

“FIRST THINGS FIRST”: MASLOW’S HIERARCHY AS A FRAMEWORK FOR REBT IN PROMOTING DISABILITY ADJUSTMENT DURING REHABILITATION

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ABSTRACT: Maslow’s theory of hierarchical human needs can be integrated into a framework for identifying the psychological priorities of those faced with severe disablement and hospitalization. Within this framework can be identified a variety of behavioral and rational emotive interventions which can be tailored to the most logical sources of the key emotional discomforts in each category of Maslow’s hierarchy. Interventions discussed range from those with a greater emphasis on educating and changing the staff-environment responsiveness regarding the patient’s more basic and “prepotent” priorities, to an increasing focus on treating the patient’s irrational belief system, as priorities at higher levels are addressed.

INTRODUCTION

The onset of severe disablement can be overwhelming to those directly affected. To the mental health clinician on a rehabilitation team attempting to provide relief to the individual with a disability, the task of determining which symptoms, irrational beliefs, or environmental conditions to address *first* can be equally challenging. To provide a framework for understanding and treatment, a variety of stage models of disability adjustment have been proposed. Many of these have had

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some basis in Elizabeth Kübler-Ross's (1969) seminal five-stage model, which included the stages of denial and isolation, anger, bargaining, depression, and acceptance. Although Kübler-Ross' stages addressed a sequence of psychological responses in confrontation to imminent mortality, *disability* could be viewed as a "partial death," and Kübler-Ross' theory was easily integrated into models of disability adjustment.

Davis (1963) and Fink (1967) were among the first to propose a sequential framework of expected responses exhibited by people with disabilities caused by polio and spinal cord injury, respectively. Evidence for a sequence of coping phases in response to mastectomies and burns, as well as polio and paraplegia, was detailed by Fallak and Britton (1974). In a comprehensive volume, Shontz (1975) blended a sequential framework with integrative field theory to provide a rather dynamic and cohesive stage theory of psychological adjustments to physical illness and disability. In 1977, Kerr presented a model which included five stages, namely "1. shock, 2. expectancy of recovery, 3. mourning, 4. defense, and 5. adjustment." A three-component model was developed by Vash (1981), which emphasized that advanced personality growth could be stimulated by the *adversity* associated with a physical condition.

Although shared by all of the models mentioned is an expected progression through a sequence of dynamic cognitive, emotional, and behavioral responses to disability, most of the authors emphasize that each stage model is merely a theoretical organizer, a point of departure from which to begin clinical analysis, and would be in better service if neither perceived as dogma nor rigidly applied as a universal standard. The author of one of the most comprehensive models, Shontz (1977) has highlighted the idiopathic nature of disability adjustment as an interpretive cornerstone in the careful analysis of each case as a unique presentation. Caplan and Shechter (1987) essentially reiterated this view and detailed both the benefits as well as the pitfalls of stage models. They stated that the limited benefit of such stage models has been the associated implication for a transition beyond a state of unpleasantness, as well as their attribution with a much needed perception of predictability during an otherwise chaotic experience, for the patient as well as for the healthcare care providers. Nevertheless, Caplan and Shechter warned that these benefits did not outweigh the risk for stage model misuses, which generally have entailed a detraction from the identification of issues unique to each patient. In addition, they explained that the misuse of stage descriptor(s) such as "denial" have been too easily associated with clinical pathologic labels.

Therefore, instead of a "stage" focus, they had redirected clinicians toward a more careful analysis of denial and depression as multilevel responses exhibited by the individual faced with the onset of a disability. In this endeavor, they highlighted the multidimensional aspects of each response complex with literature supported encouragement not to confuse denial or depression with cerebral-neuropathological behavioral sequelae. Also provided was a review of that literature which has shown that various permutations of denial and depression are in many cases understandable and adaptive responses to disability, rather than symptoms of psychopathology. In keeping with the desire to provide an organizing framework without the pitfalls of stage models, the present integration of Maslow's theories uses his schema for categorizing human motivations as an initial directory, or signpost, to aid in the rapid identification of the foremost and salient areas of concern for newly disabled individuals. This article emphasizes practical treatment considerations for the underlying anxiety that frequently precedes, as well as accompanies, both denial and depression in these patients.

Publications heralding the value of REBT specifically for the patient faced with "catastrophic" illness and/or disablement date back to Ellis and Abrams' (1978) volume entitled *Brief Psychotherapy in Medical and Health Practice*. They were ahead of their time, in this present age of managed care, by introducing the notion that Albert Ellis's Rational Emotive Therapy had wide practical application in medical settings because brief psychotherapeutic treatment was of greater value here than the more traditional long-term psychotherapies of the time. Of more importance to the present article, was Ellis and Abrams' sharp focus on assigning a high priority to treatment of the anxiety, which often precedes the denial and depression, and which occurs in reaction to thoughts of partial functional losses (disability), or complete functional losses (death). In addition, the authors devoted considerable attention to the issue of teaching patients the philosophical concept of becoming "vitally absorbed in life," which this author will later integrate with Maslow's concept of the "need" for self-actualization.

