s past. Lazare reminds us that the kind of history taking, the meaning assigned to certain historical facts, and the treatment modalities chosen depend on what conceptual model the clinician employs (1).

To illustrate this point, Lazare identifies four models operating in clinical psychiatry—medical, psychological, behavioral, and social—and, using the four different models, presents a brief history of a middle-aged depressed patient. The history and explanation of depression and focus for intervention for each model are quite different. Each model addresses different aspects of the patient’s past and ignores others. No one model offers a more complete or better understanding than the other but adds a different or unique dimension to the understanding of the complexities of human behavior. The conceptual model determines the kind of questions asked in a history, the interpretation of the history, and the focus of treatment for each professional working with the patient.

This paper focuses on the following areas: 1. the fundamentals of history taking, 2. occupational behavior concepts as a basis for history taking, 3. Moorhead’s occupational history instrument, 4. the development of a screening device, the Occupational Role History, and 5. findings or results of its application in a preliminary pilot study with adult psychiatric patients.

History Taking

“... History is not simply a subject among many others, but one of the ways in which we think.” (2, p 3) Man by nature is an historical animal. He has the capacity to remember and reflect on past experience. Without this capacity he would be doomed to live from moment to moment. History, then, “... has its origin in man’s awareness of continuity.” (2, p 44) History addresses processes over time by recognizing events that shape changes. An history-taking instrument not only reveals patterns and processes of the past but also indicates trends with import for the future. According to Moorhead, “the gathering of history is the essence of scientific method. Research itself is basically the art of recording as nearly as possible exactly what has occurred in a certain situation. Whether the researcher sets up an experiment or examines naturally occurring phenomena, he arrives at his findings through his record of historic events.” (3, p 238)

As historians, occupational ther-
Therapists need to assume responsibility for adherence to the rules of research: 1. identification of the organizing principles or theory base that directs the selection of certain phenomena for study; 2. the collection of data; and 3. the identification of a pattern for the analysis and interpretation of findings. A pattern permits meaning to be attached to a group of otherwise disconnected facts. The occupational therapist as historian then selects the organizing principles that identify patterns over time. Analysis of these past patterns allows the therapist to understand present behavior and to predict future trends.

In clinical history taking, the two common methods used for data collection are the interview and the questionnaire. Both are dependent upon the subject for information and both vary with the degree of structure imposed on the subject’s response to questions. In general, when the range of possible responses is limited and known, a totally structured format is used. When answers are not known and more in-depth information is required, less structure is used. The methods differ with respect to the personal interaction between the clinician and the subject—the interview is more personal, the questionnaire, impersonal.

In general, if the researcher is confident that questions are clear and require no explanation, an impersonal questionnaire is used. If questions require rephrasing or explanation, the more personal format of the interview is used.

The structured questionnaire has been very successful in gathering a history of the patient’s childhood diseases and other discrete information, but the semistructured interview is prominently used in taking a history of more abstract events.

Occupational Behavior
In history taking, both clinical and methodological concerns require that the clinician employ a conceptual model that provides the organizing principles for data collection and analysis. No one model offers a complete explanation for the phenomena to which it addresses itself, although it may determine a professional’s unique focus. On the other hand, lack of specificity in model selection often leads to global, vague decisions made on a clinical level and impossible data analysis on a research level. The conceptual model used for occupational history taking is the occupational behavior frame of reference.

A frame of reference is a set of principles used to delimit knowledge bases and set parameters for study and examination. Certain knowledge bases are deliberately included and others deliberately excluded. A text accompanies a frame of reference. It specifies the particular knowledge bases included in the frame.

Reilly described major assumptions of the occupational behavior frame of reference. She wrote, “Play in a chronological or longitudinal sense, we believe, is the antecedent preparation area for work. In a cross sectional sense we have found it clinically useful to see our adult social recreation pattern as a subsistent support to a work pattern. The entire developmental continuum of play and work we designate as occupational behavior.” (6, p 302)

Occupational behavior is guided by at least three interdisciplinary knowledge bases. The biological base acknowledges Man as a spontaneous, stimulus-seeking being. The bases of social-psychology and anthropology acknowledge Man as a tool user, a problem solver, and an achiever. The sociological base acknowledges Man as occupying life roles acquired in the process of socialization.

In addition to the knowledge bases guiding occupational behavior, the disease process affects occupational behavior. Whether the process emanates from biological, psychological, or sociocultural factors, it disrupts occupational role.

Although many authors have elaborated on different components of this frame of reference (7-12), the purpose here is to highlight the information necessary to administer and interpret an occupational role history. The information selected centers primarily on occupational role throughout the life cycle.

