Rehabilitation Psychology
2016, Vol. 61, No. 1, 1–6

0090-5550/16/$12.00 http://dx.doi.org/10.1037/rep0000082

COMMENTARY

The Foundational Principles as Psychological Lodestars: Theoretical Inspiration and Empirical Direction in Rehabilitation Psychology

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Historically, the Foundational Principles articulated by Wright (1983) and others guided theory development, research and scholarship, and practice in rehabilitation psychology. In recent decades, these principles have become more implicit and less explicit or expressive in the writings and work of rehabilitation professionals. We believe that the Foundational Principles are essential lodestars for working with people with disabilities that can guide inquiry, practice, and service. To introduce this special issues, this commentary identifies and defines key Foundational Principles, including, for example, Lewin's (1935) person–environment relation, adjustment to disability, the malleability of self-perceptions of bodily states, and the importance of promoting dignity for people with disabilities. We then consider the role the Foundational Principles play in the articles appearing in this special issue. We close by considering some new principles and their potential utility in rehabilitation settings. Readers in rehabilitation psychology and aligned areas (e.g., social–personality psychology, health psychology, rehabilitation therapist, psychiatry, and nursing) are encouraged to consider how the Foundational Principles underlie and can shape their research and practice.

Keywords: adjustment to disability, foundational principles, person–environment relation, psychosocial assets, value-laden principles

A lodestar is something, or someone, that provides guidance or inspiration, particularly to a group of people. The term is an apt one for our "Foundational Principles", based on Beatrice Wright's (1983) and other leader's classic works, which guide the empirical research, theory, and practice in rehabilitation psychology. Rehabilitation psychology is concerned with the psychological, biological, social, environmental, and political factors that influence the lives and well-being of people with disabilities or chronic health conditions. The goal of this article is to review these Foundational Principles and their importance to science and practice to provide a framework for the articles that comprise this special section of *Rehabilitation Psychology.*

Why dedicate a special section to the Foundational Principles? The primary reason is concern among members of the rehabilitation psychology community that the importance and utility of the Principles is being overlooked as the discipline advances. New and future rehabilitation psychologists may be unaware of the Principles and the rich empirical, theoretical, and practice heritage they represent. As evidence, consider Ryan and Tree's (2004) survey of the American Board of Professional Psychology Diplomates in rehabilitation psychology regarding the field's essential list of books. Of the 167 books listed, only six met the study's inclusion criteria and were endorsed by 20% of the respondents. None of these books appeared before 1987, nor did any explicitly emphasize the Foundational Principles, though one, the *Handbook of Rehabilitation Psychology* edited by Frank and Elliott (2000), did allude to the Principles and related constructs within some chapters (see also Frank, Caplan, & Rosenthal, 2010).

Notably absent from the list was Wright's (1983) *Physical Disability: A Psychosocial Approach,* a classic text that specifically advocated for the Foundational Principles in research, educational, and practice settings (see also Dunn & Elliott, 2005). Indeed, Wright (1972) also championed what are known as the value-laden beliefs and principles for rehabilitation psychology, which were designed to aid researchers and practitioners as they work on behalf of clients with disabilities and their families (the 20 beliefs and principles also appear in Wright, 1983).

We believe that this is a propitious time for rehabilitation psychologists to revisit the Foundational Principles and to consider whether they can inform theory development, research, education, and practice now, in the 21st century. In fact, it is quite possible

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that other principles have emerged as rehabilitation psychology has grown as a subfield. If so, these heretofore-implicit principles should be made explicit and added to those that represent the best theoretical and clinical traditions of rehabilitation psychology. Further, by highlighting the Principles, we hope to provide a resource for those colleagues who work in rehabilitation sciences, disability studies, health services research, and health policy. We now turn to the Foundational Principles.

Leveraging the Foundational Principles

As the subfield's lodestars, the Foundational Principles are meant to represent more than an abstract or aspirational philosophy. Instead, rehabilitation professionals should consciously and intentionally rely on them in research, practice, and therapeutic settings, doing so to achieve the most favorable outcomes for clients or colleagues with disabilities or other chronic health conditions. Table 1 lists the core Foundational Principles of rehabilitation psychology, each of which will be reviewed in turn.

The Person–Environment Relation

Social psychologist Kurt Lewin's (1935) seminal contribution to the larger discipline was to recognize that numerous factors in social situations routinely override the impact of person factors, including personality or other dispositional variables. Lewin (1948/1997) pointed out that the ways that people perceive their social and physical environments (also referred to as the *situation*) has a decided influence on both their behavior and subjective experiences. Although both personal and situational factors are important independently, Lewin (1935) posited that the interaction between the two is actually what produces behavior. Lewin (1935) offered a quasi-mathematical formula to explain his view: $B = f$ (P, E), or behavior is a function of the person and his or her perceived environment.

