Defining Our Common Ground to Reach New Horizons

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ABSTRACT. There are 4 broad propositions concerning behavioral science that rehabilitation psychology shares with other applied branches of psychology: (a) rehabilitation psychology research is science, (b) rehabilitation psychology research is part of a larger effort to understand human behavior, (c) practice grounded in rehabilitation psychology research is designed to alleviate human suffering and promote well-being, and (d) all scientific tools are acceptable in these quests. A model encompassing the major elements in rehabilitation research and practice is presented, and several gaps in the current knowledge base are delineated. Implications and remedies for these gaps, and for changes in professional alliances and role definitions, are discussed so that the field can pursue a consumer-based, empirically driven health care service delivery agenda for persons with chronic disease and disability.

The Division of Rehabilitation Psychology has always been a loose confederacy of rehabilitation counselors, educators, vocational specialists, advocates, con-
sumers, and psychologists representing clinical, counseling, educational, and social psychology. I was reminded of this fact recently as I reviewed our membership roster and read the different work settings listed by members. Less obvious is the historical backdrop and ongoing evolution of our specialty. At its inception many social psychologists worked with vocational rehabilitation counselors and advocates. Few today would know that Richard Lazarus—perhaps the premier stress and coping theorist of the past two decades—served on a work group for the division at the 1960 Miami conference on research in the psychosocial aspects of rehabilitation (Lofquist, 1960). Today, however, our membership has shifted such that over 48% of our membership identifies primarily with neuropsychology and as many as 30% work in independent practice.

Our diversity in professional identity and accompanying perspectives sometimes strains our sense of shared purpose and perhaps constrains our ability to forge a coherent professional agenda to advance and promote the division. In part, this may be symptomatic of a larger trend within professional psychology, in that the field has “fractured into scientifically trivial subareas, such as treatment approaches, syndromal categories, or treatment groups” (Hayes, 1997, p. 520). More than one respected colleague has confided to me within the past year that at times they have doubted their identity as a rehabilitation psychologist because their particular training, their work setting, and their areas of interests do not routinely appear in our journal and newsletter articles.

It is critical that we review the ties that bind us together, because together in our society we witness fundamental alterations in health service delivery that have direct effects on the health and well-being of the people we serve. Additionally, these changes compel us to consider the ways in which our profession, too, is evolving, in the wake of the challenges, cutbacks, and new opportunities. In many ways, as we have stated in previous writings (cf. Frank & Elliott, 2000), rehabilitation psychology has reason to be more optimistic than other psychological specialties: We have a long history of consumer advocacy and involvement, multidisciplinary collaboration, activity in public and health policy, and research partnerships with federal and state funding agencies.

Ideally, identifying elements of common ground can serve to bring our diverse groups together so that we can strive toward a shared vision. It is my purpose, then, to review several key and basic principles that define our common ground and then examine gaps in our knowledge base and the opportunities these may have for a shared vision.

**PROPOSITIONS**

By definition, rehabilitation psychology is an applied extension of the larger domain of psychology. We are unique in that psychology, at its historical and philosophical core, is a behavioral science. Many other disciplines offer some kind of mental health service, broadly defined (thus contributing to the glut of service providers in this area; Frank & Ross, 1995), but psychology has a vibrant
and rich scholarly, scientific base. The degree to which individuals actually adhere to this base and its principles varies widely for all sorts of reasons, but it is this heritage that distinguishes psychology and psychologists from many other professions in mental health.

Our work in rehabilitation settings, then, shares several assumptions Forsyth and Strong (1986) found germane to the scientific study of psychotherapy. For my purposes, the propositions they articulated can be reworded in this fashion: (a) rehabilitation psychology research is science; (b) rehabilitation psychology research is part of a larger effort to understand human behavior; (c) practice grounded in rehabilitation research is part of a larger effort to alleviate suffering and promote well-being; and (d) all scientific tools are acceptable in the quest to better understand adjustment, health, and well-being among consumers of health care delivery systems, generally, and rehabilitative services, specifically.