The sociological generalization—that human roles can be divided into the three areas of family roles, personal-sexual roles, and occupational roles—is accepted. Of these three areas the occupational role has become a major focus in occupational therapy. Familial and sexual roles are usually handled by other disciplines whose body of knowledge supports these perspectives. The occupational role cannot be viewed in a vacuum, however, and the influence and importance of the other major roles as they impinge on the occupational role are acknowledged.

Occupational roles are identified as much by social position as by tasks performed; therefore, the concept is expanded to include the child as player, the student, the worker, the volunteer, the homemaker, and the retiree as major occupational roles (8, 3).

The overriding commonality among these roles is their meaning as vehicles for social involvement and productive participation. Socialization involves the learning and processing of social data and of
tions the individual learned to perform occupationally; how the individual learned to approach tasks and role expectations; and when, if ever, the individual was more competent than he or she now appears. The instrument that Moorhead developed as a result of occupational history taking on more than 100 psychiatric outpatients at the UCLA Neuropsychiatric Institute (NPI) is a semistructured or focused interview where the investigator knows in advance the general areas to be covered and suggests questions that might elicit the pertinent information. The advantage of this method is that it allows for free exploration and probing of experiences. The disadvantages lie in the difficulty in data analysis. Also, this instrument requires 1 to 2 hours to administer, which, in acute care settings, can be a disadvantage.

Moorhead published a report in 1969 that included the variables critical to occupational function, the basic focus of data analysis, and a case illustration (3).

Need for Screening. During the past 10 years, psychiatric hospitalization has gradually telescoped and become focused on acute care. The average length of stay for adult inpatients at the NPI has diminished from 60 to 20 days or less. Since discharge is planned on admission, each discipline must quickly and succinctly assess the patient from its professional perspective. An occupational therapy evaluation of the person’s current function: with respect to decision making, problem solving, time management, and so on, is one way to ascertain how the disease process impacts on functional ability, but it does not give a perspective on acquired clusters of skills not currently observable. A screening device was needed to quickly identify and classify critical information in two major areas: 1. patterns of skills and achievement or patterns of dysfunction in past and current occupational role, and 2. the degree of balance or imbalance between leisure activities and those activities associated with occupational role.

Information from this screening provides important input to the treatment team because it is based on occupational role history, not on diagnosis. In an acute care facility, as symptoms of the disease process subside with therapy and medication, the team often assumes that patients are ready and able to resume an occupational role. It is the occupational therapists’ assessment that provides clues about whether or not a patient possesses or has ever had clusters of skills necessary for resuming or assuming an occupational role.

Development of a Screening Device. Based upon the five previously stated assumptions and the overall format of Moorhead’s occupational history, a set of questions targeted toward taking a brief life history of occupational role was developed. The designated life stage of patients ranging from young adulthood to middle adulthood influenced the development of questions. Choice of this age range was based on two propositions for understanding human development.

The first was Reilly’s proposition of “count-down-before-up” (25). This suggests that older, advanced models of behavior be used as guides for determining the direction of younger developmental periods. The second proposition specifies that later developmental periods are influenced by inputs from earlier stages (15). Middle adulthood seemed to be the right life stage from which one not only could look
ahead to future life stages that require a shifting emphasis of roles—for example, the retiree—but also could look backward to an earlier period for formulation of skills and experiences necessary for assuming competency in future roles.

In addition to the usual collection of demographic data of age, sex, marital status, educational level and diagnosis, questions pinpoint the following areas of information:

1. Sequence and continuity of occupational roles and components thereof, e.g., role models, duties.
2. Ability to identify satisfaction and dissatisfaction with interests, people, tasks, environments.
3. Simultaneous occupational roles and expressed comfort, satisfaction, and competence in each.
4. Areas of skill and problem areas.
5. Degree of balance between work, chores, and leisure activities. See Table 1 for Occupational Role Screening Interview.

Administration Guidelines. Like Moorhead’s format, a semistructured or focused interview is used with the patient as informant. Thus the questions in the Occupational Role Screening Interview are used as a guide and allow the interviewer to add and delete questions during the interview process at his or her discretion.

It is requisite that the occupational therapist interviewers be experienced and trained with this screening device and knowledgeable about the occupational behavior frame of reference.

The occupational role history interview culminates with immediate recommendations for the patient’s occupational therapy program. The results of the interview as well as the treatment recommendations are im-

Table 1

<table>
<thead>
<tr>
<th>Occupational Role Screening Interview</th>
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<tbody>
<tr>
<td><strong>NAME</strong></td>
</tr>
<tr>
<td><strong>DEMOGRAPHIC DATA:</strong></td>
</tr>
</tbody>
</table>

Worker/Homemaker
1. What is your current occupation?
2. How/why did you choose this occupation?
3. What kind of tasks does it include?
4. How did you learn the daily routine?
5. What do you like about what you are doing?
6. What do you dislike about what you are doing?
7. What are you good at?
8. What are your problem areas?
9. How many other jobs/occupations have you had?
   a. What were they?
   b. How did you go about getting them?
   c. What was your longest job?
   d. What was your favorite job and why?
10. Is there anyone you admire or want to be like, now and in the past?
11. What kind of work do your parents do?
12. Did your parents have any influence on your choice of occupation?
13. When do you do your chores?
14. How do you spend your leisure time?
15. What do you do for fun?
16. Do you have any hobbies?
17. What interests would you like to explore?
18. Do you have any close friends? How often do you see them?
19. What do you do together?
20. What was the best period in your life? What was happening then?
21. What was the worst period in your life? What was happening then?
22. What would you like to be doing a year from now?
23. How will you go about doing that?

