Psychologists and Rehabilitation

New Roles and Old Training Models

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ABSTRACT. The role of psychologists in physical rehabilitation settings has expanded considerably over the past decades. Unfortunately, the lack of clarity regarding roles, functions, and research of psychologists in inpatient and outpatient rehabilitation settings has hampered efforts to establish guidelines for training graduate students to work in rehabilitative settings. Despite ongoing debate since the Princeton Conference in 1958, no guidelines have been recommended by Division 22 of the American Psychological Association (Division of Rehabilitation Psychology) for training doctoral students in clinical and counseling psychology programs for work in rehabilitation. This article asserts that psychology graduate students who want to work in physical rehabilitation settings should (a) have core training in psychology and (b) receive coursework and practica in working with persons who have chronic illnesses and injuries.

The number of psychologists interested in the rehabilitation of individuals with physical disabilities and chronic physical disorders has continued to grow since the mid-1900s. The formation of Division 22 (Division of Rehabilitation Psychology) of the American Psychological Association (APA) in 1958 served to formalize psychologists' interest in this area of specialization. Unfortunately, the broad philosophical scope of this division has hindered the development of guidelines for training graduate students for work in physical medicine and rehabilitation settings. The more recent emergence of other specialty areas concerned with the application of psychological principles in health-care settings (e.g., behavioral medicine and health psychology) has obfuscated directives for training in rehabilitation. Current doctoral training programs in clinical and counseling psychology are in a position to meet the increasing demands for psychologists who are skilled in rehabilitation. In this article, we address the preparation of doctoral-level psychologists for future work in rehabilitation and propose that such training should begin with prerequisite core training in psychology, both experimental and applied. In addition, specialized training that emphasizes competent psychological practice with persons who have health-related disorders and disabilities in health-care settings should be provided. The appropriateness and quality of this specialized training is not dependent on the specialty area's designation (e.g., health psychology, behavioral medicine, neuropsychology, or rehabilitation psychology), but rather on the content of the curricula and practica experiences.

Definitive Problems in Rehabilitation

Persons attending the organizing conference of Division 22, held in Princeton in 1958, struggled to define the overall philosophy of rehabilitation and did not dictate specific standards for graduate training. Participants argued that rehabilitation did not constitute a separate specialty, that the current doctoral training in psychology was sufficient given practicum experience in rehabilitative settings, and that exposure to field-theory concepts was crucial to understanding the social-psychological situation of those with disabilities (Wright, 1959).

Shontz and Wright (1980), in an attempt to distinguish rehabilitation psychology from the emerging specialties of health psychology and behavioral medicine, maintained that students should be trained in the principles, values, theories, history, and social psychology of persons with disabilities as originally defined in the Princeton conference (Dembo, Diller, Gordon, Leviton, & Sherr, 1973). Eisenberg and Jansen (1983) believed that rehabilitation psychologists are more sensitive than other psychologists to the role of the environment (e.g., architectural barriers) in an individual's psychological adjustment following disability. Leung (1984, pp. 22–24) stated that students should be trained in the unique aspects of rehabilitation, the psychological situation of those with disabilities, assessment, and intervention. However, others (e.g., Grzesiak, 1981) have specifically questioned requisite training in traditional rehabilitation “values” (cf. Wright, 1972) as necessary for competent work in assessment and intervention. Furthermore, the exclusive reliance on a field-theory perspective of behavioral problems following physical disability de-emphasizes pre-injury behavioral patterns (e.g., substance abuse, social adjustment pre-injury, or impulsivity) that have major implications for subsequent psychological and medical adjustment.