Other publications regarding the specific application of REBT disability adjustment include Wallace and Maddox (1978) who proposed usefulness in treating the embarrassment associated with the functional difficulties caused by physical disability. Sweetland (1990) advocated application of REBT to the irrational belief systems and behavioral consequences exhibited by the families of those with disabilities. This author (Calabro, 1991) offered a detailed outline of many cognitive distortions and related disputations observed in response to dis-

ability, some of which have been integrated into this article. Balter (1995) advocated the role of REBT in response to the issue of disability and emphasized the utility of REBT to facilitate the individual's adjustment to societal irrational beliefs and reactions to disability. Most recently, in a candidly poignant fashion, Ellis (1997) shared his personal challenges confronting increasing disability related to his diabetes, and how he has prevented the disabilities from stopping his career by utilizing the basic principles of REBT to overcome low frustration tolerance and self-denigration.

MASLOW'S HIERARCHY OF HUMAN NEEDS

Because of increasing restrictions on length-of-stays in rehabilitation programs, adequate time for psychological adjustment to sudden hospitalization and severe disability is becoming increasingly compromised by the health care system. As a result, patients are more frequently discharged before having time to acquire the fundamental psychological coping skills which might have allowed them greater benefit within their rehabilitation therapies. A growing treatment concern has become the patient's ability to participate earlier and more extensively, without the undue limiting influences of excessive negative emotion. Discharge to home or a long-term nursing facility is often decided by an interdisciplinary team of healthcare professional who are looking closely at the patient's rate of progress and the patient's inferred motivation to participate in the program. Not surprisingly, patients who appear motivated are more likely to be seen as benefiting despite a relatively slow rate of progress. Conversely, a patient who is progressing at the same slow rate is more likely to be described as having "reached a plateau" because they may present as "unmotivated."

This article's central thesis is that rehabilitation teams can benefit from encouragement and assistance by mental health team members who can rapidly identify the unseen, but more salient "drives," by which the apparently "unmotivated" patient is nevertheless quite motivated. Furthermore, the categorical nature of those drives can suggest entry points in the application of REBT. Abraham Maslow (1943) proposed his well-known "human needs" theory of motivation, which is familiar, at some level, to most students of the health, social, and behavioral sciences. His theory can provide an applicable framework by which to determine those more salient drives, affective complexes,

need for staff/environmental modifications, and the underlying irrational belief systems of both the rehabilitation staff and patient.

The concept of an “*unmotivated*” patient is inconsistent with Maslow’s proposition that “all organismic states can be understood as motivated and motivating.” He went on to say that the state of “motivation” was determined by the relative degree to which basic categories of “human needs” were satisfied. He observed that human needs are organized into a hierarchy of relative influence, or “prepotency.” By this, he meant that unsatisfied low level, but prepotent, needs would dominate an individual’s focus and detract them from concern and pursuit of less prepotent (but more abstract) needs. If a prepotent need has not been adequately satisfied, it will dominate as the major influence on the individual’s experience. Only if a prepotent need has been met, does the person move on to greater concern with the needs of the next level. Until that point, most of their goal seeking behavior is influenced by their unmet needs. From most to least “prepotent,” Maslow’s categories include 1. physiological needs, 2. safety needs, 3. love needs (Affiliation needs), 4. esteem needs, and 5. self-actualization needs. For the newly disabled patient in a rehabilitation setting, these can be translated in the present model’s categories of 1. physiologic priorities, 2. safety priorities, 3. affiliation priorities, 4. self-worth priorities, and 5. vital absorption priorities.

The remaining sections of this article are organized according to Maslow’s hierarchy and categorization. His term “human needs” has been transposed into the term “psychological *priorities*.” This transposition is preferred because of Ellis’ (1977) and this authors’ core rational philosophy that the term “needs,” which literally implies *absolute mandates* for various states of affairs, do not exist. Nothing is essential or “needed,” not even physical survival or life itself. Certainly as humans, we *choose or prefer life* and make preferences in our behavior to sustain it, enrich it, and celebrate it’s sanctity. But its protection and continuation is *not* the ultimate “need.” Instead, for REBT practitioners who strongly hold this philosophy, physical survival is no more than the ultimate “priority.” Each section will give further description to its corresponding category in Maslow’s needs hierarchy. This will lead to a translation into the psychological priorities for the patient with a physical disability operating at any given level. Following this will be a description of the staff and hospital environment which, along with the disabling condition, has contributed to that category’s particular state of deprivation, as well as by suggestions for interventions oriented to changing the environment and staff behavior

toward the patient. Ensuing then will be a discussion of the patient's affective status and associated constellations of irrational beliefs associated with each category of priorities.

