

Experiences of people with disabilities during their rehabilitation process: Grounded Theory*

Vivências de pessoas com deficiência durante o processo de reabilitação: Teoria Fundamentada nos Dados

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ABSTRACT

Objective: to construct a theoretical model that can represent the experience of people with disabilities during the physical rehabilitation process. **Methods:** qualitative research, based on the theoretical framework of Grounded Theory. We interviewed 28 participants in three sample groups, using a theoretical sampling and data circularity to analyze initial, focused, and theoretical codings. **Results:** the phenomenon “Experiencing the process of rehabilitation” was formed by 66 conceptual codes. Its conditions were the categories: “Coping with the new condition”, “Experiencing the challenge of rehabilitation”. Action-interaction: “Finding motivation for rehabilitation”; consequence: “Adapting to the condition”. **Conclusion:** the theoretical model highlights the need to cope with the disability, leading the individual to learn how to deal with challenges and to recognize the gradual and challenging nature of rehabilitation. **Contributions to practice:** the theoretical model is innovative for explaining the rehabilitation process in people with disabilities, highlighting the importance of facing the new condition, finding motivation, and adapting. The crucial role of the health team also stands out, as do the relevance of getting in touch with others who have been through the same process. The application of this model is expected to increase rehabilitation efficiency, culminating in higher quality of life for patients. **Descriptors:** Rehabilitation Centers; Patient Care Team; Disabled Persons; Rehabilitation.

RESUMO

Objetivo: construir um modelo teórico representativo da vivência de pessoas com deficiência durante o processo de reabilitação física. **Métodos:** pesquisa qualitativa, pautada no referencial da Teoria Fundamentada nos Dados. Realizou-se entrevista com 28 participantes em três grupos amostrais. Utilizou-se amostragem teórica e circularidade de dados para análise em codificações inicial, focalizada e teórica. **Resultados:** compuseram o fenômeno “Vivenciando o processo de reabilitação” 66 códigos conceituais. Foram condições as categorias: Enfrentando a nova condição e Vivenciando o desafio da reabilitação. Como ação-interação: Encontrando motivação para reabilitação; e, como consequência: Adaptando-se à condição. **Conclusão:** o modelo teórico destaca a necessidade de enfrentamento da condição de deficiência, levando o indivíduo a aprender a lidar com os desafios, reconhecendo a natureza gradual e desafiadora da reabilitação. **Contribuição para a prática:** o modelo teórico inova ao compreender o processo de reabilitação em pessoas com deficiência, enfatizando a importância de enfrentar a nova condição, encontrar motivação e adaptar-se. Destaca ainda o papel crucial da equipe de saúde e do contato com outros que passam pelo mesmo processo. Sua aplicação promete ampliar a eficácia da reabilitação, culminando em uma maior qualidade de vida para os pacientes.

Descritores: Centros de Reabilitação; Equipe de Assistência ao Paciente; Pessoas com Deficiência; Reabilitação.

Introduction

17.3 million two-year old or older people present many types of disability. 14.4 million of them live in urban areas, while 2.9 million live in rural ones. Disabilities are classified as auditory, visual, mobility, or mental, with auditory ones as the most prevalent (6.5%)⁽¹⁾.

Physical disabilities, which can affect upper and/or lower limbs, have a significant impact on the functionality and wellbeing of individuals. The nature and duration of disabilities can vary, and they can be classified as temporary (recovery is possible with adequate treatment); reversible (may be improved or replaced with medical interventions); permanent (resistant to attempts of healing or replacement); and remediable (can be improved with the use of prostheses after amputations). These disabilities can be genetic, manifesting from birth, or acquired throughout one's life⁽²⁾.

In the last decade, there has been a considerable increase in the search for rehabilitation, and this increase in demand is expected to continue in the coming years. This dynamic results, primarily, from the increased life expectancy and the general increase of longevity worldwide. This increased the prevalence of non-communicable diseases and concomitant medical situations (comorbidities), since an important association has been shown between pre-existing chronic conditions and functional limitations⁽³⁾.