The supposed boundaries that separate rehabilitation from health psychology have confused many who have invested in training, research, and delivery of services. Attempts to delineate the unique aspects of these specialties have basically examined philosophical, historical, and semantic differences, without attending to the
commonalities shared by these specialties in routine practice in health care settings. Traditionally, the role of psychologists involved in the rehabilitation of persons with chronic physical disorders was limited to intelligence and personality assessment (Grzesiak, 1979). For many years, the role of psychology in rehabilitation was thought to apply strictly to vocational rehabilitation and not the psychological aspects of rehabilitation in general (Olshansky & Hart, 1967). Those psychologists who have been involved with the social-psychological and policy issues related to those with disabilities have made significant contributions to the field of rehabilitation (Elliott & Byrd, 1986; Yuker, 1988). Focus on the psychosocial aspects of disability does not adequately prepare students for the clinical aspects of psychological practice in rehabilitation. It is clear that many psychologists in rehabilitation prefer to work with those who have chronic illness and physically disabling conditions (Caplan, 1987). Psychologists in rehabilitation most often provide individual assessment and therapy (Jansen & Fulcher, 1982) and specialized services such as biofeedback therapy and neuropsychological assessment (Eisenberg & Jansen, 1987). Unfortunately, although the range of services provided by psychologists in rehabilitation settings has expanded, the effort to develop guidelines for training psychologists to work in these settings has stagnated.

The Necessity of Core Training in Psychology

Several psychologists in the field of rehabilitation have commented that this specialty “seemed isolated from the mainstream of psychology” (Jansen & Eisenberg, 1982, p. 3), and this predicament was due in part to the publication of articles in nonpsychological journals stating that there was a need for psychologists in rehabilitation (Shontz & Wright, 1980, p. 92). Some authors have argued that these articles distinguish rehabilitation psychology from psychology as a whole (Leung, 1984; Shontz & Wright, 1980).

Rehabilitation has been an interdisciplinary enterprise since its inception. Professionals in rehabilitation counseling, occupational therapy, social work, physical therapy, special education, psychology, psychiatry, physical therapy, and orthopedic medicine have collaborated for decades in the physical rehabilitation of persons with acquired disabilities. Of these disciplines, rehabilitation counseling is most clearly aligned with psychology, and many founding and present members of Division 22 have earned doctorates in rehabilitation counseling (Jansen & Fulcher, 1982; Neff, 1971). This important, vital discipline has accomplished much in the delivery of psychological services to those with physical disabilities. However, these programs do not provide training in the core, fundamental areas of psychology. Within the field of rehabilitation, some have tried to meet the increasing demands for psychologists by advocating and offering doctoral programs in rehabilitation counseling psychology and rehabilitation psychology. The extent to which these supply core training in the broad foundation areas in psychology is unknown and probably highly variable.

Ideally, core training in psychology provides a historical and theoretical basis for all psychology. Core training for APA-approved programs in clinical and counseling psychology typically encompasses coursework in biological bases of behavior, cognitive-affective bases of behavior, social bases of behavior, and individual behavior (APA, 1980). Core training in these areas is an absolute necessity for providing future psychologists with historical and theoretical foundations for service, research, and professional identity. Many topics in experimental psychology have much to offer in understanding clinical problems in rehabilitation. Social psychology has assumed an influential role in the research conducted in health-related behaviors (Elliott et al., 1988). Study in group dynamics may prove to be most beneficial for appreciating the complex psychosocial aspects of health-care settings.

Basic competencies in, and knowledge of, issues related to therapeutic strategies, assessment, development, personality, cross-cultural issues, and behavioral disorders are necessary for the delivery of services in any setting. Training in these core areas provides graduates with identity in the field as a whole, rather than in a specialized interest area. It is the task of the graduate to extend existing theory and perspectives into special areas of research and service. Solid grounding in the science of psychology provides for adaptation and flexibility in the rapidly changing health care system. Fundamental training in core competencies in therapeutic and research skills is common in APA-approved clinical and counseling psychology programs. The quality of this type of instruction in rehabilitation-specific programs outside accredited psychology programs is unknown.