Lewin's students, including Tamara Dembo and Beatrice Wright, among others, applied the person–environment relation broadly to the arena of disability. Consider someone with a physical disability who uses a wheelchair to navigate daily life. This individual likely frequently confronts barriers in building (lack of ramps outside, or elevators inside, older structures) and obstacles in the environment (missing curb cuts, uneven sections of sidewalk) that impede her speed, progress, and even access to places she needs to be. As the person in the situation, she knows that it is not her disability that affects her behavior—it is the situation in which she sometimes finds herself, one generally designed for able-bodied individuals rather than one with a universal design that will accommodate persons both with and without a disability.

At the same time, a casual observer might see this same woman in the wheelchair struggle to gain entry to a building. Instead of attributing her challenge to the situation, the observer is likely to assume the problem lies within her, as a result of her disability. As social psychologists construe it (e.g., Jones & Nisbett, 1971), actors (here, the woman in the wheelchair) look to the situation to explain their behavior ("There is no accessible entry here, so how am I going to get inside?"), whereas observers (the casual onlooker) focus on the actor ("She must really be unhappy or even angry; that disability must hold her back all the time"), thereby neglecting to consider the impact of various factors literally present in the environment. Indeed, the observer is apt to explain the actor's behavior by appealing to internal or even dispositional factors, rather than the external or situational ones that are largely responsible. When observers identify dispositions as being more powerful than the situation in their attributed explanations for others' behavior, they fall prey to the social psychological bias known as the *fundamental attribution error* (Ross, 1977).

For their part, rehabilitation psychologists have long recognized that the person–environment relation is a Foundational Principle that can be used to constructively consider and shape the opportunities for people with disabilities. It is conceptually linked to the next Principle, the insider–outsider distinction.

The Insider–outsider Distinction

Attributionally speaking, we know that behavior engulfs the field of perception, so that observers routinely attribute the origin for behavior to the person rather than the situation. Dembo (1902–1993) added a further attributional concept related to both the person–environment relation and the actor–observer effect. Specifically, Dembo (1964, 1970, 1982) drew a distinction between

Table 1
Foundational Principles of Rehabilitation Psychology

Principle	Definition
The Person–Environment Relation	Attributions about people with disabilities tend to focus on presumed dispositional rather than available situational characteristics. Environmental constraints usually matter more than personality factors to living with a disability.
The Insider–Outsider Distinction	People with disabilities (*insiders*) know what life with a chronic condition is like (e.g., sometimes challenging but usually manageable) whereas casual observers (*outsiders*) who lack relevant experience presume that disability is defining, all encompassing, and decidedly negative.
Adjustment to Disability	Coping with a disability or chronic illness is an ongoing dynamic process, one dependent on making constructive changes to the social and the physical environment.
Psychosocial Assets	People with disabilities possess or can acquire personal or psychological qualities that can ameliorate challenges posed by disability and also enrich daily living.
Self-Perception of Bodily States	Experience of bodily states (e.g., pain, fatigue, distress) is based on people's perceptions of the phenomena, not exclusively the actual sensations. Changing attitudes, expectations, or environmental conditions can constructively alter perceptions.
Human Dignity	Regardless of the source or severity of a disability or chronic health condition, all people deserve respect, encouragement, and to be treated with dignity.

individuals who have a disability or who receive some rehabilitation therapy (a group she termed *insiders*) and nondisabled observers (or *outsiders*) who imagine what a disability or some rehabilitation experience must be like. The insider–outsider distinction is important because outsiders often assume what a disability, whether congenital or acquired, *must be like*—and they frequently conclude that it is not only negative and disruptive to daily living but also defining for the individual with the disability. Disability, then, is not considered to be *one* quality among the myriad qualities of a person's life; rather it is presumed to be an—and perhaps *the*—ongoing preoccupation for him or her. In contrast, insiders know what the experience of being disabled is like, that its presence does not necessarily predict (let alone preclude) quality of life or well-being. Instead, disability is one among many qualities of life (e.g., mental health, stress, physical health, career, hobbies, role in the home or community; Duggan & Dijkers, 2001) that becomes a focus of the affected individual only when it is made salient by others (outsiders) or situational constraints. In point of fact, a disability can be part of a person's identity, which means it is a positive rather than a negative quality (e.g., Dunn, 2015).

