Rehabilitation Psychology

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Rehabilitation psychology is committed to the development and application of psychological knowledge and services to promote the health and well-being of individuals who live with disabling conditions. The specialty has been historically linked with institutions that serve individuals who have disabling conditions (including hospitals, schools, universities, nonprofit organizations, and federal and state agencies). Rehabilitation psychologists, therefore, have actively participated in multidisciplinary service and research endeavors, program development and evaluation, administration, policy formation, advocacy, and training. Rehabilitation psychology was originally construed to serve those who encounter “deprivation and disability” that devalued their role in society in any fashion (including institutionalization, racism, poverty, older age, and chronic disease; Dembo, Diller, Gordon, Leviton, & Sherr, 1973, p. 719). However, the specialty is typically associated with the provision of psychological expertise on behalf of persons with congenital or acquired physical, neuromuscular, and developmental disabilities.

Historical Context and Development

Many psychologists, educators, and counselors responded to federal legislation to assist workers injured in the early twentieth century during the industrialization of the American working environment. The general thrust of this legislation and accompanying programs was directed toward compensating injured workers who could not return to their jobs, and to study work-related accidents to determine
preventative measures. These efforts were complimented and expanded by legislation to assist soldiers injured in World War I and World War II. Legislation following World War II, in particular, was highly influential in addressing the psychological issues of personnel who incurred permanent disabilities.

These policies and programs addressed the psychological, vocational, educational and medical issues germane to the individual who had acquired a disability. Rehabilitation psychology gained prominence at this time, and psychologists inspired by Lewinian field theory were influential. Beatrice Wright and Tamara Dembo recognized the environmental and social factors that defined and characterized disability. Collaborating with other invested colleagues (including many notable social, clinical and counseling psychologists of the day), they received support from federal agencies and the American Psychological Association to convene and define the initial parameters of rehabilitation psychology.

Theoretical Foundations

Wright and Dembo advanced the premise that behavior associated with disability was best understood within the classic Lewinian equation, $b = f(p \times e)$. From this perspective, psychologists were to appreciate how characteristics of everyday situations impose disability vis-à-vis architectural barriers, negative and stereotypic attitudes, limited access, and lack of information. These factors limit opportunities and options and prompt behavioral reactions that are invariably interpreted by observers in a negative fashion and attributed to the presence of the disability. Wright furthered this perspective in the classic Physical Disability: A Psychological Approach in 1960, in which core "strengths" of rehabilitation psychology were proposed. These strengths – including somatopsychological relation, individuation, the insider-outsider distinction, and the recognition of assets – perpetuated the value of recognizing the individual (rather than the "diagnosis" of a disability), and an appreciation for abilities and assets of the individual and the need to identify personal goals of the individual. Wright also augmented these strengths with an explicit delineation of values inherent in rehabilitation psychology research and practice. Thus, the roots of rehabilitation psychology orient the field toward examining the strengths of individuals with disability and growth toward personal goals.

Growth and Evolution

The growth of rehabilitation psychology was stimulated by counselors who advanced vocational rehabilitation, by social psychologists who studied the mechanisms associated with stigma, and by psychologists who provided clinical services in medical settings to individuals who had incurred physical and neuromuscular disabilities. Rehabilitation psychologists seized the initiative to develop appropriate norms and psychometric properties of many psychological instruments that were
otherwise unsuitable for use with individuals with sensory or physical limitations. Wilbert Fordyce relied on an operant perspective to understand further how environmental factors can shape and reinforce “disabled behavior” and behavioral strategies were successfully integrated in rehabilitation programs for persons with chronic pain conditions. Other psychologists used behavioral paradigms to understand psychophysiological processes that could be targeted in self-regulation strategies for persons with disabilities (e.g., biofeedback). More contemporary research has demonstrated the utility of cognitive-behavioral processes in the prediction of adjustment, health and well-being of individuals with disabilities. Cognitive-behavioral strategies are often utilized by rehabilitation psychologists. Rehabilitation psychologists have worked in federally-funded collaborative studies that mandate data-sharing across medical institutions to further understanding of the health and social needs of people with severe yet low-incidence disabilities. These systems have played a pivotal role in measuring and predicting the quality of life for individuals with these conditions.