Although rehabilitation research and practice may have appeared to be “out of the mainstream” in some respects, many effective and impressive interventions have been well-grounded in basic and advanced theories of learning (e.g., behavioral methods in chronic pain rehabilitation; Fordyce, 1976). Other topics germane to rehabilitation may have suffered from the lack of application of contemporary psychological theories. Many areas in rehabilitation—such as the study of clinical problems like depression and the development of programs designed to change attitudes toward persons with disabilities—have relied heavily on traditional approaches and concepts at the expense of contemporary psychological theories (Elliott & Byrd, 1986; Frank, Elliott, Corcoran, & Wonderlich, 1987). The lack of theory-based interventions and research in some areas of rehabilitation may stem from the lack of appropriately trained psychologists interested in rehabilitation. As the demand for psychologists in rehabilitation has dramatically increased, the lack of psychologists to meet this demand has likely forced many agencies to hire mental health professionals from programs other than psychology to fill these positions.
The Need for Specialized Training

Grzesiak (1979) noted "that psychological services to the physically disabled do not differ in any substantial way from services provided to patients or clients in other settings" (p. 511). The basic competencies and skills important to the work of psychologists in behavioral medicine and health psychology are applicable to rehabilitation. Competencies that are common to these specialties include therapy and assessment with medical patients, consultation with health-care staff regarding patient behavior, and multidisciplinary in-the-field research to understand clinical problems. Of the 41 PhD programs listed in the recently released Directory of Training Opportunities in Behavioral Medicine (Society of Behavioral Medicine, 1988) virtually all include patient populations and training opportunities that overlap with those included in Caplan's (1987) Rehabilitation Psychology Desk Reference (e.g., chronic pain, neurological injury/disease, and chronic illness). It is unfortunate that although there is a great deal of communication between the specialty areas of behavioral medicine and health psychology, rehabilitation psychology has remained relatively distant from these emerging specialty areas. Training students to work in rehabilitation settings clearly can, and is, being accomplished outside the few programs that offer training in traditional rehabilitation psychology. The following specific recommendations could be implemented in any psychology program preparing students to work in health-care settings.

Assessment

Students need to be trained in techniques and issues related to the assessment of intelligence, personality, environmental and situational factors, and brain–behavior relationships of persons who have chronic injuries and illnesses. Strategies for adapting traditional assessment procedures for those who have the mobility and sensory impairments should be thoroughly explored in graduate work. Students should be familiar with the difficulty of assessing behavioral problems that may interact with somatic aspects of the disability, such as depression following spinal cord injury or rheumatoid arthritis. Because rehabilitation demands interdisciplinary collaboration, students should be exposed to common measures of outcome, such as patient activities of daily living. In addition, students should be trained to assess health status variables that have behavioral components (e.g., urinary tract infections or decubitus ulcers). Other vital areas include neuropsychological assessment, brain–behavior relationships, and ability to consult with health-care staff regarding patient motivation, personality, vocational concerns, and behavior change. Behavioral assessment is necessary in the rehabilitation of many individuals with physically disabling conditions. It is imperative that students have the ability to assess conditions that can accompany the acquisition of traumatic injury in high-impact accidents, such as substance abuse and closed head injuries. Students should be capable of conceptualizing disability and adjustment from adult development perspectives. The assessment of family dynamics and behaviors in response to the disability of a family member may be essential to understanding behavioral problems in rehabilitation.

Therapeutic Strategies

Several techniques are employed by psychologists in rehabilitation, including behavioral interventions (Ince, 1980) and biofeedback (Eisenberg & Jansen, 1987). Assessment and treatment strategies are interdependent; competent implementation of biofeedback techniques presumes a solid grounding in psychophysiological assessment (Sturgis & Gramling, 1988). Techniques are often adapted for use with clinical populations, such as hypnosis with pain syndromes. Behavioral strategies are most often incorporated in structuring rehabilitation programs for specific problems, such as chronic pain (Fordyce, 1976), traumatic head injuries (Prigatano, 1986), and spinal-cord injuries (Ince, 1980). Students should learn to develop interventions to address each individual patient's experience of stressful incidents that may occur during and following rehabilitation. Too often, professionals have assumed that a disability or chronic illness is the primary and overriding source of stress in a person's life and have failed to attend to the subjective experience of stressors unique to the person and the situation.