PHYSIOLOGIC PRIORITIES

For the recently disabled patient, the category of physiologic priorities corresponds to Maslow's concept of physiological needs, which he described as first, and foremost, in its influence on the direction of motivated behavior. Maslow emphasized the dominance of hunger and thirst as the primary physiological drives. In this regard, he also detailed the need to be free from pain and discomfort.

For the rehabilitation patient, physiologic priorities would obviously include hunger and thirst, but these are not usually left unsatisfied in our society, where food and clean water are still abundant. Medical stability, including the neurological stability to maintain a normal state of consciousness, would also be applicable here. But these are not under the direct or conscious control of the patient and are priorities with which the physicians and nursing staff are usually more concerned. The remaining key priority which predominates and which is amenable to behavioral intervention is the pursuit of freedom from pain.

Some might agree that their earliest associations with significant healthcare problems and the healthcare system have involved physical pain, possibly caused by first injections or a broken bone. Thus, a predisposition of many adults who enter a hospital, including this author, is to expect pain and work toward its avoidance. It is therefore not surprising that following stroke, spinal cord injury, or some other disabling condition, an immediate focus is on the avoidance, reduction, or cessation of discomfort rather than on the intrinsic merits and long term benefits of a particular rehabilitative theory. Following transfer from an acute medical setting to a rehab setting, the orientation of some physiatrists and rehabilitation nurses has been to dramatically reduce dependency on pain medications, which is at odds with this transition into more activity, when increased activity often brings a heightened pain experience. Perhaps it would be more prudent to maintain the medications during the beginning of the rehabilitation, to get maximum pain-free participation, and then to taper the medication down once many functional skills have been acquired.

Many years of this author's inpatient rehabilitation experience have

led to the observation that sitting discomfort may be the single most common source of distracting pain suffered by patients in rehabilitation settings. Perpetuating and central to the continued underestimation and dismissal of sitting comfort as a primary psychological priority is the likelihood that most staff who are capable of independent ambulation have beliefs associating sitting with pleasure and relief from fatigue, rather than with discomfort. The further likelihood is that most of us have never experienced it unless we have been forced to sit 2-3 hours in a wheelchair, with no or little physical ability to shift position within it or stand up momentarily, and with the cheapest grade of foam cushioning, if any, between us and the vinyl seat. Sometimes merely presenting to the staff with this level of detail, on the issue of *disparate reference points*, is sufficient to generate considerable insight and behavior change.

Another factor hindering a treatment team's insight about the primacy of the patient's sitting discomfort is the stress of the additional work and staffing necessary to transfer (move) a patient back and forth between bed and their wheelchair the necessary number of times during a particular 8 hour shift. In order to resolve the impact that inadequate staffing has had on this issue, this practitioner has had some success offering the suggestions that the physical and occupational therapists incorporate transfer training to and from bed into a 15 minute session before and after lunchtime. Another suggestion is to provide the patient with some of the more sophisticated and effective seating cushions which can provide a significant reduction in discomfort.

However, in addition to disparate reference points, the problem in responsiveness to this suggestion sometimes involves the potential for increased costs to the rehabilitation facility in having these higher-tech cushions available, an issue which goes beyond the immediate control of the practitioner. Ultimately, however, compromised responsiveness to these types of suggestions from the mental health practitioner remains an artifact of the team's limited insight about the significance of the issue. Addressing this further may require additional insight-oriented instruction and team consultation designed to close the gap between the Maslowian priority level where the staff are primarily operating (usually self-esteem) and the level of the patient on this issue (physiologic priorities). As such, it may be helpful to offer more *specific cognitive reformulations* directed at their reference points for sitting discomfort, which conceptually could include the following points as well as delivered under the following conditions:

1. Provide a definition of pressure-induced ischemia as a state of blood deprived tissue and a very significant physiologic problem. It is also helpful at this point for the mental health practitioner to demonstrate on themselves, the dramatic "blanching" which occurs when they firmly press the thumb of one hand into the back side of the other for only a few seconds.
2. Allude to the literature that has shown that unrelieved ischemia to the epidermal region of the human body will result in significant pain within 20 minutes.
3. Point out that although they as ambulatory professionals have not likely experienced this pain from sitting, they have probably experienced it many times during the winter. This has usually occurred on those occasions when the outdoor temperature has been such low that their hands have become "numb" from the cold, and consequently they had decided to run their hands under hot water. The result had been that the sensory receptors in the hands were reactivated before blood flow was reestablished, and that, momentary, but intense pain, from the ensuing ischemia, is a more accurate reference point when considering the suffering of a patient who has been sitting in a wheelchair for the last three hours.
4. Presentation of the above information might also be offered within the context of a group inservice on the application of Maslow's hierarchies to disability.
5. Within the format of the inservice might be incorporated an experiential component, whereby several volunteers attend the inservice while experiencing simulation of sitting discomfort. Without harm or risk to the participants, this can be accomplished by having the volunteers seated in wheelchairs with minimal seating cushions, with their feet strapped to the footpedals, and with upper legs strapped very firmly down to the seat (enough so that weight shifting within the wheelchair is truly restricted). In order to experience a realistic degree of discomfort, they will have to remain in this fashion for at least 45 minutes. Those from disciplines that are likely to be least biased either way on the issue, such as staff from social work or speech-language pathology, would be better encouraged as volunteer participants.

In summary, deprivations in this category of physiologic priorities have been discussed in terms of interventions aimed at the belief systems and systems and behaviors of the patient's environment. This is not to imply that the patient's irrational belief system, say regarding discomfort, should not be addressed concomitantly. Instead, the emphasis has been primarily on the environment and staff belief system for deprivation in this category because it has the potential for making

the larger and faster difference in alleviating unnecessary distress, and ultimate distractibility from the other therapies at hand in the rehabilitation program.

SECURITY PRIORITIES

Maslow defined the safety needs as those drives toward the establishment of certainty or *predictability* about the environment's continuing ability to meet the individual's physiologic needs, and consequently this category naturally follows relative fulfillment of the physiologic needs. In further definition, Maslow (1943) said the "healthy, normal and fortunate adult in our culture is largely satisfied in his safety needs," but still pursues fulfillment by seeking jobs with security and retirement plans, as well seeking insurances for medical dental needs, unemployment episodes, and disability occurrences. Maslow implied that the concept of looking toward the environment's future for sustaining the individual's continued physiologic survival was predicated on the evolvment of "needs" beyond the unconscious and reflexive level (physiologic deprivation) into the realm of cognition and expectation; which is why the category of "safety priorities" is the first in the hierarchy in which the disabled patient's suffering is more amenable to cognitive and Rational Emotive intervention. For the patient with a disability, the *security priorities* are those inspiring the quest to identify someone who is in charge, who is *knowledgeable*, who *can protect* them from additional physiologic danger and further disablement, as well as someone who possesses the knowledge and authority to minimize the disability. Related to the goal of finding this central authority figure, is the exigency to *perceive* that *communication* exists amongst team members, as well as between the team and the authority.

Again, this deprivation's first line of mental health intervention is directed at the behavior of the treatment team. The role of someone in authority is often filled by the attending psychiatrist, and communication between the team and physician has been best displayed by the time-honored tradition of daily interdisciplinary morning rounds led by the physician. Unfortunately, the practice is becoming less prevalent as an interdisciplinary event, and in many cases attendance at rounds has been reduced to the physician and a nurse, or to the physician alone. This practice is likely waning because of increased work load for staff and demand for a greater volume of reimbursable patient

contacts, when rounds contact might not constitute this for anybody but the physician. Nevertheless a return to this practice is recommended not only to present an image to the patient but because it can facilitate the degree of team communication and do so with more efficiency than do some of the other meeting formats.

Compromises to the patient's perception of security can also result from various instances in which the patient observes disagreement between two, or more of their rehabilitation therapists. The disagreement(s) may be overtly expressed. Or, they may be implied in a non-verbal fashion, that is nevertheless capable of detection by the cognitively intact patient. The nuances of the professional's limited self-monitoring for the inadvertent expressions of interdisciplinary discord, especially those that are covert and nonverbal, such as passive aggression, are complex and worthy as a separate topic of study. Nonetheless, compromises in basic civility and interdisciplinary respect are abundant and can also be targeted as areas for increasing team awareness through appropriate inservicing and staff development training.

Here is also where detailed and appropriate therapist documentation in the medical chart will facilitate the occurrence and appearance of communication. However, a thoroughly written note will have little benefit if it is *not read* by the fellow therapists. This author has frequently seen staff ask questions or make comments that clearly indicate they have not read each other's notes, and conversely have been impressed, or observed other staff to be impressed when specific references have been made to particular documentation. The mental health practitioner can set an example by extensively reviewing the patient's medical chart, remaining current in this review, and becoming well-versed in their diagnoses, medical and social history, and specific deficits. In this way, they can display accurate facts about the patient. This is important because some of the patients' anxiety may stem from their beliefs that their individuality is being overlooked by a regimented mechanical delivery of services. Remembering their specific regimen, or mentioning details which the patients have previously alluded to, can serve to reinforce their sense of individuality. In summary, the rehabilitation team is better encouraged toward behaviors characteristic of an integrated organism, where the perceived integrity of their intercommunications will determine patient perceptions of their ability to prevent or ameliorate disability.