Rehabilitation can maximize recovery and improve quality of life⁽⁴⁾. From the perspective of comprehensive care, multidisciplinary process seeks to treat and restore impaired functions or create opportunities to acquire new skills. This biopsychosocial approach facilitates reintegrating the individual in society. Rehabilitation has a significant impact on rebuilding one's self-image, increasing self-esteem, improving self-perception, and understanding social roles. At this moment, one recognizes and resignifies the context of their life⁽⁵⁻⁶⁾. Many disabilities cause significant physical sequelae, and experiencing them

causes intense changes in the daily life of individuals, changing their perspective about life by imposing many limits and provoking fear. Thus, coping with this unexpected change can cause feelings of insecurity about the future of one's body and one's future life, considering this new reality⁽⁵⁻⁶⁾.

People with physical disability can experience different developments during rehabilitation processes. In dealing with these unavoidable changes, new treatments and experiences can be proposed as potential alternatives to this new reality.

Rehabilitation can be facilitated by specialized workers in health care centers. However, the broader, more integrated knowledge about the rehabilitation of people with physical disabilities, which includes physical, emotional, social, and psychological aspects, is often flawed. This complex procedure involves not only the disabled person, but also their family and health workers. Therefore, it is necessary to develop a holistic theoretical model, one that can enable a more complete and efficient perspective about physical rehabilitation. Considering the above, the following question emerges: "How do people with disabilities experience the rehabilitation process?" This study sought to construct a theoretical model that can represent the experience of people with disabilities during the physical rehabilitation process.

Methods

Qualitative research, based on the theoretical framework of Grounded Theory (GT), from a constructivist perspective⁽⁷⁾. The setting was a rehabilitation center affiliated with the Lucy Montoro network, located in a medium-sized municipality in the inland region of the state of São Paulo, Brazil. This network includes 20 units throughout the state and provides more than 100 thousand consultations per month. This study was in accordance with the directives of the Consolidated Criteria for Reporting Qualitative Research (COREQ).

Data collection followed the GT process as

oriented by theoretical sampling, involving 28 participants divided into three groups. The first group, with 10 people with physical disabilities who were experiencing the phenomenon analyzed, was the starting point for the selection of the theoretical sample. To be included, participants had to be over 18 years old, physically disabled, involved in a rehabilitation program at the institution, and have the cognitive capability needed to provide information. Individuals who attended the rehabilitation center for less than three months were excluded from the sample.

The first contact with the participants was in person, at the rehabilitation center. The objectives and justifications of the research were explained. Data collection took place from January to October 2019 through semi-structured interviews with people with disabilities, family members/companions, and professionals of the health center. The interviews were scheduled in advance, considering the availability of the participants. Interviews were recorded, amounting to 11 hours and 48 minutes.

The high dependence of participants and the involvement of caregivers in the rehabilitation process suggested that family members and companions could offer valuable insights into the phenomenon. Based on this observation, a second group with eight participants was formed, including relatives or companions of the disabled persons. They were included due to their ability to understand and communicate experiences appropriately, also considering the fact that they were the main or most frequent caregivers of the disabled person during the rehabilitation process. Those who worked as caregivers only occasionally were excluded.

Another conjecture was that health workers could also provide an essential perspective about the dynamics of the rehabilitation process. This led to the formation of a third group, including ten professionals from the multidisciplinary team who had been actively involved in providing rehabilitation care for at least one year. We excluded health workers who were not actively involved in the practice of rehabilitation care.

Interviews started with a sociodemographic questionnaire, followed by specific questions for each group. They were conducted by an MS student trained in the technique. It should be noted that the script was adapted to attend to the particularities of each group, accordance with GT guidelines.

The main question for individuals with physical disabilities was: How do you experience the rehabilitation process? For their family, the question was: How do you perceive the experience of (name of the person with a disability) in regard to their disability? Regarding health workers, the approach was based on the question: What is your perspective regarding people going through the rehabilitation process? Supplementary questions were also asked according to the answers given to the first one. All interviews were conducted while the participants were at the facilities of at the rehabilitation center.

Regarding the analysis of interview data, it was manual, in a three-stage constructivist approach: initial, focused, and theoretical coding. During initial coding, data was broken down and analyzed in order to capture ideas and meanings expressed by participants, converting them into codes⁽⁷⁾. 968 conceptual codes emerged from the analysis of the data.

In the focused coding stage, data was grouped, categorized, and summarized to make the codes more selective and conceptual. We used an analytical tool called "3Cs" (Conditions, Actions-Interactions, and Consequences) to facilitate understanding the relationships between categories and identify the phenomenon under study. This was the theoretical coding stage. This stage is an advanced level based on previously selected codes. We identified 66 more direct, selective, and conceptual codes⁽⁷⁾.