Increasingly, more attention is being given to the need to work with families and couples in rehabilitation. Spouse behavior is often entwined with problematic patient behavior. Many persons report unsatisfying marital relationships and distress after injury (Brooks, Campsie, Symington, Beattie, & McKinlay, 1987), and satisfying significant relationships are vital to social functioning following disability. Sexual counseling is also important for these patients following their injuries. Training in family intervention skills is therefore crucial.

Group therapy skills are also important. Interpersonal group therapy has been used successfully with individuals in head-injury rehabilitation (Prigatano, 1986) and with others who have chronic medical conditions (Roback, 1984). Structured, psychoeducational training groups are useful in patient, staff, and family education. This efficacious format has been successfully used to train those with acquired disabilities in interpersonal skills to expedite social integration and adjustment (Dunn, Van Horn, & Herman, 1981).

Consultation

Psychologists are routinely asked for advice regarding patient behavior, and such questions can include a range of issues stemming from adherence to treatment regimens, behavioral disturbances, vocational potential, motivation, and family concerns. Students need to learn how to communicate effectively with peers, health professionals, family members, and patients. Students must learn to view such problems from many perspectives, given the complex psychosocial environment that envelops those who are stigmatized and in health-care settings. For ex-
ample, many issues stem from tense patient–staff and between-discipline interactions in chronic care units. Psychologists may consult individually with certain staff members or develop psychoeducational interventions for staff. Psychologists must also be prepared to interact with a wide variety of other professionals who occupy important roles in the rehabilitation process, namely, insurance representatives, lawyers, and agents from different social service and educational agencies. In these interactions, psychologists are often in difficult positions, at times advocating on behalf of the patient, and at other times defending staff decisions and treatment plans. Some psychologists may serve with legal systems in the capacity of an expert witness on vocational issues. In all consultative roles, the psychologist will encounter complex ethical issues that may tax the traditional core study in the ethics of psychological practice and research. Further study of ethical issues related to health care may be necessary.

Rehabilitation-Specific Training

The suggested curricula noted earlier can be acquired in most applied programs offering specialized training in behavioral medicine or health psychology. All of the specialized skills described earlier build on basic competencies learned in coursework in assessment, therapy, behavioral disorders, and psychopharmacology. In addition, it will be helpful for a student to be exposed to historical trends and issues in rehabilitation, and this training should include readings in influential publications and outlets in rehabilitation, behavioral medicine, and health psychology (Elliott et al., 1988; Elliott & Byrd, 1986). These readings provide a general introduction to past contributions, traditional problems, and points of divergence and convergence in these specialty areas. Advanced practica experiences can further hone the students skills with rehabilitation populations. These advanced experiences should expose students to a wide variety of medical populations and settings. Ideally, training experiences in these medical settings will familiarize the student with the protocol and customs common in health-care systems. More advanced training with a narrower range of populations (e.g., head injury rehabilitation) should be reserved for the internship and postdoctoral experiences.

Concluding Remarks

In retrospect, it appears that the original recommendations of the Princeton conference were of some value. We concur that rehabilitation does not constitute a separate specialty apart from clinical or counseling psychology. Current doctoral training in APA-approved applied programs is sufficient for training psychologists to work in physical rehabilitation settings, given appropriate practica, internship, and coursework experience in the application of psychological principles in health-care settings with persons who have chronic illness and injury. However, the implementation of these recommendations has been impeded by the tendency of many in rehabilitation to separate from mainstream psychological theory, education, and research. The field of rehabilitation will benefit from the influx of psychologists with a strong identity and commitment to the science and practice of psychology.

REFERENCES