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Experiencing the education process in physical rehabilitation*

Vivenciando o processo de educação na reabilitação física

Vivenciando el proceso de educación en la rehabilitación física

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ABSTRACT

Objective: To interpret and build a theoretical model of the user's experience in the education process in physical rehabilitation settings. **Method:** Qualitative research, based on the Grounded Theory. The setting was a Rehabilitation Center of Rede Lucy Montoro, located in an inland city of the State of São Paulo. Data collection took place from January to October 2019, based on 28 interviews with three sample groups. The collection and analysis process was guided by theoretical sampling. **Results:** A total of 122 conceptual codes emerged. The main category established was "Experiencing education in rehabilitation"; as Conditions, the categories: relying on team support, and considering the group dynamics; as Actions-Interactions, the category: experiencing instructions; and as Consequences, the categories: promoting change of habits, and finding resistance in the follow-up. **Conclusion:** The experience in the education process in rehabilitation indicates that this is an action that requires adequate communication and acceptance by the team. In group activities, although there are experiences exchanges among the members, the heterogeneity of situations shall be considered.

DESCRIPTORS

Rehabilitation; Disabled Persons; Health Education.

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INTRODUCTION

Data from the World Health Organization (WHO) reveal that one billion people in the world have some type of disability. In Brazil, the number of people with disabilities in 2010 was approximately 23.9% of the population and, of these, 7% had physical/motor disabilities which, according to the National Health Policy for People with Disabilities, concerns people with complete or partial alteration of one or more segments of the human body, causing physical functioning impairment[1].

In Brazil, the most common causes of physical disability are related to amputation, with 13.9:100,000 inhabitants/year; traumatic brain injury (TBI), with half a million people annually; spinal cord trauma, with six to eight thousand new cases per year; and neurodegenerative diseases, including peripheral neuropathy, 1:2500, and amyotrophic lateral sclerosis (peripheral), from 1 to 2.5:100,000[2].

Given this reality, the health of people with disabilities has gained greater visibility in recent years, resulting in policies aimed at building services in line with the principle of comprehensive care[3].

As an example of this movement, the National Health Policy for People with Disabilities establishes institutional responsibilities for providing conditions for the rehabilitation of people with disabilities, and guidelines for comprehensive care, protection and guarantee for health.In this direction, the Care Network for People with Disabilities was also proposed, established by Ordinance No. 793, of April 24, 2012, with guidelines that broaden access, articulation and the creation of new health care points, offering comprehensive care and multidisciplinary and interdisciplinary assistance for people with disabilities[4].

Among the care fronts for people with disabilities, the Rehabilitation Network Lucy Montoro was created by decree 52.973/2008 of the Government of the State of São Paulo, with the purpose of providing advanced rehabilitation treatment for people with disabling physical, motor and sensory-motor disabilities, aiming to achieve the highest possible level of physical and functional independence of the individual, as well as promoting supportive interaction to family members, with a holistic view of care. The Network involves multidisciplinary and interdisciplinary assistance specialized in the area of Rehabilitation Medicine, consisting of nurses, physiatrists, physiotherapists, nutritionists, psychologists, occupational therapists, social workers, physical educators, and speech therapists, with Health Education as a care strategy[5].

Health Education, as well as the practices resulting from it, has undergone extensive conceptual changes in the last century, no longer being seen as the transmission of information of a hygienist-sanitary nature carried out in formal contexts and oriented towards the prevention or treatment of illness. Thus, Health Education comes to be understood as the training of individuals to control their own health determinants through the development of action skills[6]. This way, people's autonomy is sought in the way they live their lives.

Therefore, based on the understanding of health as a permanent process of change, it is understood that Education in the context of rehabilitation involves all the learning necessary to adjust life activities to the disability and to promote healthy habits in the face of the situation experienced, through a holistic and dialogic approach[7].

However, although the National Health Policy has as its axis the promotion of health, which is essentially based on health education, there is a shortage of studies addressing the topic in the context of rehabilitation. Hence, this study starts from the following question: what is the experience of users regarding education in specialized rehabilitation services?

Considering the complexity of the practice of Health Education in its different forms of approach, unveiling the experience of Education in the rehabilitation scenario from the perspective of those involved in this process can be an opportunity for reflection on this practice. The objective of this study is to interpret and build a theoretical model of the user's experience in the education process in physical rehabilitation settings.