Issues and Problems

The early pioneers of rehabilitation psychology envisioned a broad scope for the field that could accommodate psychologists from various psychological specialties. The emphasis on shared core values and beliefs, as espoused in the influential works of Wright and Dembo, were deemed central to the field. As opportunities grew in the clinical rehabilitation setting substantially in the recent decades, the job demands were met by psychologists with backgrounds in clinical health psychology and neuropsychology who had little exposure to the field theory perspectives of Wright and Dembo. Clinicians achieved a great milestone when the American Board of Professional Psychology recognized rehabilitation psychology as a board specialty. With this specialization, however, the possible gaps between problem-oriented practice – a long-standing target of rehabilitation psychology pioneers – and the values of disability rights community may have widened. In an influential body of work, Olkin and colleagues decried the relegation of disability issues to the realm of rehabilitation psychology (as a specialty discipline perceived to be wedded to a traditional medical model), and urged professional psychology to recognize disability issues as a matter of diversity that should be addressed in every APA-accredited training program. This view, which is largely informed by scholarship (and activism) associated with the interdisciplinary field of disability studies, has also advocated an affirmation approach to counseling with individuals with disabilities. The basic principles of affirmation therapy recall many of the original values of Wright and Dembo.

Current health care service delivery systems and shrinking federal and state budgets have placed considerable financial restrictions on rehabilitation therapies, generally. Consequently, interventions that have demonstrated effectiveness but are labor-intensive – such as supported employment techniques (which uses on-site
job coaches to return persons with severe disabilities to work) and constraint-induced movement therapy (which features physical therapies to enhance motor function to limbs affected by stroke) – encounter difficulty in receiving reimbursement for services.

**Future Directions in Practice and Research**

Contemporary trends in health and health service delivery provide many unique opportunities for the advancement of rehabilitation psychology values and principles. For the first time in the history of the United States, over 45% of the population now lives with a chronic health condition (and other estimates place this figure over 50%). The health and well-being of individuals with these conditions are ultimately determined by behavioral and social mechanisms that are addressed in rehabilitation psychology. Moreover, the primary model for understanding chronic conditions advanced by the World Health Organization – the International Classification of Functioning, Disability, and Health (ICF; WHO) – defines disability by the environmental and social factors that limit ability and impose limitations in a fashion consonant with the original ideals promoted by the founders of rehabilitation psychology. The ICF de-emphasizes the explanatory utility of a medical diagnosis, and compliments alternative service models that promote independent living, improved access to institutions, and improved role functioning and mobility to reduce disability across the dimensions in the WHO model.

To promote the health and well-being of community-residing persons with disability, it is essential to form collaborative partnerships between these individuals and health service providers so that appropriate community-based services and ongoing access to information and support are available (and this will likely include an increased use of long-distance technologies to circumvent mobility problems). A greater emphasis is now placed on health promotion programs for individuals with disability. Similarly, the effective and strategic provision and usage of assistive devices and enhanced computer technologies to improve function will involve rehabilitation principles; virtual reality technologies may very well expand rehabilitation therapies to individuals who might otherwise have restricted access to traditional therapies (in-home mobility, driver training).

Theory-driven psychological research continues to inform interdisciplinary practice; behavioral neuroscience now demonstrates that physical therapies may work in informed, concentrated ways to improve function and mobility, and possible neural growth. Contemporary models now acknowledge the essential and subjective role of the individual in a manner that can accommodate the study of other assets and character strengths. To demonstrate the effectiveness of novel interventions and services, researchers will have to find ways to integrate qualitative measures in mixed-model designs, and the current emphasis on randomized clinical trials may be frustrated by the real-life difficulties of recruiting sufficient numbers of individuals with low-incidence disabilities while minimizing volunteer bias.
Relaxation

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Relaxation, a state of rest, recreation, and restoration, is vital to emotional, physical, and intellectual health. Individuals who are accomplished at relaxation are masters of the mind-body connection. They are able to promote health, mental acuity, and positive affect through highly personal and satisfying activities or states of being. Being relaxed is not an optional human condition. It is crucial to life and without the most universal form of relaxation, sleep, a person becomes at first tired and cranky, then unable to concentrate or make good decisions, and finally will evolve into a psychotic state. Relaxation is not only a personal value but also a cultural one. Psychologists are actively involved with the creation and maintenance of relaxed states through their clinical work.

Physiological Relaxation

The human heart knows relaxation. If our heads followed the heart muscle's pattern of total contraction followed by total relaxation, there might be fewer stress-