Data was transcribed and coded by the researchers as a group, starting with the first interview. Analysis resulted in additional rounds of data collection and analysis, in successive comparisons, to ensure that information was relevant and representative and there was no need to repeat the interviews. The moment of data saturation was decided upon via

consensus between researchers. Due to difficulties to access, only the professionals, two relatives, and one disabled person received later access to the content of the interview.

Professors experienced on the topic and in qualitative research, focused on GT, conducted the validation of the theoretical model and evaluated the dissertation. We presented the model to the professors, who examined it regarding its validity, relevance, and rigor. The validation took this form due to the context of the research, which took place during the 2020-2021 pandemic, when COVID-19 restrictions prevented the formation of groups with participants due to the risk of exposure to the virus.

To guarantee data confidentiality, participants were referred to, in the citations, using the letters P (patient), C (companion), and T (team), followed by a number indicating the order of the interview (P1, C1.. T10). All participants signed the Informed Consent Form. The study was approved by the Research Ethics Committee of the de Medicina de Marília under opinion No. 4735516/2021 and Certificate of Submission for Ethical Assessment No. 03108218.3.0000.5413.

Results

The first sample group was formed by five men and five women with physical disabilities, from 24 to 68 years old, complete high school, and income from one to three minimum wages. Regarding physical/clinical characteristics, four people were diagnosed with brain injuries, two with spinal cord injury, three with amputations, and one with a neurodegenerative disease.

Patients had had the disability from eight months to three years, with the exception of one case, where the disability emerged after childbirth. An analysis of the level of dependence in daily activities showed an equitable division among participants. Half reported feelings of independence, while the others described partial dependence since the start of rehabilitation. This balanced distribution highlights the remarkable

diversity in individual experiences of autonomy, emphasizing that a customized experience, sensitive to the specific needs of each participant, is necessary in the context of rehabilitation. It is worth noting that this criterion was not evaluated using a scale, but the perception of the participant about their condition.

Regarding family and companions, their age was between 32 and 71 years old, and most were women. A significant portion of the interviewees in these sample groups were experiencing the role of caregiver for the first time. Additionally, interviewees were directly related with the disabled person. This data emphasize the relevance of family relations and the significant adaptation of caregivers to their role.

The team was formed by ten female workers from 25 to 46 years old. In the third sample group, there were two social workers, one physical therapist, one psychologist, one speech-language therapist, two occupational therapists, one nutritionist, one nurse, and one physical educator. These interviewees had a professional experience from four to sixteen years, having worked in the institution from two to five. All participants had specializations. We elaborated the main category "Experiencing the process of rehabilitation", which had the conditions "Coping with the new condition" and "Experiencing the challenge of rehabilitation", the Action/Interaction "Finding motivation for rehabilitation", and the consequence "Adapting to the condition".

Experiencing the process of rehabilitation

Due to the rehabilitation process, patients had to confront the condition experienced due to their disabilities. They had to learn how to deal with this new condition and recognize that rehabilitation is often a slow process. In this context, they experienced the challenge of rehabilitation. They learned actions of care and, simultaneously, felt how this process can be tiring.

In the action-interaction movement, team support and people who experienced the same process

brought motivation and strength to face rehabilitation.

As a consequence, adaptation to this condition happened through a discovery of new values, leading to gains in independence and the overcoming of prejudice.

Coping with the new condition

Considering this new condition, we wanted to achieve a deep understanding of the phenomenon and of the process of overcoming disability and rehabilitation. Participants coping with their new condition were aware that recovery is gradual. For both the disabled person and their main caregivers, dealing with the new condition was a great challenge, which generated feelings of despair and impotence. Profound changes to lifestyle were necessary, requiring a joint effort in a continuous struggle for improvements. In this context, they also became overloaded and stressed, obstacles to the adaptation to the needs of care; also, they organized themselves in order to attend to the demands imposed by the dependence of the disabled person: *At first, I was disheartened, sad, remembering the hectic life I used to have. Being paralyzed, completely depending on others (P7). We need to do something again... it's terrible to just sit and lay down. Up to this point we are too dependent on others (P10). He had a normal life, he was a boy, had a job, had a girlfriend, had friends, and then you suddenly find out that this is over, I do get sad (A7).*

Participants understood that rehabilitation requires willpower, effort, persistence, and dedication, as it is a gradual process. They learned to control their discouragement and their hurry to evolve above their physical limitations: *I participate because I want to improve fast, 100% (P4). Sometimes the time it takes is what gets me the most tired. In my case, it has been almost a year since the beginning. In the end, it gets tiring. If there's no clear goal, it can be disheartening, and we give up in the middle of the way (P10).*

Experiencing the challenge of rehabilitation

Experiencing the challenge of rehabilitation is

an integral part of the phenomenon. It involves the learning routine of care and the struggle against the fatigue caused by the process.