METHOD

Design of Study

This is a qualitative study that used the Grounded Theory (GT) method based on the constructivist perspective of the method[8].

Local

Research was carried out in a Rehabilitation Center of Rede Lucy Montoro, located in an inland city of the State of São Paulo.

Theoretical Sampling

The collection and analysis process was guided by theoretical sampling, as recommended by the GT, divided into three sample groups. The obtainment of the theoretical sampling began with data collection from the first sample group, consisting of those who experienced the phenomenon. It consisted of ten physically disabled people, having as inclusion criteria being inserted in a rehabilitation program of the institution and having cognitive conditions to provide information. Those with less than six months of treatment at the Lucy Montoro Center were excluded.

In the construction of the first sample group, using the constant comparative method and memorandums, the hypothesis was raised that family members and their companions could contribute to the understanding of the phenomenon, as the great involvement and dependence of family members/caregivers who accompany them in the rehabilitation process were observed. Thus, questions raised about how these people see their family member's rehabilitation experiences, leading to the formation of the second sample group, which consisted of eight family members. Family members/companions who were not the main caregivers were excluded, that is, those who accompanied them less frequently than once a week.

Health professionals are important actors in the users' experience, as they are responsible for developing activities in the rehabilitation process. This way, the hypothesis that health professionals could contribute with the view of the dynamics of the rehabilitation process on the phenomenon was formulated.

Finally, a third sample group was required, consisting of ten professionals from the multidisciplinary team (social worker, psychologist, physiotherapist, occupational therapist, speech

therapist, nurse, nutritionist and physical educator) who have worked directly in the care practice in rehabilitation for at least one year from the date of collection, with professionals on leave for any reason during the period of research data collection being excluded.

Data Collection

Data collection took place from January to October 2019 through semi-structured interviews, recorded through digital voice recording, previously scheduled with the participants according to their most convenient dates and times.

The interview began with a sociodemographic data sheet for all respondents and specific questions for each sample group. The questionnaire was changed for each participating group according to the GT. For the physically disabled, the interview had the following guiding question: what is your experience regarding education in the rehabilitation center? For family members, the following question was asked: do you notice the progress of activities given in rehabilitation? And for the professionals, it was asked: talk about the educational practices carried out in this Rehabilitation Center. According to the content of the answers, other issues were raised. The interviews were carried out when the participants were at the rehabilitation center.

Data Analysis and Treatment

The treatment of material from interviews, carried out manually, followed the coding process according to Charmaz's constructivist methodological approach[8], which takes place in three stages: initial coding, focused coding, and theoretical coding. In the initial coding, data were fragmented and analyzed to conceptualize the ideas and/or meanings expressed by the participants, transforming them into codes. At this stage, 968 codes emerged.

Focused coding, the second coding stage from a constructivist perspective, allows for separating, classifying, and synthesizing large amounts of data. At this stage, 122 more targeted, selective, and conceptualcodes were identified[8].

Theoretical coding is a sophisticated level of coding that follows selected codes during focused coding. Theoretical codes specify the possible relationships between the categories developed in the focused coding[8]. To help establish relationships between the categories and identify the research phenomenon, the analytical tool coding paradigm or pragmatic model was used, the "3Cs": conditions, actions-interactions, and consequences[9]. At this stage, five categories and nine subcategories emerged.

Since the first interview, the collected data were transcribed, coded and, when analyzed, led to the next collection and comparative data analysis, successively, until data saturation, determined when repetition of data and lack of new information, as well as consistency to meet the objective of the study, were observed[9]. The validation of the theoretical model was carried out by professors with extensive experience in qualitative research, especially with Grounded Theory, through the Google meet platform. This form of validation was undertaken due to the pandemic of COVID-19 experienced between 2020 and 2021, which restricted the options for constituting groups with research participants due to the risk of exposure to contagion.

Ethical Aspects

The study was approved by the Human Research Ethics Committee of the proposing institution, with Opinion no. 3.077.526/2018. To keep information anonymity, the participants were identified in the citations by the letters P (Patient), A (Companion, Portuguese word *Acompanhante*) and E (Team, Portuguese word *Equipe*), followed by an ordinal number corresponding to the lines (P1, A1... E10). All participants signed the Free Informed Consent Form (FICF), following the precepts of Resolution no. 466/12 of the National Health Council.

