the future there will be increasing emphasis on empirically supported therapies (ESTs) in our field and REBT in its specific form will fail to meet the criteria of an EST. Indeed, REBT is not even mentioned in Lydon and Jones’s (2001) edited text on the empirically supported cognitive therapies. There are no academic centers of excellence where the empirical study of REBT is being conducted and as I noted in a previous section there is no well-validated therapist adherence or competency scale to determine that REBT will be correctly and competently delivered in any future efficacy studies.

Having said that, I do think that REBT's ideas will continue to be incorporated into generic CBT and will have their impact in future psychological education programs to which they are particularly suited. As such, REBT concepts will be alive and well but perhaps not under the rubric of REBT. Whether future authors acknowledge REBT as their source is debatable. But as Ellis reminds us, if this does not happen, it would be bad, but it would not be awful.

REFERENCES


Rehabilitation Psychology

Timothy R. Elliott and Warren T. Jackson

Keywords: physical disability, rehabilitation, counseling, cognitive-behavioral therapy

The rate of permanent disability has increased steadily over the years, accompanying the aging of our population, increasing rates of survival from severe physical trauma, and the precipitous rise of debilitating, incurable chronic disease. Considerable evidence attests that people who possess adaptive social-cognitive characteristics typically experience a more optimal adjustment following disability than persons who have deficits in these characteristics (for a comprehensive overview on this field, see Frank & Elliott, 2000). These characteristics are essential in adhering to self-care regimens, preventing further complications and enhancing quality of life. CBT has great potential in promoting adjustment, well-being, and personal health among persons with disabling conditions. Cognitive-behavioral interventions are the most promising and widely accepted treatments in rehabilitation psychology.

Thus, the great variety of patient and family needs in rehabilitation and community settings provides a wonderful opportunity for application of virtually all CBT approaches: behavior management, learning theory as it applies to didactics and patient education, cognitive techniques that inform psychoeducational interventions, and empirically supported CBT protocols for specific disorders and adjustment difficulties. In rehabilitation settings, CBT may be conceptualized in its broadest form.

VARIED APPLICATIONS

Types of Injury/Illness

The successful practitioner of CBT must have familiarity with all of the different disorders that are commonly encountered in various rehabilitation settings. Disorders may be classified as central neurologic (stroke, head trauma), peripheral neurologic (spinal cord injury, Guillain-Barré syndrome), orthopedic (fractures, joint replacements), medical (major surgery, chronic metabolic illness), psychiatric (schizophrenia, mental retardation), and combined. Substance use disorders are considered elsewhere in this volume; however, they are certainly prevalent in rehabilitation settings (alcohol abuse, therapeutic dependence on pain medication) and often these disorders contribute to the onset of a disability and to the development of preventable secondary complications following disability (e.g., ER visits, infections, skin ulcers).

Treatment Settings

There has been a definite trend over the past 15 years for rehabilitation resources to be reallocated from the traditional inpatient postacute setting to outpatient and home-based programs. In addition, new initiatives such as telehealth approaches are being developed to augment
ongoing treatment after discharge from acute and postacute treatment facilities and return to the community. Individuals may qualify for educational and/or vocational assistance from state or private agencies that will then participate in the rehabilitation process. CBT is applicable in inpatient settings when there are numerous treating professionals present and after their return to the community, when individuals may live independently or receive assistance from family members or home health therapists.

INTERDISCIPLINARY TREATMENT CONTEXT

In hospitals and other rehabilitation settings, practitioners of CBT will almost always be working with an interdisciplinary team. Depending on the particular setting, teams will generally include some combination of the following disciplines: physiatrists (physicians specializing in rehabilitation medicine) and psychiatrists; consulting physicians such as neurologists, orthopedists, internists, and others; nurses; physical therapists (PT); occupational therapists (OT); speech therapists; social workers; and vocational rehabilitation specialists. CBT is most potent in such practice environments when the practitioner formally communicates to other team members about the specific behaviors targeted for intervention during team meetings and is available for informal consultation with other staff members during the therapy week. Often, the practitioner will work very closely with nursing staff, PT, OT, and speech therapy when implementing behavioral management plans. A good working relationship with these disciplines is necessary for proper implementation of interventions.