As part of their training, rehabilitation psychologists learn not to *essentialize* disability, that is, to see a physical, cognitive, emotional, or other disability as the defining or essential feature of a person. Simply put, the presence of a disability should not be used to categorize people so that this one feature supersedes all other aspects of an individual (Bloom, 2010; Dunn, Fisher, & Beard, 2013). If a disability did override all other aspects of the person, then adjusting to it would hardly seem possible.

Adjustment to Disability

When crafting psychosocial terms to refer to how newly disabled people cope with their conditions, rehabilitation psychology strives to be specific. The term *adaptation,* for example, entails how people with acquired disabilities understand and how the psychological and physical changes are gradually integrated into their identities, body images, and daily living. Adaptation, then, is an active somatopsychological process experienced by those with acute disabilities as they move toward an idealized state known as *adjustment* (Livneh & Antonak, 1997; Smedana, Bakken-Gillen, & Dalton, 2009). Adjustment, in turn, occurs once individuals are satisfied with and accepting of their own person–environment relations, so that any physical or psychological losses or changes do not represent preoccupations (however, this perspective is not shared universally; see, e.g., Olkin, 1999). Thus, after disabling events, adjustment occurs when people adopt constructive perspectives on their abilities and what can be accomplished in the future (Wright, 1983). Other markers of adjustment include

- being independent, having problem-solving skills for daily living;
- possessing a sense of personal mastery;
- being able to navigate social and physical environments; and
- developing and maintaining a positive self-concept.

As descriptive models, the linked processes of adaptation and adjustment to disability imply that not all people with disabilities become equally accustomed to their conditions; some will fare better than others. Wright (1983) introduced a third process called *acceptance* into the general discussion of adjusting to an acquired disability. An individual with a disability displays acceptance when the disability does not reduce his or her self-worth or future outlook, thereby representing a realistic appraisal of the circumstances accompanied by positive efforts and attention to available assets.

Psychosocial Assets

Wright (1983) believed that regardless of how severe a disability might be, every person with a disability should be seen as possessing or being capable of developing some psychosocial *asset* or set of assets. In this principle, Wright was an early contributor to the field of positive psychology, which emphasizes the importance of positive factors in theory and practice. This Foundational Principle highlights the potential array of resources that are distinctive in each person and can be a point of pride during or after a rehabilitation experience. Rehabilitation psychologists should inquire about a person's assets or strengths for individuation purposes and to encourage maintaining and/or developing positive perspectives for the future.

An asset can be tangible (e.g., income) or intangible (e.g., self-concept), linked to personality (e.g., sense of humor, resilience), attainable or already achieved (e.g., degree, awards), or even a motivational quality (e.g., self-discipline) or an outside interest or esoteric hobby (e.g., coin collecting, memorizing baseball scores or team rosters). Thus, an asset can remind people with a disability about what they have accomplished or are capable of doing in the future, as well as what skills can be learned or even relearned in the face of bodily changes or injuries (for a broader discussion of assets, including additional examples, see Dunn, 2015).

Self-Perception of Bodily States

Research in both social psychology and rehabilitation psychology has indicateed that subjective perceptions often determine how people think, feel, and act (e.g., Wegner & Gilbert, 2000). The attribution literature is rife with studies demonstrating that we do not see reality from a veridical perspective, rather, our perceptions of our reality (or the reality of others) are tempered, even biased, by our expectations, stereotypes, and past experiences (e.g., Fiske & Taylor, 2013). Within rehabilitation psychology, practitioners know that the experience of particular bodily states, such as pain or fatigue, is based on individuals' and others' self-perceptions of the phenomena and not only the actual sensations (e.g., Fordyce, 1976, 1984; Mann, Keefe, Jensen, Vlaeyen, & Vowles, 2015). People's perceptions and, in turn, their behaviors are malleable, so they can be influenced or altered in adaptive or maladaptive directions on the basis of attitudes (their own and those of observers, including health care providers), expectations (their own or those offered by family, friends, and medical staff), and environmental reinforcement (physical, social, and psychological). The influence of psychosocial factors on the perception of bodily states does not negate the validity of the individuals' experience or pathologize their response. Naturally, rehabilitation researchers and practitioners work to encourage clients' perceptions in positive directions that promote adjustment to disability and a beneficial person–environment relation emphasizing their individual worth.