Deprivation in the patient's perception of security are most evident in their experience of anxiety. Several forms of irrational beliefs are associated with the patient. Patients tend to have distorted beliefs about the staff's inability to provide the correct and unique treatments

for their needs, as well as their inability to prevent further discomfort, pain or disablement. Morbid beliefs about “only going to a hospital to die,” or that “once there, they have little chance of leaving,” are also common. Providing information about the unique training of the staff and their motivations may be helpful. In addition, effective reframing of these distortions can include a careful presentation of fact-based information regarding more accurate probabilities that the patient will survive and eventually leave the hospital.

For example, if the patient states “Many years ago my uncle was hospitalized following a stroke and died there without ever making it home; I’ll probably suffer the same terrible fate,” you might respond, “You’re generalizing from one instance with your uncle which may have been due to unique circumstances with his stroke. Even if your stroke is similar, that was a long time ago; and now technology has improved to the point of better odds for your survival. In fact, most people who have your disability are eventually discharged to a satisfactory lifestyle which may continue for many years.”

Another contributing distortion are patients’ beliefs regarding their inability to tolerate and emotionally survive the loss. Here it is helpful to provide the patient with the information that most people can and do grow to tolerate situations that at one time they ardently believed they could not; and that this will probably be true for the patient as well. For instance: “It’s hard to remember now, but you have memories of times when you *have been able to tolerate* similar stress, although it may not have lasted as long as this. You may remember surviving the extreme pain of being in the dentist’s chair and having a tooth removed. You may remember surviving the terrible pain of childbirth. Indeed, despite the fact that you’re still feeling upset, you’ve actually done an excellent job of keeping your sanity despite some very difficult circumstances. In fact, if you think back over the last several days, you’ll recall that you don’t always feel like this; you’re able at times to experience some periods of relief.”

A third category of cognitive distortions leading to anxiety involves the belief that no choices in life are left available to them in their present disabled condition and hospital environment. The underlying belief is that they are helpless to regulate and change their treatment and condition. Cognitive restructuring should include highlighting the ways in which they can exert some control as in the following example:

Patient: I have no say or control over what is happening to me here. I have to do what they tell me to do at every given moment.

Clinician: To a certain extent you're right, but you've put yourself in similar situations before. You've chosen to be in other environments where you have not been totally free to behave in whatever manner you choose. On jobs that you've held, you've lived with regimentation. The truth is that even with the regimentation that you have here, you probably have more control than you're able to notice right now. You could, for example, choose another doctor if it came down to that. You could even have yourself transferred to another hospital. You could negotiate changes in your therapy schedule or treatment with my help. You can even have some control over your present physical condition by participating to your fullest extent in physical therapy. Most important, you can choose how you look at this situation and how you feel. You see, you're really not 100% helpless. You're just a fraction of that, as we all are in our lives, no matter what our physical and situational resources may be.

AFFILIATIVE PRIORITIES

This group of concerns corresponds to Maslow's "love needs." On one hand, patients are preoccupied with getting the opportunity to relate with either specific family, friends, staff or other patients who they think have a deep understanding of their experience. Fundamentally, these patients are looking to share their hopelessness about their loss and are seeking guidance from those with the closest first-hand experience on how to manage these feelings. On the other hand, these patients are also preoccupied with the state of deprived contact with their family and friends, and afraid they will not be able to reinstitute or sustain these relationships even when discharged from the rehabilitation facility.

To address the former, in one rehab facility in which this author has worked and still consults, a peer advisory program was started in which former patients, this author, and the director of volunteer services banded together to address these affiliative priorities. This program entailed former patients becoming enlisted as volunteers and on-call to be assigned for recreational visits with inpatients. The volunteer "ex"-patients were assigned to inpatients who were identified as having strong unmet affiliative needs by staff. Attempts were made to match the volunteer and the patient's age grouping and disability. Also recommended are efforts to recruit professionally qualified staff with significant disabilities to whom the patient can have access in direct

treatment and/or merely the opportunity to observe them as models whose successful functioning helps decatastrophize the prospect of life with a disability.

The patient's mood may be characterized by a blend of anxiety and depression. Underlying irrational beliefs may be expected to contain elements of isolation and self denigration about their worth to significant others as expressed in the following examples:

Patient: I feel so alone and singled out with a terrible thing that most people never have to face.

Clinician: Many do face it in much the same way as you. There are over a million new strokes each year and tens of thousands of other occurrences in the other disability categories. Even those people who are your age, and are functioning the way you used to function, could be faced with a disability this next year. In fact, chances are that every young staff member which you see here will eventually be faced with a loss of functioning from some type of interaction with the environment, whether that be cancer or just the process of aging itself. Through daily aging, each individual is also gradually becoming disabled; in your case, it's unfortunately been compressed into a brief interaction with the environment. Ultimately, however, nobody escapes it.