These propositions, like the ones Forsyth and Strong (1986) proposed, are open to discussion and debate. But they are certainly congruent with our heritage: The reciprocal nature between the extant psychological research and rehabilitation psychology was stated explicitly at the 1958 Princeton conference (Wright, 1959). From my perspective, these propositions serve as directional and interpretive guidelines from which we can view our research and practice. To elaborate further, it will be helpful to consider a conceptualization of adjustment developed in our critique of this literature in working toward a positive psychology of disability (Elliott, Kurylo, & Rivera, 2002; Elliott & Rivera, in press). In this conceptualization, adjustment following disability is a dynamic and fluid process in which characteristics of the person and the injury, their social and interpersonal world, the environment in general, and the historical and temporal context interact to influence physical and psychological health.

As depicted in Figure 1, adjustment is influenced by several factors (see left side of the figure). Individual differences that influence adjustment include demographic characteristics, disability-specific characteristics, predisability behavioral patterns, preinjury psychopathology, and personality constructs. The social–environmental domain can be operationalized in terms of social supports and societal barriers, family relationships and caregiver–care recipient interactions, and environmental factors that promote or impede independence, mobility, and integration.

These influence the phenomenological and appraisal processes that constitute elements of adjustment and, in turn, predict psychological and physical health outcomes (see far right side of the figure). The centerpiece of our model is the highly subjective ways in which people exercise control over their internal states with a variety of self-regulatory processes. These are active social–cognitive behaviors that involve personal goals and aspirations and the interference and disruption of their pursuit. It also involves cognitive activity associated with negative outcomes such as ruminations, the cognitive “undoing” of events, and assignments of blame that appear to distract or deplete energy necessary for more positively valenced processes. Cognitive activity associated with optimal adjust-
ment in this component is often conveyed in constructions of personal meaning and purpose, positive side-benefits and growth, and value shifts.

These components are framed within the developmental continuum that flows left to right (see bottom of the figure). The dynamic continuum encompasses changes in any of the aforementioned five areas as people age, as technologies advance, as relationships shift, and as health and public policies evolve. This continuum reflects the ongoing process of growth, adaptation, and development in the person and the environment, and in corresponding alterations in interactions between these entities.

Rehabilitation psychology has long embraced the Lewinian field-theory perspective to understand behavior within the $B = f(P,E)$ equation (Dunn, 2000). However, aspects of this equation receive different emphasis from stakeholders, depending on their perspective. For example, physicians place greater emphasis on the nature and concomitants of a specific condition, and this is evident in the medical rehabilitation literature. Psychologists and other rehabilitation professionals tend to place greater weight on the person (Wright & Fletcher, 1982). Consumers and their advocates are much more sensitive to the demands and

![Figure 1. Model for understanding adjustment following disability. From “Positive Growth Following Acquired Physical Disability,” by T. Elliott, M. Kurylo, & P. Rivera, in C. R. Snyder and S. Lopez (Eds.), Handbook of Positive Psychology, 2002, p. 690, New York: Oxford University Press. Copyright 2001 by Oxford University Press. Reprinted with permission.](image-url)
issues centered in the environment in which any behavior is framed (Olkin, 1999). These groups represent essential stakeholders in any program of care and service, and the critical distinctions between these areas of emphasis ultimately reflect their opinions regarding future service and intervention. Thus, medical professionals are concerned about continued support for medical advancements, treatments, and management of disability; consumers and advocates are invested in rectifying social barriers that impede full access and integration, and they support the availability and provision of assistive technologies to enhance independence and quality of life.

In reviewing the adjustment literature, I made several compelling observations. Consistent with the propositions borrowed from Forsyth and Strong (1986), the extant literature indicates that constructs and variables grounded in established psychological theories and associated research apply to persons receiving rehabilitative services, regardless of physical health conditions, with very few (and extreme) exceptions. Stated differently, the concepts and characteristics that predict adjustment among people in general also predict adjustment among persons with physical disabilities and other chronic health conditions. Indeed, rehabilitation psychology has excelled in practical applications of otherwise esoteric, “academic” theories to the understanding and alleviation of problems encountered in the clinical setting, including applications of Lewian field theory (Dembo, Leviton, & Wright, 1956), operant behavioral principles (Fordyce, 1976), psychophysiology (Ince, 1980), and behavioral neuroscience (Taub & Uswatte, 2000).