RESULTS

The research included 28 participants, 10 of whom were physically disabled, eight companions/relatives, and 10 professionals from the multidisciplinary team.

In the characterization of the participants, in relation to the physically disabled, there were five men and five women, aged between 24 and 68 years old, and with level of education ranging from some high school (30%) to complete high school (30%). Of the interviewees, regarding the time of disability, the number ranged from eight months to three years, except for one case of postpartum disability.

In relation to family members/companions, the age ranged from 32 to 71 years, with a predominance of women (75%), with 62.5% experiencing the role of caregiver for the first time, and 87.5% having a consanguine relationship with the disabled person.

The professionals interviewed were all women, aged between 25 and 46 years. Time since the end of undergraduate course ranged from four to 16 years, and professional experience from four to 15 years. As for the professional category, two social workers, a psychologist, a physiotherapist, two occupational therapists, a speech therapist, a nurse, a nutritionist, and a physical educator were interviewed.

The main category established was "Experiencing education process in rehabilitation"; as Conditions, the categories: relying on team support, and considering the group dynamics; as Actions-Interactions, the category: experiencing instructions; and as Consequences, the categories: promoting change of habits, and finding resistance in the follow-up. The relationship among them culminated in the elaboration of Figure 1.

Experiencing Instructions

Experiencing instructions is the condition of the phenomenon and expresses how the instructions are carried out, their process and the results people with disabilities achieve in the rehabilitation service. They take place through different teaching strategies and, sometimes, the professionals' lack of preparation for educational actions is identified. Furthermore, they are considered essential, productive, and enlightening when participants find sense/meaning.

From this perspective, it is found that the instructions provided by professionals help in understanding care related to the conditions they experience in their daily lives and in recognizing