Patient: It's terrible to be so dependent because of the burden that I've put on the staff and will place on my family. My family will have to do and give me things which I can't return. I can't go out and earn money for them. I can't do the things with my husband (wife or significant other) that we used to do together. I can't go and drive my children where they need to go. I'm of no value to them anymore.

Clinician: There is no burden for the staff since they have voluntarily chosen to provide their time and expertise in exchange for both money and the opportunity to earn it in a way that they find more satisfying than something else. With respect to your family, no person returns what another does for them in exactly the same way. Now that you're disabled, this is true to a somewhat greater extent. Although your significant other now drives the children to the dentist, you can still reciprocate by preparing a nice lunch and listening to how their week went. Although you can no longer work, your past hard work and sweat still may be working for you in the form of disability insurance with which you can continue to help support the family. In many instances, it's not going to be what you do together as a family, but the

fact that you are there to do it with them, even if it is only listening to music, or talking, or watching television.

Patient: It's not fair that friends and acquaintances who knew me before will now reject me. I guess they were no good anyway.

Clinician: There are friends and acquaintances that are always going to be rejecting us in some respect. In their mind, they have only contracted to be there to enjoy certain aspects of you. If some of those aspects were physically-based, then that part of your friend's contract may no longer be valid. No friendship is unconditional. To condemn them for what was important to them about you when you first met is to condemn the value of positive memories of good times with that friend. Those memories are a valuable possession within your stockpile of pleasant memories—so why throw them away by devaluing them?

Patient: Strangers and people whom I have just met stare at me more and treat me differently. They shouldn't first see the disability, but they seem to; and it prevents them from getting to know me. But who cares anyway? They're not really worth my efforts.

Clinician: They may be worth your efforts; there's no way to tell for certain before you take some risk. But even if their decision is not to reciprocate, they are neither deserving of nor worth the energy of your condemnation—especially if the energy drain takes away from your making new efforts to pursue others. Yes, unfortunately you are very different from most at first sight. You've had the same reaction to yourself in the first days after your disabling loss. Humans naturally tend to notice those who are visibly different. It can be somewhat of a disadvantage, but it can also be an advantage when you want to stand out in a crowd, which those who are different will to a greater extent.

SELF WORTH PRIORITIES

Maslow said that the “(self) esteem needs” were closely connected to, and often expressed themselves in tandem with, the “love needs.” In Maslow's definition of this category, he described a need to obtain and maintain a firm high evaluation of oneself, that is based on real capacity, achievement and respect from others. Included here is a desire to perceive oneself as strong, adequate, and having the option for choice, control, and relative independence in functioning. For this article's REBT orientation, Maslow concept of *self-esteem* is better reformu-

lated as Ellis' (1977) concept of self worth. Self worth is an experience of unconditional and immeasurable positive self regard. Its experience is predicated on the capacity for distinguishing between one's inalienable value in "being" and the nature of one's behavior and personal attributes. Maslow's concept of *self esteem* can be viewed as dependent on "real" achievements and physical attribute or capacities, while Ellis' *self worth* is an experience of positive self regard which is independent of attributes or performance. As it applies to disability adjustment, it is throughout this category of psychological priorities that the patient's capacity for experiencing rational self-worth is most vulnerable.

Few who have been a patient in a hospital, even for a minor condition or brief stay, are likely to argue the extraordinary ease and speed with which being forced into the role of a patient can threaten self-worth. For the significantly disabled patient, it is even harder to maintain a sense of autonomy when, by circumstance, they are denied the freedom to choose in one of the first realms of childhood which defined autonomy, namely bowel and bladder evacuation. On these issues, it is emotionally difficult for the patient to accept the help that may now be required for these functions. The circumstances can be quite challenging to some of the more rationally centered individuals with disabilities. As such, staff can benefit from periodic resensitization to the patients' vulnerability and difficulty maintaining their self-worth as unique, valuable, and not relegated to a lesser status because they must depend on others for the many aspects of basic mobility and self-care. These patients will benefit from staff reminders to them that they are *not a burden* and that the staff will strive to give them maximum choice in receiving help with their bowel, bladder, feeding, dressing, and mobility. Nursing and other rehabilitation staff would benefit the patient by arranging the proper difficulty level with the assistance of the mental health professional, and such that the patients feel *competent* on tasks with which they are presented; and not so they feel compared to other patients or any individual in the manner in which the task is accomplished. Cognitions that produce depressed affect associated with deprived self worth involve negative distortions about a disabled lifestyle, distorted comparisons to others, and lowered ratings of self-worth with two of the more commonly observed core formats as follows:

Patient: The quality of my life now as a person who can't walk is terrible because I must now depend on others for many things to survive.