Adapting daily activities and care to new demands was crucial in the experience of rehabilitation. It increased routine safety, while giving more autonomy, independence, and progress in dealing with the condition, bringing everyone closer to what was done before the disability was installed: *At first, I was more afraid that wounds would appear, or an infection, it was hard. Today I know what to do to avoid that (C2). There is a lot I couldn't do but I became independent, that they taught me... it my life a lot easier (P3). Bringing him to his context again... making him go back to developing the activities he used to everywhere, in an adapted or readapted way (T3).*

Participants reported difficulties continuing rehabilitation, since it is a tiring process, both because it requires them to commute to consultations, and because of the time it took to participate of the activities: *I wake up at 03h30 am, and get there about 06 am, so the service can start at 8 am. Then, theres activities until 12 pm. Sometimes I have transportation, sometimes I have to wait in the support house. It's tiring. In those days, I end up not eating properly, and everything gets unregulated, my schedule, everything is different (P10).*

Finding motivation for rehabilitation

"Finding motivation for rehabilitation" is an action and/or interaction of the phenomenon, that is, it is an experience that becomes motivation for the rehabilitation process, which happens when people in rehabilitation feel the support of the team and find strength in one another.

Participants described that they experience the feeling of encouragement and care during the rehabilitation process. Statements also reported that interviewees felt strengthened by the support of the team: *The team gives me strength, never to give up. Sometimes we get here disheartened, and the person starts talking to you, raise you up (P7). I think people who work here are quite welcoming. They treat us so well that we can talk to them as if they were our friends, they know how to talk to us (P4).*

Contact with other physically disabled people proved to be favorable to the rehabilitation process, and was valued by participants as they reported on motivational feelings and sharing. This was uplifting and gave them strength to dedicate themselves and overcome challenges in the process they were experiencing: *Here, I find friends who have been through the same thing I have. What I take from this experience is the possibility of overcoming this situation, I learned a lot from the patients themselves. Some of them were in situations more difficult than mine, and were more determined to recover than I was. This can teach us a lot* (P3).

Adapting to the condition

Adapting to the condition is the consequence of the phenomenon. It can be noted when the person discovers new values, conquers independence, and overcomes challenges.

Participants reported that rehabilitation allowed them to rethink their lives and change their values, to the point of seeing it as a life lesson that allowed them to rediscover priorities, with an eye to quality of life and health care: *I was very scared on the first day... To me, this was a completely new reality, I had never had any experience with this kind of thing. To me, it was a life lesson. You can value things you didn't use to* (P6). *When I got there, I wanted to walk without crutches. Then, I found that this is not the most important thing. Today I do use crutches, but I drive, I do everything on my own, independently* (P3).

In this category, we noticed that participants got more autonomy, self-esteem, and self-confidence, reached objectives and had the experience of overcoming challenges: *Imagine hearing from a doctor that you'll never walk again, you will be on a bed and depend on other people, and then you see that you are getting there, that there is something you can already do on your own... for us this is a huge reason for joy* (P7). *In rehabilitation, we work to try and give more quality of life to all disabled people we attend. I think that to rehabilitate is to make the patient more independent* (T2).

In the experience participants had with rehabilitation, it is clear that they needed to overcome their own prejudice and accept their condition. To do so,

they counted on the help of professionals: *So, the psychologist worked that side for me very well, and I managed to overcome this part* (P3). *Then, when physical therapy started, and occupational therapy, they liked it, they started becoming friends with other patients who were similar* (C6).

Discussion

Using trigger questions, we gave space for the participants to share their experiences with disability and rehabilitation. Coping with this new reality is not easy, especially considering one's limitations and dependence in daily activities.