Human Dignity

No matter its severity, any form of disability—physical, intellectual, cognitive, or other—or the presence of some chronic illness has no bearing on an individual's right to be respected, encouraged, and treated as a person. As Wright (1987, p. 12) expressed it, "An essential core-concept of human dignity is that a person is not an object, not a thing." Indeed, Wright (1983, pp. x–xxvi) created a list of 20 "value-laden beliefs and principles" aimed at promoting rehabilitation research, practice, and services for people with disabilities (see also Wright, 1972). In the main, these beliefs and principles capture the spirit of the Foundational Principles, and we encourage rehabilitation psychologists to either reacquaint or familiarize themselves with these additional principles. A particular focus of the value-laden beliefs and principles is the desirable development of therapeutic alliances between clients and their health care givers, thereby promoting comanagement rather than a traditional professional–patient hierarchy. We see in these value-laden beliefs and principles the seeds of the current emphasis on patient-centered care, self-management programs, and the active engagement of persons with chronic health conditions in their care.

Foundational Principles in Action

The Foundational Principles have served generations of rehabilitation psychologists well. How are they currently being used in research and practice? To explore the current role of the Principles, we provide an overview of this special section of *Rehabilitation Psychology* to look at how authors have been guided by their application across the entire range of rehabilitation psychology in clinical practice, theoretical research, education and training, and public health. These articles demonstrate, to paraphrase Kurt Lewin, "there is nothing so useful as a good set of Foundational Principles."

Nierenberg et al. (2016) remind us the burgeoning focus on positive psychology is grounded in the Foundational Principle indicating the need to be mindful of an individual's *psychological assets* in addition to any impairments that may be present. They argue that rather than understanding the distress that can accompany disability solely as the presence of psychopathology, it can be understood from a positive psychology standpoint as a deficit of well-being. They go on to describe how treatment can be guided by a focus on assisting in the development of a sense of well-being rather than ameliorating pathology, echoing the principle that *adjustment to disability* is a dynamic process that involves making constructive changes. Building on and integrating the foundational work of Fordyce (1976) and Wright (1983), Alschuler, Kratz, and Ehde (2016) present a study that identifies the independent contribution of vulnerability factors and resilience factors to pain-related outcomes among individuals with spinal cord injury, amputation, or multiple sclerosis and chronic pain. Their findings also support the importance of including Psychological Assets in our theoretical models and clinical approaches. Their results suggest that both resilience and vulnerability factors are critical to understanding pain outcomes, noting that resilience factors uniquely impact specific outcomes—particularly those that are more psychosocially focused. This article utilizes data from persons with disabilities (PwDs) who have received cognitive-behavioral therapy–based treatment, which is guided by the principle that *self-perception of bodily states* is influenced by attitudes, expectations, or environmental conditions.

Continuing the emphasis on the importance of the individuals' perceptions, *adjustment to disability* and the importance of *psychological assets*, Monden, Trost, Scott, Bogart, and Driver (2016) provide a review of the impact of injustice appraisals on physical and psychological outcomes after injury. Guided by these principles, the authors cite literature that has suggested that by attending to appraisals of injustice, rehabilitation psychologists can better understand, and work with, PwDs. Perhaps more important, by attending to the Foundational Principle of Fundamental Negative Bias, one may reconsider injustice appraisals, which are usually construed as an intrapersonal variable, as a reflection of repeated and ongoing injustices in the social and physical environment.

Two articles explore the role of the Foundational Principles in education and training. Tackett, Nash, Stucky, and Nierenberg (2016) describe how the Principles can guide clinical supervision in rehabilitation psychology. They emphasize the importance of values clarification—on the basis of the Principle of Human Dignity—and that rehabilitation psychologists need to *explicitly* incorporate foundational principles into the process and content of supervision. The authors take a clinical approach, presenting several case presentations and how the Principles can be used to guide the supervision interaction and be reflected in the clinical care of the trainee. Stiers (2016) expands the focus to broader education in rehabilitation psychology. He groups Wright's Foundational Principles into three categories: individual psychological processes, social psychological processes, and values related to social integration, reflecting the key education topics. He then goes on to review the literature supporting the inclusion of the Principles in each category and provides the key points for teaching, suggested readings, discussion questions, and specific suggestions for teaching methods.