[Here the disputational goal is to bring about awareness that dependency is a relative state of affairs]:

Clinician: Indeed, you must now ask others to do certain things that you can't do yourself. The fact is, you have always been dependent on others for your survival. Before your injury, you depended on the economic situation to be sure that you had a job. You depended on that job for money to provide the food and shelter necessary to survive. You depended on grocery stores, farmers, construction workers, etc. to provide all the things which most would consider necessary to live a quality life as we know it. Everyone is dependent. Even the President of the country depends on the voters to keep him there. As times change, so do our dependencies. For example, your grandfather may not have depended on grocery stores to get food because he grew his own. But circumstances were such that he emigrated to this country and lived in the city where he couldn't farm and now needed to depend on others from whom to buy food. Furthermore, when you rate this undesirable state of affairs as awful, you erroneously conclude that a) it is the worst thing that could ever happen; b) it is intolerable; and c) therefore shouldn't be.

Patient: I'm so physically imperfect compared to most and therefore less valuable.

Clinician: Eventually you would have been anyway. Even those young, attractive and famous performers that you may have admired are only that way temporarily. Each day they are growing older and being replaced by younger and more physically attractive stars. Today's Olympic gold medalist may be considered by some to be at the point of physical perfection with respect to a particular skill. But that doesn't mean that there isn't some unknown athlete out there who is even better. Even if there isn't someone better at that moment in time, that gold medal athlete is only considered perfect temporarily—that is, until the time that someone breaks her record. Physical perfection is a fleeting, temporary illusion at best.

VITAL ABSORPTION PRIORITIES

According to Maslow (1943), the term “self-actualization” was first introduced by Kurt Goldstein (1939). In defining the need for self-actualization, Maslow described it as a need which did not emerge until the previously mentioned four categories had been satisfied. He further defined it as a desire to become “more and more of what one is, to

become everything that one is capable of becoming." Presented wonderfully within a psychospiritual framework, Vash (1994) contended that the experience of the disability is better viewed by the individual as inherent and inseparable from the process of self-actualization, and is better embraced rather than mourned.

For the purposes of conducting REBT for disability adjustment, the pursuit of what Ellis and Harper (1975) called "vital absorption" is another way to look at the nature of the individual's self-actualizing priorities. Ellis defined vitally absorbing interests as those which are either long range, constructive, and/or creative. This can include ritualistic spiritual activities, reading a novel, writing an extended piece, composing a musical creation, an art project, a political or social commitment, following a series on television, or something as simple as tending to a small window garden. The important aspect of a "vitally absorbing" activity is that it be in state of dynamic existence and partial completion so that it helps engage the individual's consciousness even when s/he is not engaged in the activity at the moment; thus helping to distract from the pursuit of irrational ideation about the disability.

Howard Rusk (1977), known as the father of modern rehabilitation, saw the value of vitally absorbing interests in the disability process, even when that interest was on very small scale. During World War II, Howard Rusk was an internist and officer in Army Air Corps. In this capacity, he is credited as first instituting the concept of modern rehabilitation, which he did within a military hospital. While making rounds one morning, he approached a young bedridden patient whose mood had noticeably deteriorated over the course of a day. When asked why by Dr. Rusk, the patient responded that it was because an orderly had cleaned away a spider web that had been above his bed. He went on to say "All I can do is lie here looking up at the ceiling, and the one thing I have enjoyed in the last three weeks has been watching that spider make her web, catch flies, and have young spiders. That web kept growing bigger and better every day and now it's gone." Although, Rusk did not use the specific term "vital absorption," this incident triggered his realization that adjustment to the adversity of disablement would need to devote a central role to getting patients involved in long term projects. In fact, years later, at the Rusk Institute for Rehabilitation (which is now part of NYU Medical Center), Rusk had made it a practice to put a plant next to each patients' bed so that they could become absorbed in watching the plant grow from day to day.