School
(College/High School)
1. What school(s) did you go to?
2. How did you do in school?
3. What did you like about school?
4. What didn’t you like about school?
5. What were you good at in school?
6. What were your problem areas?
7. What did you major in? How did you decide on that major?
8. Who did you admire during that period? Why?
9. Did you have any favorite teachers?
10. What kinds of things did you do for fun?
11. Where did you live during that time?
mediately communicated to the occupational therapists responsible for implementing the patient’s overall treatment.

**Interpretation of Data.** Information yielded from this screening tool can be categorized according to two dimensions: role status and balance.

Role status is determined on the basis of the quality of performance over time. Role status criteria were determined as follows:

1. **Functional:** those patients whose pattern of skills and achievement were present and in good order in past and current occupational role.

2. **Temporarily impaired:** those patients whose occupational role skills were evident in the past, but by their report were currently disorganized or disrupted, therefore needing intervention.

3. **Dysfunctional:** those patients whose patterns of skills were only sporadically evident in the past and were disorganized both in past and current occupational role, therefore needing intervention.

### Table 2
**Demographic Data**

<table>
<thead>
<tr>
<th>Age</th>
<th>Sex</th>
<th>Marital Status</th>
<th>Educational Level</th>
<th>Diagnosis</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range: 18-57</td>
<td>Male: 9</td>
<td>Single .... 12</td>
<td>High School Only .... 3</td>
<td>Bi-Polar ......... 7</td>
<td>Worker .............. 6</td>
</tr>
<tr>
<td>Mean: 31</td>
<td>Female: 11</td>
<td>Married .... 5</td>
<td>Some College .... 11</td>
<td>Depression ......... 3</td>
<td>Student .............. 7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Divorced .... 3</td>
<td>Completed College .... 3</td>
<td>Conversion Hysteria .... 1</td>
<td>Homemaker .............. 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Post-College .... 3</td>
<td>Schizophrenia ......... 3</td>
<td>Homemaker/Student ........ 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Attention Dysfunction .... 1</td>
<td>Homemaker/Worker ........ 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Paranoid ......... 1</td>
<td>Unspecified ........ 1</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Acute Psychosis ......... 3</td>
<td>Anorexia Nervosa ......... 1</td>
</tr>
</tbody>
</table>

### Table 3
**Case Vignettes—Role Status in Good Order—Functional**

<table>
<thead>
<tr>
<th>Role History</th>
<th>Role Status</th>
<th>Balance</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case: J.W., Black, married, 57-year-old female, bi-polar, depressed</td>
<td>Ongoing leisure pattern</td>
<td>Counsel regarding “Empty Nest Syndrome” and continued involvement in community activities</td>
<td></td>
</tr>
<tr>
<td>No current problems as homemaker/mother of 20-year-old son residing in home at this time but planning to move out</td>
<td>Continuous satisfaction in homemaker/mother roles</td>
<td>Maintain existing skills</td>
<td></td>
</tr>
<tr>
<td>Continuous work and/or volunteer history</td>
<td>Continuous college record</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuous high school record</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Role History</th>
<th>Role Status</th>
<th>Balance</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case: L.S., Black, single, 30-year-old female, bipolar, depressed</td>
<td>Functional</td>
<td>Expose to new interests</td>
<td></td>
</tr>
<tr>
<td>No problem as worker (Attorney for 5 years)</td>
<td>Continuous satisfaction in student role in high school and college</td>
<td>Re-involvement in old interests</td>
<td></td>
</tr>
</tbody>
</table>
In determining the degree of balance or imbalance between leisure activities and those associated with occupational role, the criterion is whether an individual identified any interests, hobbies, and activities that he or she did on a consistent basis separate from occupational role activities.

Reliability and predictive validity of the screening tool are in the process of being established.

The Pilot Study

The pilot study of the occupational role history involved the following components.

Subjects: Twenty adult male and female inpatients were selected at random as subjects for the pilot study by the two occupational therapists working on the two adult inpatient units at the UCLA NPI, a 162-bed psychiatric hospital. The subjects do not represent a statistical sampling of psychiatric patients in general nor of the NPI in particular. Their diagnostic categories include a preponderance of bipolar disorders since these are the research interest of one of the ward psychiatrists. Neither do the subjects represent a uniform sampling of major occupational roles for this life stage. Demographic data of the 20 patients appear in Table 2.