GAPS IN OUR KNOWLEDGE BASE

Unfortunately, in developing this conceptualization and considering implications for a positive psychology of adjustment following disability, and in claiming our common ground in rehabilitation psychology, I identified several pertinent issues that temper the lofty ideals embedded in the propositions stated earlier.

First, our research and practice is problem-centered and problem-oriented. Despite exhortations by Beatrice Wright throughout the years (Wright, 1988; Wright & Fletcher, 1982), our work has become increasingly dependent on the detection and resolution of problems as defined by our training and service institutions. Consequently, we must reconsider ways in which we can understand optimal adjustment, well-being, happiness, and life satisfaction among the people we serve. To a certain extent, this bias has been interpreted by some as a professional embrace of a medical model of behavior (Olkin, 1999). In my cynical moments, I suspect that—much like other vested members of the health care provider community—we have a pecuniary interest in the detection of serviceable (i.e., reimbursable) problems (Kaplan, 1994, 1996). I have long believed that applied psychologists are handicapped in identifying resources and positive attributes as a result of the clear slant in our training and practice in the
assessment of problematic behavior (Wright & Fletcher, 1982). We owe a great debt to our colleagues in social psychology for leading the scientific study of happiness, personal fulfillment, life satisfaction, and meaning (Myers & Diener, 1995). There are several projects now underway to rectify this imbalance in our literature. Yet I harbor grave concerns that, as Stephen Hayes has observed, we have “been far too committed to the . . . psychotherapy office and the 50-minute hour” (Hayes, 1997, p. 522) to the extent that colleagues who pursue this line of research will be eventually undone by incredulous looks and questions that will sound something like, “So, how can I bill for that?” “How does this help me in the real world?” and “Then, what good is it?”

Second, we do not understand the phenomenological and appraisal processes that effect change and promote adjustment. Despite the fact that this factor is the centerpiece of our model, this component remains the proverbial “black box” in which constructs and variables enter and exit on the other side significantly correlated with indices of adjustment (Elliott et al., 2002). We have yet to determine what kinds of value shifts occur following disability, how and why these occur, and their relationship to a sense of acceptance and well-being (Keany & Glueckauf, 1993). Consequently, when positive changes occur for an individual, we do not know why. To understand the cognitive–behavioral mechanisms underlying optimal adjustment—and the precursors of such processes—it is imperative that we develop and use qualitative devices that are sensitive to the perceptions and beliefs through which people find meaning rather than despair following disability. In some cases, procedures such as content analyses are being used to capture this elusive information (King & Patterson, 2000; King, Scollon, Ramsey, & Williams, 2000).

Relatedly, it is instructive to note that appraisal processes are typically better predictors of adjustment than are objective measures of stress (Lazarus & Folkman, 1984). It is critical that we understand the unique problems and concerns that consumers face as they experience and identify them. Too often problems are identified by health care providers in a “top-down” fashion to serve the interests of the institution or to chain an individual’s personal experience to a researcher’s Procrustean bed of theory and group means (Shewchuk & Elliott, 2000). Effective program and policy development for persons with disabilities and their families may be realized when these people are recognized as experts on their service needs, and they can exercise an element of choice, control, and direction in the delivery of services (Kosciulek, 2000).

Generally, individuals have great capacity for making choices and participating in decisions about treatment options in a manner that meets their own personal priorities (Auerbach, 2000). We already know that when people are able to set their personal goals for rehabilitation and attain them, interventions are more effective (Glueckauf & Quittner, 1992; Webb & Glueckauf, 1994). Consumers and their family care providers have many ideas about helpful solutions to address their needs, and many of these can be provided in a cost-effective fashion in the community and in the home (Elliott & Shewchuk, in press). We also know, however, that changes in medical rehabilitation have radically cir-
cumscribed consumer input in treatment planning and goal setting; moreover, we do not routinely solicit consumer input in any systematic or useable fashion.