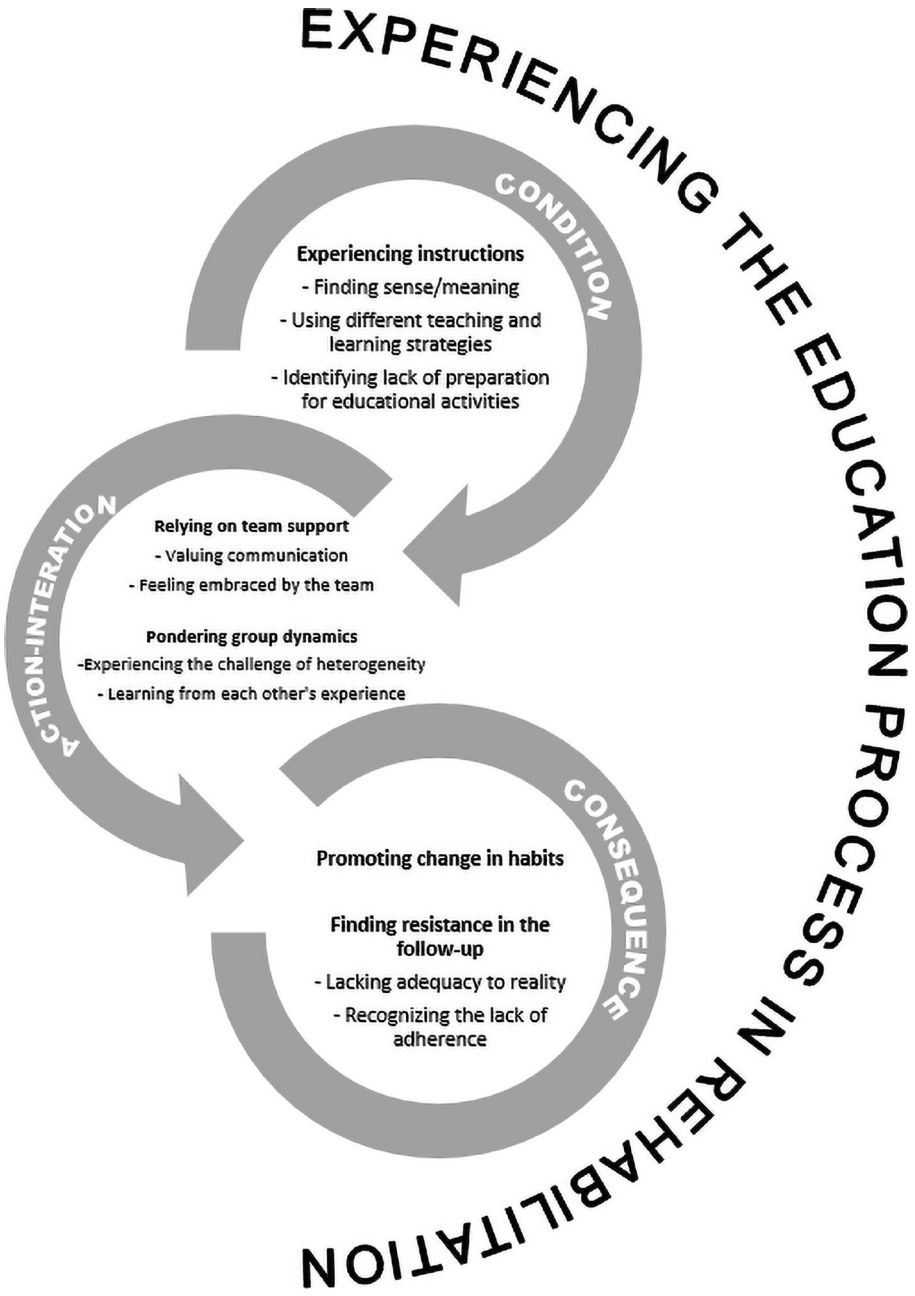

Figure 1 – Diagram representing the theoretical model "Experiencing the education process in rehabilitation" – Marília, SP, Brazil, 2021.

the importance of the proposed activities in the rehabilitation process. There are indications that losses resulting from the disability can be explained, aiming at the comprehension of what is happening, expanding the involvement and cooperation in the activities developed.

(...) I learned several things that I didn't know and I can learn from what they explain (...) everything that is worked here is in our daily lives. (P4)

We explain the entire process of losses resulting from the starting point of the disability (...) he starts to understand what is happening (...), they build a history in rehabilitation that is much more consistent, much more aware and much more participatory. (E5)

In the interviewees' experience, the existence of different ways of carrying out educational actions in the rehabilitation process is observed, when, in some circumstances, professionals use the time of physical activity intervention itself, individually or in group dynamics, in a dialogued and exemplified way, and in other circumstances they use dynamics such as lectures, use of audiovisual and didactic resources.

(...) they show on the computer everything right, the food that is good, the ones with more cholesterol, like red meat, these fatty things (P9).

We don't use resources. We use the service itself and exemplify with the activities they undertake here (...). We do it together with the patient and explain (...) (E7).

In the experience of educational actions in the rehabilitation process, especially the professionals feel that they need more

preparation to develop them, as they believe they are unaware of possible strategies that would help improve this practice.

(...) We don't have any theoretical basis to conduct our classes, because it would really improve our practice a lot. Because we work on a lot of content, which is something we have mastered, but the way we are going to convey it to the patient, I never thought about it, what would be the best way to teach it (E2).

Pondering Group Dynamics

Pondering the group dynamics is the action/interaction of the phenomenon and refers to the experience facing the challenge of participants' heterogeneity and learning from the experiences of the other, as described below.

Research participants indicate that, in group work, it is necessary to consider the heterogeneity of the participants, since each member has specificities regarding the diagnosis and prognosis, which represents a great challenge, as it can generate anguish and frustration for those involved in the activity. In addition, for the physically disabled, certain group activities can be characterized as embarrassing, since they deal with each person's intimacy.

(...) sometimes it is such a heterogeneous group that it can generate more anguish and more frustration in patients. (...) it's very complicated, thinking about the emotional issue. (E4)

(...) like she used to say "- What about urine? (...) If you ask me here alone, the two of us, I'll talk, but with four, five people I don't know (...) oh, I didn't like it, no. (P3)

Given this reality, it is noted that professionals seek alternatives to maintain the group care modality and, at the same time, address individual demands. In the context analyzed, it is observed that professionals also choose not to carry out activities with the groups, given the complexity and individuality of the conditions they present.