CAVEATS FOR MODIFYING CBT PROTOCOLS

A major challenge to applying CBT in rehabilitation settings relates to the cognitive and physical difficulties experienced by patients. Modifying protocolized CBT is a skill that must be developed so that the unique capabilities of the patient are accounted for without sacrificing the empirical foundation of CBT. When dealing with patients with cognitive impairment or physical discomforts, it is generally recommended that the practitioner focus intervention on a limited domain of material and use repetition and written aids to promote learning and generalization. Hibbard, Grober, Gordon and Aletta (1990) offer a set of practical adaptations of CBT to compensate for cognitive deficits. In a recent volume edited by Radnitz (2000), the specifics of CBT as it applies to a variety of disabilities are presented: spinal cord injury, amputation, pain-related musculoskeletal disorders, chronic illness, cognitive impairment, visual and hearing impairment, autism, mental retardation, learning disabilities, and communication disorders.

ROLE OF COGNITIVE-BEHAVIORAL ASSESSMENT

Effective CBT begins with sound assessment of well-operationalized target behaviors, a definition of environmental antecedents, and determination of consequences that maintain the behavior as well as discovery of patient cognitions about self, others, and the world that moderate behavior. The data-based approach of CBT is quite compatible with the workings of the interdisciplinary treatment team as assessment information can be used for diagnosis, treatment planning, and outcome evaluation.

ACUTE CARE AND REHABILITATION SETTINGS

It is generally accepted that what defines a treatment setting as "acute" is the medical status of the patients in it rather than some characteristic of the facility. Thus, patients in an acute care setting are medically unstable and likely to experience rapid changes in status. The NICU and medical stabilization floors are good examples of acute care settings. Patients at this level are not able to tolerate several hours of therapy. Rather, the patient takes part in bedside rehabilitative therapy in an effort to minimize the effects of physical deconditioning so that the transition to formal rehabilitation is as smooth as possible. Upon medical stabilization, patients are transferred to a rehabilitation setting. Such environments take many forms, ranging from highly medicalized centers attached to large tertiary care hospitals to freestanding outpatient clinics that may provide a broad range of services to a general patient population (e.g., PT clinic) or specialty services to a particular patient population (e.g., chronic pain treatment).

It is essential that the practitioner conduct sensitive and thorough assessment of patient characteristics as soon as possible in the medical setting. A variety of behavioral disturbances may be observed soon after admission; yet these should be interpreted within the context of the admitting diagnosis and the behavioral patterns and level of personal adjustment that predate the admission. It is crucial to identify behavioral patterns that can complicate adjustment and compromise rehabilitation efforts and find areas that should be targeted in subsequent CBT.

Many individuals who acquire disabilities in high-impact incidents, for example, often have alcohol abuse problems that contributed to the accident. Others may have demonstrable problems with impulsivity and poor social judgment. Individuals who require surgical repairs for
skin-related breakdowns accompanying diabetes or paralysis may have avoidant tendencies. Some individuals may have experienced traumas that placed them at risk for anxiety problems. For example, Koch and Taylor (1995) provide an excellent review of the psychological sequelae associated with motor vehicle crashes: posttraumatic stress disorder, depression, pain-related conditions, and phobic avoidance of stimuli associated with the accident. The authors emphasize the importance of assessing the nature and subjective meaning of the accident and examining the functional relationships between physical injuries and emotional disorders. Treatment issues include selecting the appropriate CBT interventions, determining the proper sequence of application, and managing complications such as litigation and medication adherence.

In the rehabilitation setting one of the most important functions of CBT is to help the patient optimize his or her therapy participation by increasing the frequency of behaviors that are therapeutically on-task and decreasing the frequency of therapy-competing behaviors. Contemporary behavioral strategies eschew use of aversive stimuli and punishment. Rather, focus is now on differential reinforcement of other (DRO) behavior whereby reinforcement is provided when the patient fails to perform a problem behavior during a specific time interval. The Premack principle is also applicable. Herein, a naturally occurring high-frequency response (e.g., resting quietly on exercise mat) reinforces a lower-frequency target response (e.g., participating in uncomfortable passive range-of-motion exercises). McGlynn (1990) offers an excellent critical review of behavioral approaches to neuropsychological rehabilitation pertaining to six categories of target behavior: inappropriate social behavior, attention and motivation, unawareness of deficits, memory, language and speech, and motor disturbance.

Inpatient rehabilitation programs often offer some form of patient and family education, but participants' educational needs persist long after their return to the community. Problems with attention, motivation, pain, and subjective stress may hinder education. Team members often refer patients with problems that disrupt therapeutic agendas (e.g., inappropriate interpersonal behaviors, pronounced mood disturbance) for psychological interventions. Individualized CBT may be employed to address these issues; brief, strategic interventions are more likely to be useful and valued by patient and staff (e.g., motivational interviewing, relaxation training, problem-solving skills training). Interventions that compete with required treatment hours in PT and OT may conflict with team goals, and patients may have difficulty appreciating these interventions at the expense of prescribed rehabilitation therapies. CBT groups in the inpatient setting may be more time-efficient in delivering a manualized protocol (e.g., assertiveness training, coping skills training), but participants might not share a sense of cohesion and individual needs may be neglected. Groups may be particularly helpful in normalizing individual experiences and fostering recognition and interest in CBT as a treatment option following discharge.