I should emphasize that I am not advocating some blanket statement for consumer involvement, nor I am deferring to some postmodern tenet that “knowledge without experience is suspect.” I respect the intentions of innovative attempts to formalize consumer input at administrative levels of research and practice. I am concerned that we have often capitulated scientific rigor and critical thinking when we acquiesce to criticisms of insensitivity and irrelevance. Consumers, advocates, and colleagues would all be better served if we respectfully yet critically evaluated such feedback and found ways to empirically distill the information we apparently need with the expert use of available techniques.

In the original propositions, I noted that all tools are important and available to us in the pursuit of science. Therefore, I am advocating for the innovative and sophisticated use of qualitative assessment devices that will help us understand the experience, needs, and solutions perceived by consumers, so that we can provide these individuals with the programs, services, and supports they identify as useful in their daily lives. In our research program, we have learned that problems and concerns associated with chronic health conditions are complex and multifaceted, and even family members differ considerably in their perceptions of problems and their solutions (Elliott & Shewchuk, in press). Qualitative methods can be used to help people identify, articulate, and prioritize the problems they encounter in ways that can help us develop programs to address needs that may not be readily apparent to consumers (Kurylo, Elliott, & Shewchuk, 2001; Shewchuk, O’Connor, Fottler, & Trinh, 2001).

Furthermore, my stance is reflective of a larger migration in health care away from a paternalistic system to one that is based on a “participatory ethic” (Mechanic, 1998, p. 283). Such a shift is reflective of the changing demographics of an aging yet highly educated society (Mechanic, 1998). It also reflects the needs of the increasing number of persons with chronic health conditions in our society in which a considerable life span can be expected. In these scenarios, collaborative partnerships are sought in part because social and behavioral mechanisms may have greater influence on quality of life and daily health than the activity of any single service provider (Israel, Schulz, Parker, & Becker, 1998; Kaplan, 1999; Lengnick-Hall, 1995). The degree to which policymakers and the general public would support partnership models is essentially unknown, however. Therefore, evidence of cost-effectiveness and utility of consumer-driven health care programs must be obtained and communicated by those who have the skill and expertise to conduct such work.

Third, things change. A fundamental facet of our model is its dynamic element, exemplified by changes in public and health policy, in the availability of new assistive technologies and devices, and in medical and educational advances. Some of the changes are not positive: We have all experienced the erosion of support, reimbursement, and emphasis in formal rehabilitation programs at all levels of health care. Many of these changes have redefined our roles.

We can view the dynamic element of our model as providing us with potential
opportunities for positive growth and influence. For example, there are many new statistical tools available that permit us to understand changes within individuals over time, and these multilevel modeling techniques can provide information that can have an immense impact on program development and evaluation. Combined with qualitative information acquired with increased consumer input—as many of these tools are designed to handle dichotomous and ordinal data—we will soon be able to understand who responds best to what and why, who is at risk, and who responds optimally regardless of treatment options. These new tools help us understand individual rates of change unencumbered by group averages. Notably, several of our colleagues have seized the initiative in demonstrating the interpretive impact of these tools (Clay, Wood, Frank, Hagglund, & Johnson, 1995; Frank et al., 1998; Warschausky, Kay, & Kewman, 2001). The potential of these techniques is such that within 10 years the use of grouped mean comparisons to analyze change will be obsolete and antiquated. We can soon have predictive models that supply us with rich, enlightening information about individual responses to traditional and innovative programs throughout health care.

IMPLICATIONS: WORKING TOWARD A SHARED VISION AND NEW HORIZONS

If we are to advocate for a science-based, consumer-driven health care system, we will be most effective if we wield our skills in behavioral science at the individual, institutional, and societal levels of decision-making, where resources are allocated and dispersed (Elliott & Klapow, 1997; Elliott & Shewchuk, 1996). I see several immediate and practical implications of these propositions and the corresponding gaps that exist in our current level of knowledge.