(...) I have to respect each one's individuality. (...), we can discuss that topic, within that group, but in different ways, where everyone participates and everyone understands each one's needs in a different way. (E6)

So, at Speech Therapy, we don't form a group, we attend individually. Because it would be very difficult. As patients arrive in very different ways. (E10)

Even with such difficulties in the experiences of a group approach, the participants reinforce that there is an exchange of experiences and bonding between those involved, highlighting group activity as a valuable strategy for the development of educational actions in health and the mutual growth of those involved.

You end up seeing the other person's experience. There are a lot of things that you mirror in the other, so it ends up strengthening you. (P6)

It has given positive feedback, they recognize themselves there in the other (...) they create a bond. We realize, then, that one also encourages the other to seek (...). (E4)

Relying on Team Support

Relying on team support is the action/interaction of the phenomenon and refers to the valuation of communication and the feeling of welcoming on the part of the rehabilitation team.

Based on the reports, it is noted, in the interviewees' experiences, an appreciation of the way communication is carried out, since there is dialogue and respect for the autonomy of the person with a disability in decision-making regarding rehabilitation. Thus, the person with a disability feels him/herself an integral part of the process.

They always talked to me, made me feel comfortable about therapy. (...) All of them have always worked on this part so as to leave this possibility of making some change in some part that was not good for me. (P3)

When I have doubts, I like to ask (...) I come and say: I'm not succeeding (...) and then we work (...). (P9)

The feeling of affection experienced by people with disabilities and by their relatives/companions was cited as a differential of the rehabilitation team, from a perspective of embracement and commitment, reflecting in learning encouragement.

I think love helps the patient a lot (...) you know that sometimes we even get touched (...) here, everyone needs it, they are all disabled, we see that you have charisma, patience. (A1)

(...) here I am learning with those who know (...) I can only be grateful for having the opportunity to be here, to learn, to be able to learn and pass it on to her and see the affection that everyone has with us, with her (...). (A8)

Finding Resistance in the Follow-Up

Finding resistance in the follow-up is the consequence of the phenomenon and refers to the difficulties encountered by the participants in following the instructions developed in the rehabilitation process educational actions. It takes place when participants do not follow the instructions because they think that theydo not fit the reality in which they live, and because they do not have the support from family members at home.

I like strong food (...) they say I can't eat it. She even gives me a menu, (...) to drink juice, eat some cookies (...) and I don't have any of that. It's good, but the instruction she gives me, I don't do it right. (P5)

I have a little difficulty to the things they ask me to do here at home. Because I live with my grandparents and I don't count on their help and I have no support (...). (P2)

In the experiences of people with physical disabilities, there is recognition that adherence to the content developed in the education process is of great relevance for the continuity of treatment; however, they are not always followed by people with disabilities, and this results in a feeling of frustration among professionals, especially when they realize that there has been a complication.

Gosh! We have so many expectations, but sometimes we get very frustrated. You see a patient who left with a stroke and came back

amputated (...) it's very sad. Because you know he just didn't follow anything you said (...) (E2)

Promoting Change in Habits

Promoting change in habits is the consequence of the phenomenon and refers to the change in habits experienced by the participants with the understanding of the instructions, resulting in clinical control, quality of life, and disease prevention.

I see that they pass on knowledge, that they provide information for the person to change a habit (...) if it generates change, it is because education is being efficient. (E8)

The liquid, especially water, he had a lot of difficulty in drinking water and is now much better. With learning, we progress more and more. (A1)

The Phenomenon: Experiencing the Education Process in Rehabilitation

Experiencing the education process in physical rehabilitation is the central category. Its condition is that in the process, different teaching and learning strategies are used, so that the disabled find meaning in educational actions; however, sometimes, what is found is the professionals' lack of preparation.

In an action/interaction movement, it is found that the educational actions in the rehabilitation process demand support from the health team, which occurs through adequate communication and embracement; and, when considering the group dynamics, the study participants identify that the heterogeneity of situations is experienced in it. Even so, in the group context, there is an exchange of experiences.

As a result, they state that, on the one hand, educational actions promote behavior change, but, on the other hand, they often lack adaptation to reality and, thus, they recognize the difficulty in implementing the actions.