COMMUNITY-RESIDING INDIVIDUALS

Individuals and families who live with chronic disease and disability have more influence on their health status than any single health service provider. In most conditions, secondary complications and declines in health and personal adjustment are mediated by behavioral and social pathways. Therefore, psychological and social issues must be successfully navigated in some fashion—with or without professional assistance—to attain optimal adjustment following disability.

Vocational Rehabilitation

Traditionally, many persons with disability have received support from state vocational rehabilitation (VR) agencies, mandated by the federal government to assist qualified persons to return to gainful employment or other meaningful activity (for an overview, see Elliott & Leung, in press). Work and other related activity is associated with greater well-being and personal health among persons with disability. CBT is often integrated in VR programs to promote work adjustment. Although many technologies are relevant to this enterprise, supported employment strategies utilize low-cost counselors to teach clients relevant work skills and behaviors, and then maximize generalizability by shadowing clients following job placement to provide feedback and supervision on-site. This support slowly tapered off over time. Several clinical trials document the efficacy of supported employment in successfully increasing the employability of persons with a variety of disabilities including traumatic brain injury, mental retardation, and psychiatric disorders (Elliott & Leung, in press).

Other effective VR programs have been developed in multidisciplinary chronic pain rehabilitation programs that feature rigorous work hardening exercises complemented by CBT in individual and group formats. Although VR has often been synonymous with state agencies, recent legislation (e.g., the Ticket to Work and the Work Incentive programs) provides greater incentive and opportunities for CBT practitioners to participate in helping persons with disabilities return to work (Elliott & Leung, in press).
Individual Adjustment and Well-Being

In outpatient clinics and mental health centers, practically any CBT can be modified and applied for use in individual and group formats with community-residing persons with disability. There are situations in which individual CBT may be preferred over group interventions. For example, individualized CBT for depressed persons with multiple sclerosis may be more effective than group interventions because the practitioner can tailor strategies to the unique needs of the progressively degenerative symptoms experienced by the individual (Mohr, Boudewyn, Goodkin, Bostrom, & Epstein, 2001). However, assertion and other interpersonal skills may be best taught in group formats (Gleeckauf & Quitter, 1992). These skills have long been recognized as essential in navigating tense interpersonal encounters and in managing the debilitating social stigma associated with visible disability. Social skills training is associated with greater well-being, mobility, and acceptance of disability among clients (Gleeckauf & Quitter, 1992). In all of these circumstances, CBT is more likely to be successful when it is designed to meet the needs and problems as perceived and experienced by the client.

Similarly, practitioners of CBT should be familiar with overarching social issues that impede personal adjustment. Advocates have developed disability-affirmative therapy to help individuals find meaning in their circumstances, develop personal goals in the face of stigma and discrimination, and facilitate rewarding significant relationships with others based on acceptance and understanding (Olkin, 1999). Although clinical trials of this approach have yet to be conducted, disability-affirmative therapy clearly embraces the basic tenets of CBT and may be applicable to persons with considerable capacity for insight and learning.

Family Adjustment

Many persons with severe disability return to communities that lack resources for independent living, or their needs are such that a family member must assist daily in their self-care, health promotion, and activities of living. This can be a protracted career for some family members. Individuals who incur a severe disability in young adulthood may have a normal life expectancy and require the assistance of an unpaid family caregiver. Social problem-solving training has been successfully adapted and provided to family caregivers of stroke survivors in telephone sessions (Grant, Elliott, Weaver, Bartolucci, & Giger, 2002). In this study—the only clinical trial to date in this area—family caregivers receiving CBT reported less depression and greater satisfaction with services over time than persons assigned to the control groups. CBT can be delivered in the home with long-distance technologies, circumventing problems with transportation and mobility, and increasing generalizability of the intervention.

See also: Clinical health psychology

REFERENCES


Relapse Prevention

Frederick Rotgers

Keywords: addiction, relapse, relapse prevention, substance abuse

Mark Twain, the smoker, was a chronic relapper who quipped, with no little irony, "to cease smoking is the easiest thing I ever did. I ought to know because I've done it a thousand times." The maintenance of behavior change following treatment of substance use disorders has been one of the major conundrums in the addictions treatment field.

Although methods to support changes in substance use or other so-called appetitive behavioral problems (problems...