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As a general rule of procedure, all questions in Table I were asked of patients in the worker and homemaker roles. If the patient was a student, initial questions pertained to the student role, then proceeded to questions about summer or part-time work experiences, and leisure activities.

Results
The screening instrument worked as expected and was effective in enabling the investigators to categorize patients along two dimensions: 1. status of occupational role function, and 2. balance or imbalance between occupational and leisure activities. Of the 20 patients screened, 8 were determined to be occupationally in good order, or functional; 6 temporarily impaired; and 6 dysfunctional in occupational role. Six patients were classified as having a balance between occupational and leisure activities, whereas 14 patients were classified as having an imbalance.

Based on the information derived from screening, red flag areas for immediate occupational therapy intervention were identified as well as areas that might be at future risk.

Six case vignettes are presented in Tables 3, 4, and 5 to illustrate the process and rationale for categorization as well as to identify the red flag areas for occupational therapy treatment intervention. Categorization includes role history, role status, and balance between occupational and leisure activities, as well as areas for treatment intervention.

As a result of this history taking, unanticipated findings were

<table>
<thead>
<tr>
<th>Case Vignettes—Role Status Is Dysfunctional</th>
<th>Role History</th>
<th>Role Status</th>
<th>Balance</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case: M.K., Caucasian, single, 18-year-old male, attention deficit with drug abuse</td>
<td>Current problems “hang out until 21”</td>
<td>Dysfunctional</td>
<td>No pattern of work or productive participation</td>
<td>Develop steps for attending and completing a task</td>
</tr>
<tr>
<td></td>
<td>Poor 2-month military function</td>
<td></td>
<td></td>
<td>Begin exploring occupational choice process</td>
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<td></td>
<td>Part-time sporadic work</td>
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<tr>
<td></td>
<td>Unable to finish high school, did complete equivalent examination</td>
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<tr>
<td></td>
<td>No satisfaction in schooling</td>
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</tr>
<tr>
<td>Case: J.F., Caucasian, single, 24-year-old male, bi-polar, manic</td>
<td>Current problems in student role</td>
<td>Dysfunctional</td>
<td>Some leisure interests</td>
<td>Develop progressive levels for attending to a task</td>
</tr>
<tr>
<td></td>
<td>Seven years sporadic attendance at four colleges</td>
<td></td>
<td>No current pattern of productive participation</td>
<td>Explore potential for roles other than the student role</td>
</tr>
<tr>
<td></td>
<td>Poor performance and no satisfaction in student role—high school and grammar school—“Couldn’t sit still”</td>
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</table>
gleaned. One was the overall lack of close friends currently and historically among even the most functional patients. The importance of a confidant in the social support system of the elderly makes this a critical area for examination in adolescence and early childhood.

A second finding was that the historical review evoked the salutary effects of past successes and achievements and was therefore beneficial in the face of present circumstances. On the other hand, for one young man, the historical review was painful because it focused sharply on repeated patterns of failure.

A further finding was related to the fact that each patient's medical chart reflected primarily a history of symptomatology and family relationships with the exception of the patient's current occupational role. Information of past skills in occupational roles was lacking. The Lazare position that history taking and treatment intervention are obtained from the conceptual model used was empirically evident in the NPI setting.

Conclusion

The current Diagnostic and Statistical Manual of Mental Disorders (Third Edition) (DSM III) includes "Highest Level of Adaptive Functioning Past Year" as part of evaluation (26, p 5). According to DSM III "Adaptive function is a composite of three major areas: social relations, occupational functioning and use of leisure time." (26, p 28) Social relations include all relationships with people, especially family and friends.

Occupational functioning refers to functioning as a worker, student, or homemaker. Use of leisure time includes recreational activities or hobbies. Levels of adaptive functioning range from superior through grossly impaired and are based on the patient's highest level of performance for at least 3 months during the past year. The DSM III presumes that, generally, an individual returns to his or her former level of adaptive functioning following an episode of illness. Although the inclusion of adaptive functioning as part of diagnostic criteria is of tremendous significance, it does not go far enough. It fails to acknowledge the developmental nature of skill acquisition and transition throughout the life cycle.

Occupational therapists contribute to the treatment team vital historical information concerning an individual's past and present experiences in occupational role and in understanding how the disease process, family, and personal/sexual role may impact on occupational function. This unique occupational therapy focus allows a broader view of patients, beyond diagnostic entities and role in family membership, to include the important dimension of occupational role function.

Acknowledgment

This article was based on a presentation at the 1981 Annual Conference of The American Occupational Therapy Association, San Antonio, Texas.

REFERENCES