DISCUSSION

The experience of the education process in rehabilitation is a complex phenomenon that involves multiple factors. By interpreting it from the perspective of different sample groups (people with disabilities, family members, and professionals), it was possible to show that intervention is essential, since the purpose of rehabilitation is to bring applications to the daily lives of people with disabilities.

In health education, there is a new focus on educational practices, to strengthen people's ability to choose, allowing them to actively participate in the decision-making process and in the implementation of strategies to improve their health conditions[10,11]. As observed in the participants' statements, although the process has challenges and difficulties, they find meaning in educational actions and manage, to some extent, changes in lifestyle habits in favor of improving health conditions.

It is understood that, in the education process, especially when it comes to the rehabilitation process, initially, the person becomes aware of the physical, emotional, social or environmental changes and, subsequently, has conditions for effective involvement. In rehabilitation, it is necessary to understand the transition processes (health-illness-disability) and develop therapies that help people regain stability and well-being, aiming at training and empowerment to face the continuity of their lives[10]. From this perspective, even if the group activities provided in rehabilitation are limited by the heterogeneity of situations, living with the other and exchanging experiences contribute to facing this difficult task.

Even in the face of challenges, the group dynamic is conceivedas an instrument at the service of autonomy, self-care of individuals, and the continuous development of health level and living conditions. The group promotes contact among different subjects and enables new movements and experiences based on the encounter with the other, thus configuring both a space of conjunction of singularities – an instance that refers to subjects' diversity – as well as a shared space, of the connection of plurality[12].

It has been considered that living with a group that brings together people with similar problems helps the participants, in terms of being able to break down barriers and receive constructive feedback and suggestions for their care. Therefore, the group can be a valuable alternative to help in coping with conditions that generate suffering[12].

In view of this, the modality of care in groups has been gaining space in health services, as it allows for the optimization of work with the reduction of individual consultations, minimizing the gap of lack of care that exists in Brazilian public health[13]. However, it should be noted that the group often gets together only as a practice of fulfilling the steps provided and required by managers, becausethere is still some unpreparedness of professionals on how to carry out an educational group and on the whole process of group dynamics, due to the lack of theoretical and methodological references[14], as observed in the present study.

In this context, the need for flexibility by the professionals in their planning is highlighted, considering the need to systematize a group action plan, aiming to access individual and relational contents. It is necessary to understand that joining a group presupposes individual and collective movements and, in this regard, the group needs moments of introspection and extroversion, towards group belonging[15].

However, this study reveals that professionals are not always properly prepared for the task, and it is indicated as essential that they learn about problematizing educational practices, to promote reflections contextualized with the person's life history, what permeates their health-disease process[16].

In the participants' experience, it is understood that they rely on the support of the team through embracement and communication. To achieve comprehensiveness and humanization of care, health practices shall be based on embracement, dialogue, bonding, co-responsibility, and active listening between the professional and the health service user. It is understood that, through understanding and good communication, the user will become an active member of the rehabilitation team[12–15,17].

It should be added that, inembracement, qualified listening, and demonstration of respect and understanding of the

users' demands, the health professional can fulfill a large part of their expectations, thus building a relationship of bond, trust and support between them. Moreover, the professional can help them to conceptualize their problems, face them, visualize their participation in the experience and their solution alternatives, as well as helping them to find new patterns of behavior[17,18].

Study participants, when experiencing the process of education in rehabilitation, are able to find meaning in the instructions given and incorporate new practices into their daily lives. Thus, they advance in the search to use knowledge and empowerment for decision-making and the maximization of their autonomy and independence in theperformance of basic activities of daily living, in a conscious transition about what they are capable of doing and to successfully assume their new identities. The acquisition of knowledge and the learning of skills are considered important aspects in the rehabilitation process[10,19].

In the development of educational actions, the use of the dialogic pedagogical perspective is strongly recommended, as the objective is to promote a meeting of subjects who seek to reflect and transform existing knowledge, having as a starting point the concrete conditions of people's lives. This allows for a continuous and significant construction of knowledge through dialogue between popular and scientific knowledge, aiming at the development of autonomy and responsibility of individuals in health care[20,21]. The need to address themes that are meaningful and the use of an appropriate language that allows for the development of a critical reading of reality is also highlighted[22].