Disabilities are challenging and long-lasting, often permanent conditions. This affects one's perception of oneself, requiring adaptation to a new physical condition and relationships. Many factors influence the way in which these persons face their lives. Dealing with the consequences of the disabilities requires patients to overcome emotional, social, cultural, sexual, body image, and self-esteem issues, leading to profound reflection on their own existence. This process leads one to reconstruct their identity, to adapt and resignify⁽⁸⁻⁹⁾.

In the participant report, we can notice the feeling of sadness due to the degree of disability installed, almost quickly and due to the fact they became dependent on the care provided by a relative, who take the responsibility for this activity without having the appropriate conditions or being properly trained to do so. Dependence is seen as a symbol of that which was lost⁽¹⁰⁾, which brings much suffering and challenges.

In the general context, disabilities require restructuring the living conditions of the disabled person and their family. It is inarguable that the presence of a physical disability in an individual will also have repercussions on family members and people around them, who also experience a mourning process. Thus everyone must find a new form to organize⁽¹¹⁾.

Some interviewees understand that rehabilitation aims, especially, at the independence of people with disabilities, that is, there is an interest for direct

physical improvement, but an adaptation to the residual sequelae of injuries is likely to be necessary as well. As participant reports showed, the search for independence is much more than a peaceful and loving process. Changes in quality of life, for example, of both the disabled person and the caregiver, make this process long and painful, and transform care in a mixture of feelings.

Daily care, although crucial, can generate stress and overload for caregivers. This ambiguity in their feelings has been highlighted by several authors. On one hand, continuously providing care can lead to fatigue; on the other, it strengthens emotional bonds due to the proximity and the mutual feeling of care. Furthermore, the process of rehabilitation and the improvements reached can encourage the caregiver, especially in situations where time investment is prolonged and the activity is vital for the survival of the person receiving care⁽¹⁰⁾.

Learning how to deal with the new condition and accept how slow the recovery process is can bring forth feelings of despair and impotence, requiring joint effort and a continuous struggle. We recognize that functional gains are gradual and almost imperceptible, causing frustration in the way⁽¹²⁾. Rehabilitation also encourages ambiguous representations, especially as it is a slow process that involves progress and loss, and involves different professionals, family, and disabled people, generating, in some cases, motivation, satisfaction, hope, and expectancies, with an incessant search for improvement; while, in other cases, it leads to fear, frustration, anger, sadness, and despondency^(10,13). Disabled women attended by the professionals of a basic health unit experienced negative feelings, such as fear, insecurity, restricted accessibility, and lack of contact with professionals and the service⁽¹⁴⁾.

Despite the difficulties in rehabilitation, participants, both caregivers and disabled persons, are happy as they perceive improvements in the process. Caregivers, due to their constant proximity, feel each progress closely. Following these advancements pro-

vides them with the motivation to continue, since they perceive that their dedication is a contributing factor. Additionally, when caregivers feel more supported, they can feel relief from their burden, even when confronted with continuous responsibilities⁽¹⁵⁾. Learning how to readapt to daily life activities, and to the extra care now required, was an important aspect of the rehabilitation process, one which allowed more safety in the performance of care and generated gains in autonomy.

Participant statements report improvements in daily routine activities, including cognitive and communicational ones, which also emphasizes the fact that rehabilitation is a process that requires motivation and persistence. Thus, we can see a trajectory permeated by profound changes in the lives of people, which culminate in experiences of adaptation and in overcoming personal issues, as well as those related with daily life, mobility, and others.

Thus, it becomes clear that rehabilitation must be designed as a unique process, customized to the person, in order to favor their engagement in the activities. Nonetheless, this depends on the interest, motivation, and time each person has to cope and seek to minimize their functional difficulties, in addition to requiring harmonious, interdisciplinary work^(12,16).

In this context, team support, through embracing and experience, was decisive for patients to overcome difficulties in continuing their follow up. Embracing takes place through qualified listening, concerned with the real needs of the subjects, expanding possibilities of care without eschewing specialized, technical attention, while broadening the perception of biopsychosocial needs based on interdisciplinary action, considering the logic of integral health care^(13,17).

According to directives for the functioning of the network of Care to the Person with Disability, embracing is an essential element of care to reorganize health services, and expresses the relationship between people and professionals⁽¹⁸⁾. This is a unique aspect of the rehabilitation process, characterized by its dedication to care, attention, caring nature, respect,

and the good conversations that encourage walking forward, establishing a relationship of mutual trust⁽¹²⁾.

