PERSON-CENTERED, PARTICIPATION-ORIENTED COGNITIVE REHABILITATION

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AKA, Holistic Brain Injury Rehabilitation

Originated by Yehuda Ben-Yishay, PhD, Leonard Diller, PhD, George Prigatano, PhD

- Principles need not only apply to Day Programs

Addresses the needs of the whole person

- Cognitive, emotional, social, physical, spiritual

Cognitive rehabilitation in the context of the person’s overall:

- Goals
- Strengths
- Weaknesses
- External resources and barriers
VARYING PHILOSOPHIES AND APPROACHES

- Impairment focus vs. goal/outcome focus, i.e., *participation-oriented*
  - Medical Model
    - Intervention directed at the individual who is ill or injured
  - Vs. Social Model
    - Intervention directed at the social system in which the “disabled” or “ill” person operates
  - Top-down
    - Executive and metacognitive skills
  - Vs. bottom-up
    - Specific cognitive abilities (e.g., attention, memory)
Based on standardized holistic evaluation

- Holistic: Physical, cognitive, emotional, spiritual, social & physical environment
- Ideally interdisciplinary
  - Brain injury MD, neuropsychologist, OT, SLP, PT, SW or family counselor
  - Additional medical evaluations as required
  - Other options: Specialists in vocational re-entry, family adjustment, vision disorders, vestibular disorders, substance abuse, mental health

- Functional evaluations
- Neuropsychological evaluation
- Identifies both strengths and weaknesses
- Mayo-Portland Adaptability Inventory (MPAI-4)
Most persons with BI will benefit from focused CR or CR + limited services

- Complicating factors:
  - Other cognitive problems
  - Emotional or behavioral disorders
  - Marital or family issues
  - Physical medical problems
  - Substance use
  - Impaired self-awareness
  - Improved cognitive function is of little real value to the person

Some may require comprehensive day treatment

- Severe and pervasive disabilities
- Significant emotional and behavioral problems, lack of self-awareness

Correct determination = effective and cost-efficient
Collaborative goal-setting focused on participation outcomes
- Patient and family work with team to negotiate long term goals
- Foundation for a *Therapeutic Alliance*
- “Begin with the end in mind”
  - Community reintegration
- Goals = positive outcomes valued by patient
  - Not list of disabilities to be remediated
- Goal-setting = executive function training
- Discharge goals vs. step goals
Basic Principles

- Specific, Goal-oriented treatment plan
  - Therapeutic alliance
  - Communication with other team members
  - Regular meetings with and without patient/family
  - Strategic use:
    - procedural learning
    - learning vs. environmental interventions
    - Medications
  - Plan/practice for generalization
  - Contextualized CR
  - Work/independent living trials
  - Family/significant other participation
BASIC PRINCIPLES

- Standardized Monitoring of Progress
  - Record progress toward discharge & step goals
  - Modify treatment plan as appropriate
  - Standardized measures, e.g.,
    - Everyday Memory Questionnaire, Dysexectuvie Questionnaire
    - Goal Attainment Scaling for individualized goals

- Regular re-evaluations
Much better than expected: Participant learns and uses problem-solving and goal management strategies in addressing life problems almost all the time independently.

Better than expected: Participant learns and uses problem-solving and goal management strategies in addressing life problems about 75% of the time independently.

Expected Outcome: Participant learns and uses problem-solving and goal management strategies in addressing life problems 75% of the time with prompting.

Less than expected: Participant has not learned and does not use problem-solving and goal management strategies.

Much less than expected: Participant refuses to engage in systematic problem-solving.
**BASIC PRINCIPLES**

- Make the most of nonspecific effects, ie, placebo effect
  - Therapeutic alliance
  - Positive expectations, hope
    - Danger of “nocebo” effect
  - Patient and significant other engagement
  - Support/encouragement from significant others
Post-discharge planning
- Anticipate obstacles, need for reinforcement/practice
- Environmental/social support
- Self-management training/family training
- Regular follow-up/refreshers as needed
### Summary

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<thead>
<tr>
<th>Key Principle</th>
<th>Rationale</th>
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<tbody>
<tr>
<td>Standardized holistic evaluation</td>
<td>Cognitive impairment often associated with other factors that affect outcome</td>
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<td>Match evaluation/treatment to case complexity</td>
<td>Maximizes efficiency; minimizes cost</td>
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<td>Collaborative, participation-focused goal-setting</td>
<td>Participation goals are of most value to patients and family</td>
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<td>Specific goal-oriented treatment plan</td>
<td>Only target impairments and barriers that affect valued outcomes</td>
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<tr>
<td>Standardized monitoring of progress</td>
<td>Standardized assessment increases reliability; modify treatment based on ongoing assessment</td>
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<td>Use nonspecific effects</td>
<td>Maximizes successful outcome and are often necessary (but not necessarily sufficient) conditions for successful outcome</td>
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<td>Plan for post-discharge</td>
<td>To sustain gains: plan self-management strategies, follow-up, refreshers</td>
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REFERENCES