As I have written elsewhere (e.g., Elliott, 1994), it is imperative that we stay grounded in our scientific heritage and current in our use of available theories, techniques, and technologies. We must use sophisticated qualitative devices commensurate with our training and expertise to better understand the people we serve, so we can expedite consumer-driven and relevant health care delivery programs. We can use this information with advanced multilevel techniques to help us learn who responds optimally to various services, and this information can be used to assist decisions about resource allocations at all levels of health and public policy.

When Mother Nature speaks to us, however, we must be prepared to listen. Science wields an aimless blade. Good theories are egalitarian, and data well-gathered should be unbiased. If we ask consumers and their families what they want, and study what works best, we may find that people respond well to occasional telephone contacts with a nurse (Grant, Elliott, Bartolucci, & Giger, 2001). They may benefit from booster sessions provided via an Internet connection with a low-cost provider at the other end. And they may prefer these activities over face time with one of us in our office. We may find that consumers
who do not want to actively participate in health care decision making—or who consistently make ineffectual choices about service options—may be the ones who require the attention of high-cost service providers. If we can help people live healthy and happy lives at home and in the community, will we be ready to redefine our practice roles, and what changes might occur for our institutions that we support?

It is imperative that we initiate collaborative partnerships with consumers to develop relevant supports and health care programs. It is a bitter irony that other disciplines are recognized as champions of consumer-driven health care and models of shared decision-making. Perhaps we grew complacent with our template of rehabilitation goals stamped out by treatment teams for every admitted inpatient and with the obligatory statement of career interests written down on state forms in every vocational rehabilitation office. In reality, inpatients have very little choice about the therapeutic goals set in the negotiations between administration and third-party payers, and local labor market opportunities and declining and variable state budgets typically dictate vocational options.

Nevertheless, effective programs need to be developed that address the needs and problems identified by the people who live with them, so that these individuals can become more active and independent in their own self-management and operate competently as stakeholders in their own health care (Wagner, Austin, & Von Korff, 1996). Perhaps a more incisive question posed by Auerbach (2000) concerns the study of outcomes in which consumers are given treatment options in health care programs with definite trade-offs, taking into account individual differences so we can determine cost-effectiveness of collaborative decision-making. Clinical trials of this sort will have to contend with the conundrum presented by consumers who are rather comfortable with a paternalistic system, who injudiciously regard their personal health, or who present with a lack of financial, personal, and social resources.

It is essential that we continue our efforts to attract, mentor, and support the next generation of researchers in our field. Many of us mentor junior colleagues in the enterprise of grantsmanship, but I wonder if at times we are less attuned to the new and creative perspectives that many of these colleagues bring to us. Theory-driven research that advances our knowledge of human behavior while simultaneously addressing the challenges and issues facing health care can be particularly influential. But in the early stages of pilot study this kind of research is unlikely to be attractive to granting sources, and it is simply not unusual for consumers to see little relevance in the early applications of many theories. It is incumbent on us as senior colleagues to nurture and support novel, innovative thinking: New problems and new tools can yield tremendous benefits to our knowledge base, and “dreaming up ways to test theories . . . is a creative act” (Strong, 1991, p. 207).

We will not solve the problems we face by “plowing over the old fields.” Creative solutions will necessitate strategic risks and critical assessment of existing systems that may not welcome innovative partnerships. I am personally convinced that any health care system that places first priority on keeping
inpatient beds occupied and preserving fee-for-service models of care will not reward or support those working toward science-based, consumer-driven health care programs. Those who think “outside the box” may very well have to relocate. Certain professional alliances we now have may prove confining, and some may find more promising collaborations with colleagues in public and community health in developing community-based, consumer-oriented programs.

The times, the opportunities, and the problems we face require creative acts. The great diversity we have in our division provides us with a rich intellectual foundation from which we can share ideas and cross-fertilize between many areas of psychology. In this fashion, then, our diversity and our heritage provide us with resilience, strength, and hope for creative solutions to meet current and future challenges.

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