Physically disabled persons reported that the main source of encouragement for them to overcome their situation and go through rehabilitation is the strength gained from socializing with other disabled persons, who, despite undergoing similar struggles, are judged as “better” or “worse”, helping them patients grow and gain the strength to fight. Contact with other people in similar or more complex situations make them more resilient when dealing with adversities, giving them new hope that they will be able to recover their role and status in the family and social context⁽¹²⁾.

Sharing experiences with other physically disabled persons, seeing oneself in others who have been through similar struggles, and perceiving oneself as part of a supportive and understanding group are vital for social reintegration. Seeing that others perform daily activities helps adaptation, and encourages people to develop abilities to be able to lead an autonomous life. Therefore, the authors emphasized the relevance of the group care provided by the physical rehabilitation centers⁽¹⁰⁻¹²⁾.

Rehabilitation allows the physically disabled person to reconsider their life, reevaluate values, and discover new priorities, promoting a better quality of life. The perspective through which these people see life and disability changes. Some make statements about resignifying disability and the process of rehabilitation.

The main goal of the rehabilitation process is to improve functionality and, above all, quality of life. Considering that personal perception has a crucial role in this regard, health workers, family, and the disabled person themselves must devote significant attention to redefining their condition. This process is gradual and results from the understanding of grief, the adaptation to new roles, the losses, and the gains brought about by the disability⁽¹³⁾.

The experience of overcoming these hurdles, considering the gains, was remarkable, and the reha-

bilitation experience had very positive meanings. Performing self-care activities is perceived as dignified and reduces the dependence of the disabled person, in addition to signaling an improvement from the perspective of caregivers, since they, in turn, feel rewarded when they notice that their relative is improving as a direct result of their role as caregivers^(11,19).

Considering that rehabilitation seeks to transfigure daily life, in an attempt to work with what is there “today”, with the ability that remains, in order to achieve the greatest level of independence possible within the functional potential of each individual, adapting as best as possible to their new condition, participant statements showed that they achieved independence that was reflected in many areas, such as self-esteem and self-confidence, which is the goal of rehabilitation⁽²⁰⁾.

Data from this research has brought forth important reflections on health care practices in this context, guiding more effective action to attend the needs of these persons, and revealing the experience of the rehabilitation process. We would also like to emphasize the importance of educating nursing workers capable of providing care that is attentive, humane, inclusive, high quality, and capable of dealing with the issues of physically disabled persons.

Study limitations

Study limitations include the possibility of subjective interpretation in the application of GT, in addition to the complexity of the method and the potential for confirmation bias. Regarding the composition of the sample, its representativeness, size and size, as well as potential biases in participant selection can be limitations. Regarding data collection and analysis techniques, quality is paramount, and adequate training is essential to avoid researcher bias.

Another limitation is the fact that the theoretical model used with participants was not validated. This can prevent the generalization of our findings beyond the specific context of the study. We would

also like to mention the experience of people with disabilities, who may not have access to multidisciplinary rehabilitation services, since this process includes health care as a whole.

Contributions to practice

The theoretical model has an innovative approach in the description and categorization of different stages and components of the physical rehabilitation process in disabled people. It highlights the importance of coping with the new condition, experiencing the challenges of rehabilitation, finding motivation, and, ultimately, adapting to the new condition. Furthermore, it emphasizes the importance of the health team and of socializing with others who are going to the same process. This approach provides a broad and holistic perspective about the rehabilitation process, enriching our understanding of this complex phenomenon.

Applying this theoretical model can promote a broader and more effective approach to the rehabilitation process, leading to better results and to better quality of life to disabled patients.

Conclusion

The rehabilitation process is crucial to improve the experience and the state of health of people with disabilities. The theoretical model “Experiencing the process of rehabilitation” showed that coping with the new condition and the challenges associated with it is of the essence. This leads the individual to understand how to deal with the disability, which involves learning how to care and recognizing that rehabilitation is often a slow and grueling process. The motivation and strength to go through rehabilitation are found in the support from the team and from people who are going through the same process, which helps adapting to this condition. This leads to the discovery of new values, increased independence, and to the overcoming of prejudice.

Authors' contribution

Concept and project, analysis and data interpretation, writing of the manuscript, relevant critical review of the intellectual content, final approval of the version to be published, and agreement to be responsible for all parts of the manuscript: Pereira NS, Alarcon MFS, Selleti JDN, Marin MJS.

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