participation after controlling for demographic and injury-related factors.
Method: Patients with ABI (n=100) were assessed within approximately two weeks of enrolment in inpatient rehabilitation. Predictor variables included demographic and injury-related characteristics and the following neuropsychological factors: active and passive coping, attention, executive functioning, verbal memory, learning potential, depressive symptoms, motivation, extraversion, neuroticism and self-awareness.
Results: Bivariate analyses revealed that passive coping, executive functioning, depressive symptoms, extraversion and neuroticism were significantly associated with HRQoL and/or participation. Hierarchical regression analyses showed that neuropsychological factors significantly explained additional variance in HRQoL (18.1%-21.6%) and participation (6.9%-20.3%) after controlling for demographic and injury-related factors. A higher tendency towards passive coping was the only significant neuropsychological predictor (beta=-.305 to -.464) of lower HRQoL and participation.
Conclusion: This study shows that neuropsychological functioning and in particular passive coping, plays a role in predicting HRQoL and participation after inpatient ABI rehabilitation and emphasizes the importance of addressing patients' coping styles in an early phase of ABI rehabilitation.
Correspondence: Ieke Winkens;
i.winkens@maastrichtuniversity.nl

Investigating the Comprehensive Inventory of Thriving (CIT) as a rehabilitation outcome measure
Hennessy, Maria[1]; Hunt, Nicole[2]; Morris, Kayla[1] and Sealey, Cindy[2]
[1]Psychology, College of Healthcare Sciences, James Cook University, Townsville, Qld, Australia
[2]Community Rehabilitation North Queensland, Townsville, Qld, Australia
Reliable and valid outcome measures are needed in community rehabilitation settings following acquired neurological injury. The Comprehensive Inventory of Thriving (CIT) (Su, Tay and Diener, 2013) was investigated for this purpose. The CIT is a 54 item self-report measure that provides 18 subscales and seven main scales of thriving: Relationships, Engagement, Mastery, Autonomy, Meaning, Optimism and Subjective Well-being. Participants (n=76) were administered the CIT on admission to a community rehabilitation service. The mean age of participants was 54.8 (SD = 17.7), with 43% being male. The main diagnostic groups were cerebrovascular disease (28%), traumatic brain injury (17%) and Parkinson's disease (12%). Internal consistency was moderate to high (α =.6 to .9) for all subscales with the exception of Support (Relationships) and Skills (Mastery); and high (α=.79-.93) for all indexes with the exception of Subjective Wellbeing. Correlational analyses supported the scale groupings. However, the subscales of Support (Relationships) and Skills (Mastery) did not correlate significantly with any subscales. Additionally the Subjective Well-being scale should not be calculated, but instead its three subscales (Negative Feelings, Life Satisfaction, Positive Feelings) used individually. In terms of demographic variables, there were no significant gender differences on CIT scales. Age had low correlations with two Relationships subscales only (Trust r=.23, p=.04; Loneliness r=-.25, p=.03). Diagnostic group minimally influenced CIT scores. Significant between-group differences were only found for Accomplishment (Mastery), with post-hoc analyses indicating higher levels for the cerebrovascular group. The CIT shows considerable promise in rehabilitation outcomes as a reliable and valid multi-component measure of wellbeing.
Correspondence: Maria Hennessy;
maria.hennessy@jcu.edu.au

Session 12 – Measuring outcomes

The Minimal Clinically Important Difference for the Mayo-Portland Adaptability Inventory (MPAI-4)
Malec, James F.[1]; Kean, Jacob[2] and Monahan, Patrick[1]
[1]Indiana University School of Medicine/Rehabilitation Hospital of Indiana, Indianapolis, Indiana USA
[2]University of Utah, Salt Lake City, Utah, USA
Background/Aims: The Minimal Clinically Important Difference (MCID) of a measure is critical to identify responders to intervention. Because each holds advantages, distribution- and anchor-based methods are commonly used together to triangulate on the MCID. We used such a multi-modal method to identify the MCID for the MPAI-4 and a moderate, i.e., more robust, level of change (RCID).
Method: Data were for individuals with acquired brain injury in rehabilitation programs throughout the U.S. in the OutcomeInfo Database (n=3087) with two MPAI-4 ratings. Anchored estimates were referenced to a subsample with the Supervision Rating Scale (SRS; n=2726). Finally, hypothesized MCID and RCID values were evaluated through clinical provider ratings of case protocols.
Results: T-scores (standard deviation=10) were used in all analyses; consequently, ½ standard deviation = 5 on the T-score metric (5T). Other distribution-based analyses found the standard error of measurement (SEM)=4.07 (small difference); 1.96XSEM=7.98 (moderate difference); and 2.77XSEM=11.27 (large difference = Reliable Change Index; RCI). Receiver operating characteristic (ROC) analyses anchored to the SRS suggested significant change on the MPAI-4 occurred between 7.5T and 8.5T. Among those who received intensive rehabilitation, 72% changed ≥5T and 54% changed ≥9T compared to 12% and 4%, respectively, among those receiving only supported living services. Virtually all clinical raters (99%) considered a 9T change to indicate improvement;