In view of this, the observation of difficulty in adherence to treatment calls for professionals to critically reflect on the posture, role and performance of the multidisciplinary team in the context of health education, which may be disconnected from reflective listening and from cultural and psychosocial demands that interfere with daily praxis. Adherence difficulties may reveal the necessary confrontations for people with disabilities, when recognizing that changes are slow, gradual, and with possibilities for advances and setbacks[23].

As a limitation of the study, we can point out that it is a theme that involves multiple meanings and that it is explored in only one reality. The present study, however, shows its relevance as it draws the attention to educational actions in the rehabilitation settings, an emerging and pertinent subject for contemporaneity, still little studied in national and international literature, which requires continuous in-depth study and improvement, aiming at its understanding and proper implementation.

CONCLUSION

Analyzing the experience of study participantsregarding education in the context of physical rehabilitation, it is found that aspects such as humanization of care, qualified listening, promotion of active user participation, good communication and embracement were experienced, promoting the feeling of support and favoring engagement in the rehabilitation process.

The model developed represents an advance on the theme of rehabilitation as it exemplifies that the education process promotes behavioral changes.

The rehabilitation settings proved to be a rich space in learning experiences, considering the different possibilities of encounter of people with disabilities, family members, and professionals from different specialties, which involves a plurality of knowledge and the possibility of exchanges. For educational actions, different teaching-learning strategies were used, which showed effectiveness, but suggested the need for better preparation, as evidenced by the report of resistance in the follow-up, justified by lack of adequacy to reality and lack of adherence.

RESUMO

Objetivo: Interpretar e construir um modelo teórico da vivência do usuário no processo de educação no cenário da reabilitação física. **Método:** Pesquisa qualitativa, pautada na Teoria Fundamentada nos Dados. O cenário foi um Centro de Reabilitação da Rede Lucy Montoro, localizado no interior do Estado de São Paulo. A coleta de dados ocorreu de janeiro a outubro de 2019, a partir de 28 entrevistas com três grupos amostrais. O processo de coleta e análise foi guiado por amostragem teórica. **Resultados:** Emergiram 122 códigos conceituais. Foi estabelecida como a categoria central "Vivenciando a educação na reabilitação"; como Condições, as categorias: contando com o apoio da equipe, e ponderando sobre a dinâmica de grupo; como Ações-Interações, a categoria: experienciando orientações; e como Consequências, as categorias: promovendo mudança de hábitos, e encontrando resistência no seguimento. **Conclusão:** A vivência no processo da educação na reabilitação indica tratar-se de uma ação que demanda comunicação adequada e acolhimento por parte da equipe. Nas atividades em grupo, embora existam trocas de experiências entre os integrantes, é necessário considerar a heterogeneidade das situações.

DESCRITORES

Reabilitação; Pessoas com deficiência; Educação em saúde.

RESUMEN

Objetivo: Interpretar y construir un modelo teórico de vivencia del usuario en el proceso de educación en el escenario de la rehabilitación física. **Método:** Investigación cualitativa, pautada en la Teoría Fundamentada en los Datos. El escenario fue un Centro de Rehabilitación de la Red Lucy Montoro, ubicado en el interior del Estado de São Paulo. La recolección de datos ocurrió de enero a octubre de 2019, a partir de 28 entrevistas con tres grupos de muestreo. El proceso de recolección y análisis fue guiado por muestreo teórico. **Resultados:** Se encontraron 122 códigos conceptuales. Fue establecida como la clase central "Vivenciando la educación en la rehabilitación"; como Condiciones, las clases: contando con el apoyo del equipo, y ponderando sobre la dinámica grupal; como Acciones-Interacciones, la clase: probando/ viviendo orientaciones y; como Consecuencias, las clases: promoviendo cambio de hábitos, y encontrando resistencia en el seguimiento. **Conclusión:** La vivencia en el proceso de la educación en la rehabilitación indica tratarse de una acción que exige comunicación adecuada y acogida del equipo. En las actividades grupales, aunque existan cambios de experiencias entre los integrantes, es necesario considerar la heterogeneidad de las situaciones.

DESCRIPTORES

Rehabilitación; Personas con Discapacidad; Educación en Salud.

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