The final two articles look at the application of the Foundational Principles as they inform the WHO International Classification of Functioning, Disability and Health (ICF; 2011) and rehabilitation psychology in public health. Sánchez, Rosenthal, Tansey, Frain, and Bezyak (2016) remind us that the ICF is rooted in Principle that person and environmental variables interact to determine participation and quality of life (QoL). They investigate the ICF model in persons with serious mental illness and report that after controlling for other factors, environmental variables of social support and societal stigma are key factors in predicting QoL, confirming the ICF model and reinforcing the value of the Person–Environment principle in shaping theory and understanding outcomes in rehabilitation. Bentley, Bruyère, LeBlanc, and MacLachlan (2016) apply the Principles to global health issues as outlined in the *World Report on Disability* (World Health Organization & World Bank, 2011). They assert that the principles of person–environment interaction, importance of social context, and need for involvement of persons with disabilities can guide rehabilitation psychology as we embrace global health demands. It is clear in reading the recommendations from the World Report on Disability (World Health Organization & World Bank, 2011), the task force writers were, at least implicitly, guided by our Foundational Principles.

Lodestars for Rehabilitation Psychology's Future?

Are there any new or emerging foundational principles to guide rehabilitation psychology? One new principle may be the evolving language for disability and its role in promoting cultural competence regarding disability. In the psychological community, the idea of cultural competence for psychologists refers to acquiring skills for understanding, appreciating, respecting, and interacting with people whose beliefs and experiences are different from one's own due to a diverse array of factors (e.g., race, ethnicity, social class), including the presence of a disability or chronic health condition. Recently, Dunn and Andrews (2015) suggested that to develop cultural competence regarding disability, psychologists should adopt identity-first language alongside person-first constructions when interacting with people with disabilities. For example, interchangeably using *person with a disability* and *disabled person,* or *people with diabetes* and *diabetics,* can help to address the concerns of disability groups while promoting human dignity as well as scientific and professional rigor.

Although the American Psychological Association (APA) has championed person-first language for disability (and sometimes membership in other minority groups), particularly where writing and speaking are concerned (APA, 2010), advocates of disability culture and disability studies have challenged both the rationale for, and implications of, exclusive use of person-first constructions. Instead, they suggest also using identity-first language, which treats disability as a function of political and social forces that occur within circumstances that are largely designed for nondisabled people. Identity-first language has the advantage of being linked to disability culture, thereby encouraging

> connection, camaraderie, and shared purpose among the diverse range of people with disabilities; it entails pride in being associated with the largest minority group in the United States, as well as motivation to positively and constructively address . . . social, political, and economic needs. (Dunn & Andrews, 2015, p. 5)

With time and when used in appropriate contexts, identity-first language may well be recognized as a new Foundational Principle or at least as a clarifying extension of person-first language.

Another emerging paradigm that has its roots in the Foundational Principles is the inclusion of stakeholders in the rehabilitation research enterprise. *Participatory action research* (White, Nary, & Froehlich, 2001; White, Suchowierska, & Campbell, 2004), *community-based participatory research* (Agency for Healthcare Research and Quality, 2004), and, more recently, *stakeholder engagement* (Selby, Forsythe, & Sox, 2015) are some of the terms that have been used to describe the practice of engaging people with, and affected by, impairments as equal, authentic partners in all aspects of the research enterprise, including designing, conducting, implementing, and disseminating research. Earlier in our field's history various rehabilitation scholars—including Tamara Dembo (1964) and Rhoda Olkin (1999)—and agencies, most notably the National Institute on Disability and Rehabilitation Research (now the National Institute on Disability, Independent Living, and Rehabilitation Research), have emphasized the importance of the insider perspective in rehabilitation research. However, the integration of stakeholders has not become common practice in the rehabilitation research environment (Ehde et al., 2013). The Patient-Centered Outcomes Research Institute (PCORI), established by the U.S. Congress in 2010 to fund comparative clinical effectiveness research, has brought considerable attention to the necessity of engaging stakeholders in clinical research by requiring PCORI-funded research to be stakeholder-driven across all stages of research (Selby et al., 2015). PCORI provides methodological guidelines for stakeholder engagement in research (PCORI, 2015) that may guide rehabilitation psychology research and inform this foundational principle of inclusion.

Looking Ahead

The Foundational Principles play an important role in the history of rehabilitation psychology, as they have guided theory development, scholarly inquiry, and informed practice. But their true value lies in the manner in which they inform our current and future work as rehabilitation psychologists and lead to improved QoL for people with disabilities. We are grateful to the authors in this special section for demonstrating the continuing utility of the Principles as lodestars for research, training, and clinical practice in rehabilitation psychology. We trust that their work will encourage readers to incorporate the Foundational Principles into their own science, teaching, and practice. By doing so, the Principles will continue to guide developments in and advance the cause of rehabilitation psychology.

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Received December 28, 2015
Accepted December 28, 2015 ■