One of this author's close acquaintances, Leo, was a resident in a

VAMC nursing home unit, and there he had mastered the skill of finding vitally absorbing activities despite the adversity of his physical limitations and the restriction of his environment. Leo recently died at the age of 86, and although mention of him is in part a memorial, even if he were still alive, it would be worth describing his extraordinary ability to orchestrate his ritualistic structure in the pursuit of long term projects, activities and relationships. Leo had been a resident there for over five years. Each day was conducted in the same sequence. Following breakfast, he would read the day's paper. This would be followed by rolling his wheelchair to sit by the nurses station for an hour where he would have the opportunity to greet all the staff who intermittently returned to engage in documentation or other professional communications. This would be followed by reading for an hour in one of his Western novels. He'd have lunch, then call his wife, and speak to her for 10 minutes (which he also did after every evening meal). Then, he would return to the day room where he would play cards with his roommate for the next hour or so. This would be followed by two or more hours of work on one of his art or crafts projects. The projects would either be a complicated paint-by-number kit, a large jigsaw puzzle, a complex three-dimensional model, or other type of craft project, and each of which could take a week, or more, for him to complete. His regularity in these creative pursuits was such that the day room was adorned with his paintings, completed and framed puzzles, and various other works of art. In starting a project, he would first designate where it would be displayed or which patient or staff member would receive the completed product as a gift. In this era of sophisticated technology, patients with even the most severe limitations can be directed toward vitally absorbing activities. There are innumerable gadgets for interfacing with a computer, books on tape, book page turning devices, magazines for most hobby interests, and organizations for most of these interests or political causes that can be accessed via newsletters, magazines, computer, or telephone.

Sometimes a direction to read a book like the *Fountain Head* by Ayn Rand is helpful to teach a patient about the concept of vital absorption and self-actualization. In this classic novel, the main character, named Howard Rourke, is an architect who creates building designs for his own pleasure and not for the approval of society, and he does so because the act of creation is what defines him. At a simpler level for many patients, redirection to childhood memories of how creative and fulfilled s/he was in play activities can also be helpful teaching this concept. As follows, the nature of the cognitive distortions blocking

vital absorption surrounds the restricted view that patients can have that the remaining, or new opportunities, which were not considered vitally absorbing in the past, could never be as pleasurable as what they have lost:

Patient: My life is so much more restricted and inconvenient. No one could find a decent quality in a life under such circumstances.

Clinician: Some people actually achieve quality of life in the challenge of adversity and restriction of available activities. In fact, some individuals find life as they (the patient) knew it before the injury to be rather empty and boring. These people actively seek out the challenge of managing inconvenience. For example, they may give up the many conveniences and activities of civilization to go out on expeditions to remote wilderness. In these situations, they are inconvenienced and relatively disabled; but survival is possible with effort, and they enjoy that effort as well as redirection to activities that had always been available, but that they had never enjoyed in quite that way. Indeed, because of various circumstances (e.g., financial and social), we are all to some extent inconvenienced, limited, and faced with the challenge of survival and finding those experiences that are enjoyable.

Patient: I've lost so many of the things that I enjoy doing that it's not possible to find any meaning in the few that are left.

[The credit for some of the following disputational response goes to another disabled veteran (not Leo) who was interviewed in a film about people with disabilities]:

Clinician: Let's imagine that before you acquired your disability, you were able to enjoy a wide range of about 1,000 different activities. But now let's further imagine that because of your new condition you've lost the possibility of experiencing 300 of those 1,000 activities. That's quite a loss. But let's also assume that out of the initial 1,000, most people never get the opportunity or time to experience more than 400 or so different types of activities. So, of the initial 1,000, you'd still have 700 from which to select your 400. Selecting your 400 is indeed a big job—but each could bring enjoyment when you finally find them. But you'll only get to a few of them if you spend too much time at the funeral for the lost 300. You may remember that as a child, you were able to leave that funeral-for-the-lost-activities rather quickly. As a child, when your toys were taken away or when it was raining outside, you may have been upset for a while, but then you changed your focus and found pleasure and amusement in whatever was available—even if it was only a handful of coins which you could pretend were soldiers

battling each other from the creases of your bed sheets. You were able to *change your values and find a multitude of pleasures* in what remained. With a little practice, you could bring the capacity to do that back. It's a skill that we've all had. We just don't use it that often as adults.

SUMMARY

Presented has been Maslow's hierarchical theory of human needs integrated into a *framework* for identifying the psychological priorities of those faced with severe disablement and hospitalization. Along with that framework has been proposed a variety of behavioral and Rational Emotive interventions tailored to the most logical sources of the patients key emotional discomforts in each category of Maslow's hierarchy. Inherent, in the schema proposed, is a linear dynamic of changing treatment focus as upward movement occurs through Maslow's hierarchy. This treatment shift is from a greater emphasis on addressing the staff-environment regarding the patients more basic and "prepotent" priorities to a gradually increasing focus on the patient belief system, as priorities at higher levels become more applicable to the patient. When considering the specific cognitive distortions and disputations discussed in this article, it is important to keep in mind that there are numerous other variants as well. Obviously the clinician cannot always wait for distressed patients to express their thoughts in the same language as the examples provided. Clinicians are encouraged to conduct a thorough and flexible analysis of the patient's report, behavior, affect, and the surrounding circumstances, in deciding the exact nature of the interventions aimed at the environment, the patients behavior, and cognitive distortions held by both.

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